THE GAT HANDBOOK
2011-2012

TENTH EDITION

Medical recruitment, training and working patterns have undergone major changes in the last few years, and the specialty of anaesthesia has not emerged unscathed. Thanks, largely, to the innovative approach of our specialty and our already well-organised training structure, we have been better prepared to weather these storms than many other medical specialties. However, evolution comes again, in the form of national recruitment, with the implementation of the 2010 Curriculum for CCT in Anaesthetics and the effects of Andrew Lansley’s White Paper.

The aim of this handbook is to help trainees negotiate their way along the many and varied paths, from appointment at CT1 to CCT, and finally to appointment in a consultant position in their chosen field. There is a wealth of well-researched information and advice contained within its pages, written by those who have been there and done it before. Whether you want to conquer the world of academic anaesthesia or leave the rat-race behind and take solace as an occasional-anaesthetist surfing by a beach on the other side of the world, you will find advice to aid you in your journey here.

If you think your career may progress along the staff grade, associate specialist or specialty doctor pathway then please read The SAS Handbook (www.aagbi.org/professionals/sas), also produced by the AAGBI. This handbook is edited by experienced SAS anaesthetists and gives excellent advice specifically aimed at staff grade, associate specialist or specialty doctors, highlighting the differences and implications of this rewarding career pathway.

We hope you find this collection of articles valuable; as ever, the GAT Committee appreciates your comments and feedback.

Good luck with the challenges that lie ahead, and we hope that the information here helps you on your path to a happy and fulfilling career.

Best wishes,
Kate McClung
GAT Chair 2011-

Kate McCombe Nicholas Love Editors 2011

Every effort was made to ensure that the information in this book was accurate at the time of going to press, but articles (particularly those to do with the organisation of training) have a tendency to go out of date, so you are advised to check with the appropriate organisation for the most up-to-date information.

Acknowledgements: We would like to thank the Medical Protection Society (MPS) for their generous support as sponsors of this publication. MPS is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world. MPS has a wealth of experience and expertise in helping doctors and other healthcare professionals with ethical and legal problems that arise from their practice. As a responsible organisation, MPS believes in the value of education and risk management. It is an integral part of the development of every healthcare professional.

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THE ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND (AAGBI)

OBJECTIVES & STRUCTURE

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) was founded in 1932. The AAGBI adopted a new constitution in 2008 and today its objectives are:

- to advance and improve patient care and safety in the field of anaesthesia and disciplines allied to anaesthesia
- to promote and support education and research in anaesthesia, medical specialties allied to anaesthesia and science relevant to anaesthesia
- to represent, protect, support and advance the interests of its members
- to encourage and support worldwide co-operation between anaesthetists

The AAGBI pursues these objectives with vigour and enthusiasm on behalf of both anaesthetists and the general public. Current membership stands at over 10,000, accounting for approximately 90% of anaesthetists in the UK. Trainees make up more than 3000 of these and are represented by the Group of Anaesthetists in Training (GAT) Committee. The headquarters of the AAGBI are at 21 Portland Place; an elegant, 18th century Grade II* listed building on London’s ‘Grandest Street’. The AAGBI’s former, HRH The Duke of York, officially opened the building in November 2003. It houses meeting rooms of various sizes, a restaurant and a museum, together with the busy administrative staff of the AAGBI.

The activities of the AAGBI are co-ordinated by a Council. Voting members of Council are the executive officers, elected members and the AAGBI chairman and honorary secretary. Council also has a number of non-voting co-opted members (presidents of the UK and Irish Colleges, convenors of the Scottish and Irish Standing Committees, armed forces representative, editor of Anaesthesia News, chairman of the SAS Committee and others). From October 2011, the voting members of AAGBI Council meet ten times a year. Meetings are also attended by the vice-presidents.

Branching out from these central strategic bodies are the standing committees of the Association, such as Education, Standards, Safety, etc., and the ever-changing number of working parties tasked with producing the popular AAGBI ‘glossies’. Collaboration with the other major anaesthesia organisations is facilitated by AAGBI representatives sitting on the Council of the RCoA and the Anaesthetic Sub-committee of the British Consultants and Specialists Committee of the British Medical Association (BMA). Within the Association is the AAGBI Foundation, a charity set up to administer grants and awards to trainees and consultants, to promote education and research, and on whose initiative the Overseas Anaesthesia Fund (OAF) was born.

WHAT EXACTLY DOES THE ASSOCIATION DO?

A large amount of the work of the AAGBI is in education and development within the specialty. Three scientific meetings are organised each year: Annual Congress (www.anualcongress.org) is the largest and takes place each September at a venue in either United Kingdom or Ireland. The WSM London (www.aagbi.org/education/events-search/) is held every January and includes a Core Topics day. The CAT Annual Scientific Meeting is in June/July (www.gatasm.org) and rotates around a Continuing Education Day jointly with the RCoA, as well as numerous seminars throughout the year. All events are open to all anaesthetists, but members of the AAGBI enjoy discounted rates. GAT also holds several in-house seminars on topics relevant to trainees. A recent innovation is the series of Core Topics days held outside London. (www.aagbi.org/education/events-search/CORE)

The AAGBI has a number of working parties in progress at any one time to set standards and address concerns within the specialty. These then produce a ‘glossy’ publication of their findings and recommendations. The 2010-11 working parties include those writing guidelines on ‘Ultrasound in Anaesthesia and Intensive Care’ and ‘Occupational Health and the Anaesthetist’, as well as revisions of the ‘Fatigue and the Anaesthetist’, and ‘Checking Anaesthetic Equipment’ publications. The ‘glossies’ are available on the website (www.aagbi.org/publications/publications-guidelines) or as hard copies from Portland Place.

In 2008, together with the RCoA, the journals Anaesthesia and the British Journal of Anaesthesia, the AAGBI formed the National Institute of Academic Anaesthesia (NIAA). NIAA (www.niaa.org.uk) is now the main source of funding for anaesthetic research in the UK. The NIAA has been awarded Partnership status by the National Institute for Health Research (NIHR). This means that many studies funded by the NIAA Research Council grants are adopted onto the NIHR portfolio and are eligible for support from the NIHR Comprehensive Local Research Networks. The AAGBI also bestows numerous grants and awards upon its members for research and travel through the Research & Grants Committee (www.aagbi.org/research/article). It also administers significant monies for projects in developing countries via the International Relations Committee and sponsors a number of overseas lectures. The Overseas Anaesthesia Fund (www.aagbi.org/international/overseas-anaesthesia-fund) aims to provide books and equipment to anaesthetists and anaesthetic assistants in developing countries.

Anaesthesia: Europe’s leading anaesthetic journal, is the monthly scientific journal of the AAGBI and is circulated to all members. With Anaesthesia comes Anaesthesia News, the newsletter of the AAGBI. It aims to keep members up-to-date with specialty news as well as taking a more light-hearted look at our specialty.

WHY DO WE HAVE A COLLEGE AND AN ASSOCIATION?

The AAGBI was responsible for introducing the Diploma of Anaesthesia and the Faculty of Anaesthetists to the
Royal College of Surgeons in 1948. This ultimately led to the formation of a separate College of Anaesthetists, which received its Royal Charter in 1992. The AAGBI and the RCoA have many objectives in common. However, the AAGBI can act in areas in which the RCoA cannot, for instance, in matters affecting the terms and conditions of service and in representing the interests of anaesthetists. Both bodies share the setting and maintenance of standards, the promotion of education and, more recently, areas such as the development of guidance on the European Working Time Regulations. Collaboration is, and needs to be, close on many issues. However, the RCoA, with its Royal Charter and Ordinances, is bound by statute to protect the public. It also has other statutory duties such as setting the fellowship exams, advisory appointments committees and duties to its fellows. The functions of the RCoA are therefore constrained by these statutes. The AAGBI, whilst sharing similar objectives, can act more obviously for the benefit of anaesthetists. Fortunately for us all, the RCoA and the AAGBI work closely and in harmony.

WHY JOIN THE AAGBI?
The membership fees are extremely good value, particularly for trainees, who enjoy a tiered subscription rate. Some of the benefits of membership are:

- Up to £1 million of free personal injury and life insurance cover for patient transfer
- Free subscription to Anaesthesia, the renowned international monthly journal
- Free monthly newsletter Anaesthesia News keeping you up-to-date with new developments
- Free fortnightly e-newsletter that keeps all grades of anaesthetists up-to-date with current developments and upcoming events
- Free access to the AAGBI’s guidelines
- Special rates for AAGBI scientific meetings including the GAT ASM
- Special rates for seminars at Portland Place

GROUP OF ANAESTHETISTS IN TRAINING (GAT)
GAT is a democratically-elected body that exists to represent trainees in anaesthesia at a national and international level. It is part of the Association of Anaesthetists of Great Britain and Ireland and all trainee members of the AAGBI are automatically members of GAT. The membership continues to grow year on year and currently runs at around 3000, accounting for over 70% of anaesthesia trainees within the UK, and accounting for approximately one third of the AAGBI membership.

The GAT Committee represents the views and perspectives of anaesthetic trainees on the Council of the AAGBI and a plethora of other committees and working parties. We also have representation on other national medical bodies such as the Anaesthetic Subcommittee of the Central Consultants and Specialists Committee and the Junior Doctors Committee of the British Medical Association (BMA). Information is relayed back to the membership primarily via the GAT website: www.aagbi.org/professionals/trainees

THE HISTORY OF GAT
Trainee anaesthetists were first permitted to become associate members of the AAGBI in 1956. However, they had no representation and no voting rights. In 1967, under the Association presidency of Dr Pinkerton, the Associates in Training Group was established, and a constitution drawn up. The elected committee of five trainees met twice a year to represent less than 100 members and initially had non-voting representation on Council. In 1970, the constitution changed: two
members of the trainees’ committee were admitted to Council with full voting rights, and all trainee members were given full voting rights within the AAGBI. The name also changed to the Junior Anaesthetists Group (JAG). In the early 1990s, as juniors became known as trainees, JAG became GAT and the number of elected members rose to ten. In the 21st century, GAT has around 3000 members, all of whom have voting rights within the AAGBI. An annual postal ballot of all GAT members is held to elect the committee of twelve and we meet four times a year. We have been representing trainees since before the formation of the Royal College of Anaesthetists and our work, and breadth of representation, has grown enormously. We have representatives from all over the UK and links with anaesthesia trainee bodies in Canada, Australia, New Zealand and Europe. We strive as a group to maintain transparency and accuracy through our work, allowing trainees to make their own informed opinions on issues that will affect them as professionals, both at the current time, and in their future.

ROB BROOKM头
Previous GAT Chairman 2010-2011

The College Council
The College Council is made up of 24 elected members:
• 20 consultant members who have been Fellows for more than four years: elected for a six year term of office, can be re-elected for a further 4 years
• Two specialty doctors (formerly known as SAS doctors): elected for four years, can be re-elected for a further four years
• Two trainee members within four years of gaining the fellowship: four year term of office only

The Council elects the president and two vice-presidents annually. The president can serve a maximum of three years (if re-elected) and the vice-presidents can serve for up to two years if re-elected.

Several co-opted members of the council represent the interests of other organisations, including the AAGBI, the RCoA’s Patient Liaison Group, a representative of NHS Trust clinical directors and a professional standards adviser.

The College Council meets monthly to discuss issues and determine College policy on challenges facing the entire medical profession, with particular relevance to their impact on anaesthetists. Such issues include revalidation, changes in government policy relating to healthcare, and other matters related to training, education and professional practice.

The Royal College of Anaesthetists (RCoA)
INTRODUCTION
The Royal College of Anaesthetists (RCoA) is responsible for ensuring the quality of patient care by educating, training and setting standards in anaesthesia, critical care and pain medicine. The Royal College Charter gives the College responsibility for administering examinations and continuing the medical education of all anaesthetists. Standards for training are achieved in conjunction with the General Medical Council (GMC).

THE COLLEGE COUNCIL
The College is also represented by its Council members on a large number of external committees, such as the AAGBI Council, GAT Committee, Academy of Medical Royal Colleges and the Faculty of Intensive Care and Pain Medicine. In addition, the College is asked to contribute to various working groups and publications from the wider healthcare community such as the GMC, Conference of Postgraduate Medical Deans (COPMed), Department of Health (DoH), Centre for Maternal and Child Enquiries (CMACE) and National Confidential Enquiry into Patient Outcome and Deaths (NCEPOD).

COLLEGE STAFF AND VOLUNTEERS
A little recognised aspect of the RCoA is that the College employs over 50 administrative staff, whose responsibilities are divided between 4 operational directorates:
• Professional Standards
• Education
• Training and Examinations
• Office of the College Secretary

In addition to the valued work of these employed staff members, the fact that the College is able to administer its various duties is due to the significant contribution of a large number of volunteers. For example, ensuring the delivery of high quality training is the responsibility of over 300 college tutors and 50 regional advisers; there are also nearly 400 assessors who advise on consultant appointment committees.

TRAINEE ISSUES
THE CURRICULUM AND EXAMINATIONS
The College is responsible for writing the curriculum for training of anaesthetists in the UK. As a result of changes to regulations set by the GMC, the curriculum was re-written in 2009 and implemented nationally over the course of 2010-11. The College used the curriculum review as an opportunity to modernise the training programme to reflect changes in the practice of anaesthesia and the methods used to assess the knowledge, skills, attitudes and behaviours of anaesthetists in training.

As a result of consultation with medical educationalists, and in keeping with recommendations by PMEB and subsequently the GMC, several changes have also been made to the structure of the examinations over the past few years, including the removal of ‘negative marking’ in the MCQs and changes to the marking scheme for the SAQ and OSCE examinations. The college makes no profit from the examinations; the fee reflects the level of planning and manpower that is required to run the examinations fairly and efficiently. Over 130 examiners volunteer annually to conduct the examinations and over 160 visitors come to observe and provide feedback on the process. The Examinations Committee is committed to a rigorous quality assurance process to ensure that the examinations are as fair and reproducible as possible.

NATIONAL RECRUITMENT TO ANAESTHESIA TRAINING
In 2009, the Department of Health stipulated that recruitment to training in medical specialties be coordinated nationally. In 2010, all CT2 and ST3 posts were appointed by the national recruitment programme which was run by the RCoA in liaison with the NHS West Midlands Workforce Deanery and the DoH. In 2011, co-ordinated recruitment was applied to all points of entry for anaesthesia (CT1, CT2, ST3) and CT1 entry to ACCS programmes. A great deal of work and collaboration
between the College and other stakeholders, including the Deanseries and the many consultant anesthetists involved in short-listing and interviewing, has ensured that the 2010 process avoided the problems of the previous DoH-led national recruitment programme, the Medical Training Application Service, or MTAS. Further information on the recruitment process can be found on the RCoA and MMC websites. The RCoA provides information about national recruitment on its website, which can be accessed from the Training section: http://www.rcoa.ac.uk.

TRAINEE REPRESENTATION WITHIN THE RCoA

Until the end of 2010, trainee representation within the RCoA consisted of the two elected Council members, and the Trainee Advisory Group (TAG) which has a membership chosen to represent all years of training, specialist interests and all four devolved nations. The increasing workload placed on the trainee membership elected by registered doctors. The current Council consists of 12 doctors and 12 lay people. Appointments were made by the Public Appointments Commission. The membership consists of 12 doctors and 12 lay people. Historically, the Council was much larger and included membership elected by registered doctors. In order to practise medicine in the UK a doctor must be registered with the GMC and hold a licence to practice. In recent years proposals have been advanced (currently subject to further piloting) that retention of a licence to practice would be subject to the process of ‘revalidation’ every five years. It is likely that revalidation will take place every 5 years and be based on appraisal/ARCP and review of local robust clinical governance systems. A doctor can remain on the medical register and call themselves ‘Dr’ by paying a reduced registration fee, but not retain the privileges of being a doctor; these doctors do not have a licence to practice.

The GMC sets standards for the medical profession. The most current set of standards can be found on the GMC website (http://www.gmc-uk.org/guidance/index.asp) including Good Medical Practice and a number of specific and more detailed sets of guidance in many areas including ‘Consent’ and ‘Cardio-Pulmonary Resuscitation (CPR)’. Any doctor coming under the scrutiny of a Fitness to Practice panel will have their practise compared to these formal guidance documents. All doctors should be aware of their existence and refer to them regularly.

The duties of a doctor are described in ‘Good Medical Practice’ under a number of headings:

- Good clinical care
- Maintaining good medical practice
- Teaching and training, appraising and assessing
- Relationships with patients
- Working with colleagues
- Probity
- Health

In 2010 the GMC increased its role, input and function when work and remit of the PMETB was transferred to the GMC. Currently, the GMC regulates medical school recognition and curricula and has recently produced guidance for medical students, ‘Tomorrow’s Doctors’. It continues to be responsible for the foundation years and now has an enhanced role in postgraduate education.

The GMC is currently responsible for the investigation, adjudication and prosecution of doctors under its Fitness to Practise procedures. Any relevant complaint received is allocated to a Stream depending on its seriousness. A Stream One complaint is the most serious and will often refer urgently to an Interim Orders Panel which will convene to review a doctor’s registration within 21 days of initial receipt of the complaint. An IOP has the power to suspend a doctor’s registration for up to 18 months whilst the GMC investigates their fitness to practise. Only seven days’ notice of an IOP hearing needs to be issued to a doctor before such a hearing takes place. A Fitness to Practise panel will ultimately consider a doctor’s fitness to practise and can erase them from the register in the most serious case.

In late 2010, the government announced the abolition of the Office of Healthcare Professions Adjudication (OHPA) in a “bonfire of quangos”. Adjudication will therefore remain with the GMC, although the composition of panels is being reviewed in 2011, and is likely to result in a tribunal format in the future, with a legally qualified chairman, a medical member and a lay member adjudicating on a doctor’s fitness to practise. Further plans are under consultation during 2011 to move most of the Fitness to Practice panels, and many GMC staff, from London to Manchester.

THE GENERAL MEDICAL COUNCIL (GMC)

Most doctors know the GMC for two reasons: it is the body that registers them and issues their licence to practise (current fee: £420 annually) and the body that may discipline them via formal Fitness to Practise procedures. The GMC currently however has four main functions:

- Registration of doctors
- Setting of standards for doctors
- Educational role – undergraduate (longstanding), foundation programme (longstanding) and postgraduate (more recent since the assimilation of PMETB into the GMC)
- Regulation of doctors’ fitness to practise

The GMC is statutorily bound by the Medical Act 1983, most recently revised by 2004 and 2008 Amendments. The main governing body of the GMC is its Council, an appointed body of 24 members. The current Council was appointed from January 2009. Appointments were made by the Public Appointments Commission. The membership consists of 12 doctors and 12 lay people. Historically, the Council was much larger and included membership elected by registered doctors.

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For example, did you know that: contracts.

Your contract, know your rights is covered here: Make billions of efficiency savings in order to get U.

The contract campaign, ‘know the workplace.

Important over the coming years as Government seeks

To make billions of efficiency savings in order to get U.

The contract campaign, ‘know the workplace.

Regional Representation

The Regional Junior Doctors Committee (RJDc) represents junior doctors at a regional level in Scotland and England. In Northern Ireland and Wales there are no RJDcs and this representation occurs at a national level via Northern Ireland JDC (NJDC) and Welsh JDC (WJDC). NJDC, WJDC, Scottish JDC (SJC) and English RJDc elect reps to JDC (UK). The four RJDcs in Scotland elect reps to SDC rather than JDC (UK).

RJDcs meet four times a year and, in England, roughly correspond to deanery/strategic health authority boundaries, although there is some overlap. National JDCs also meet four times per year and both RJDcs (in England) and national JDCs take issues forward to JDC (UK).

The RJDc meetings are open to junior doctors living or working in that region, whether BMA members or not. RJDc meetings allow junior doctors to ask for advice, to receive updates on national issues, and to contribute to the debate at SDC and JDC (UK) through their elected members.

The BMA website contains links to each RJDc and national JDC (except SDC) including dates of meetings and minutes of previous meetings as well as ways to contact each committee: bma.org.uk/rdc. Further information on SDC can be obtained by visiting the BMA Scotland web pages: www.bma.org.uk/sc/.

BMA MEMBER BENEFITS

REPRESENTATION

The BMA is officially recognised by Government and by the Doctors’ and Dentists’ Review Body as the only organisation representing the views of all NHS doctors employed under national agreements. The BMA has sole bargaining rights for those doctors, whether or not they are members and has represented doctors in negotiations since the beginning of the NHS in 1948.

National and local negotiation terms and conditions of service ensure that doctors’ employment rights are protected.

EMPLOYMENT SUPPORT

If you have an employment query regarding contracts, pay, leave, working relationships, rotas or discrimination then you can contact the BMA on 0300 123 1233, email support@bma.org.uk or fill in the online enquiry form via the website. The phone line is staffed from Monday to Friday 8:30am – 6:30pm. Advisers aim to dealing with enquiries when you first contact them.

Further information can be found here:

www.bma.org.uk/careers/index.jsp

ETHICAL ADVICE

The Medical Ethics Department offers comprehensive ethics advice in response to enquiries from individual doctors. The team are on hand to respond to calls and emails from members. In addition to case-specific, personal advice the department also produces written guidance for members, available via the BMA website or the library, on a variety of ethical issues and aspects of medical law.

IF YOU WANT TO GET INVOLVED, HOW DO YOU DO IT?

LOCAL REPRESENTATION

The BMA aims to meet at least one junior doctor per employer as a BMA representative, to represent colleagues at the employer’s level, and to help solve work-related problems for its members.

The role involves providing advice (e.g. on pay, monitoring, accommodation standards and travel expenses) and attending local negotiating committee meetings, where doctors of all grades and managers meet to negotiate any variations from the nationally agreed contract.

Full training and access to several guides for representatives are provided, as well as who to contact to get further information.

The BMA Careers Service provides information and guidance. Career Essentials has modules on portfolios, time management and working relationships. Further information can be found here:

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www.bma.org.uk/careers/index.jsp
NATIONAL REPRESENTATION

JDC (UK) meets in London and represents all junior hospital doctors in the UK. It has sole negotiating rights with HM Government for all doctors in training employed in the NHS. JDIC, NJICD and SDIC provide valuable input on ‘quadrinational’ issues to JDC (UK) as well as negotiating independently within Wales, Northern Ireland and Scotland. If you wish to attend a JDC (UK) meeting as a visitor then this can be arranged by emailing info.jdc@bma.org.uk.

JDC (UK) has subcommittees responsible for education and training (E&T) and negotiation of terms and conditions of service (Negi) for junior doctors. These two subcommittees make up the executive committee of JDC (UK) which meets more regularly and carries out the day to day work of the committee. Reps are sent from JDC (UK) to committees within the wider BMA and also to organisations outside the BMA.

There are other opportunities to influence the policy of the BMA nationally including attendance at the Junior Members Forum (JMF), the Junior Doctors Conference and the Annual Representative Meeting.

If you want to get involved, go to your RJDC meeting, attend JDC (UK) as a visitor, or apply for a place at the JMF or the Junior Doctors Conference. You will be made most welcome.

CONTACTING THE BMA

The BMA website (bma.org.uk) has most of the information you may need. If you cannot find what you are looking for then call 0300 123 1233 or email support@bma.org.uk or info.jdc@bma.org.uk and someone will get back to you. It has never been easier to tell the BMA what you think or to keep up to date with what is going on. Let the BMA know what you want from it – either on the discussion pages of YouTube or via Facebook and Twitter:

youtube.com/bmuy
facebook.com/thembA
twitter.com/TheBMA

Christopher Smith
Previous BMA JDC representative to CAT 2009-2010
SJR, East Coast School of Anaesthesia

MEDICAL EDUCATION ENGLAND

Medical Education England (MEE) is an Independent Advisory Non-Departmental Public Body with a remit for medicine, dentistry, pharmacy and healthcare science. It was established after the Tooke report through the original vision of MEE holding the budget for training (as does its Scottish counterpart, NES) was shelved in favour of a wholly advisory body. In addition, nursing and midwifery education were taken out of its remit.

Among its thirty members are four representatives of the medical profession from the BMA, several presidents of medical Royal Colleges, representatives of the GMC, undergraduate and postgraduate deans and similar office holders for the other professions, and the Department of Health and patient representatives. MEE has oversight of the places where the real work and number-crunching is done: the four Programme Boards, including the Medical Programme Board.

The MPE is responsible for ensuring that:
1. training posts are filled by high quality and appointable candidates
2. the principle of curriculum-based training is supported and delivered
3. training is supported by capacity in the service to deliver training to a high standard
4. the needs of academic medicine are recognised in order to promote the excellence of medical care
5. progress is monitored, and risks to delivery are reviewed regularly and managed within acceptable levels

In practice, this is where decisions on training numbers and programmes are made. Two of the greatest challenges facing the MPE at present are the two significant overproductions: those of more doctors than there appear to be career posts for, and in particular of more CCT holders than consultant opportunities. Both these look set to be long term threats to the stability of medical professional structures.

According to its website, Medical Education England "represents the greatest opportunity since the establishment of the NHS in 1948 to align professional training, education and workforce needs with the needs of the service and patients". It may well develop that opportunity in the future; at present MEE has yet to find its feet and establish an indispensable role.

Mark Porter
Chairman of the BMA Consultants Committee, Member of NHS MEE
Consultant, University Hospitals Coventry and Warwickshire NHS Trust
ANAESTHETIC TRAINING, COMPETENCIES AND ASSESSMENTS

TRAINING

Recently, there have been dramatic changes to postgraduate medical training in general and anaesthesia has not escaped this process. There has been an overhaul of training grades, the introduction then abandonment of run-through training and now the introduction of the 2010 Curriculum for a CCT in Anaesthetics. This new curriculum has been radically rewritten to comply with the document Standards for Curricula and Assessment published by PMETB in 2008. The RCoA has taken this opportunity to introduce new units of training and to revise or merge others to reflect changes in anaesthetic practice and service needs. The new anaesthetic training programmes aim is to produce “well-trained, high quality clinicians, with the broad range of clinical leadership and management skills and professional attitudes necessary to meet the diverse needs of the modern National Health Service [NHS] and who can embark upon safe, independent practice as consultant anaesthetists in the United Kingdom [UK]”.

This current anaesthetic training programme as overseen by the RCoA is described as “a competency-based, supervised, continuously evaluated and tightly regulated programme, with the potential for tailoring to suit individual requirements and interests”.

WHAT IS COMPETENCE?

The Royal College of Anaesthetists (RCoA) defines competence as: “possession of the knowledge, skills and attitudes required to undertake safe clinical practice at a level commensurate with stated objectives.” The Oxford English Dictionary enlightens us with this definition: Competence n. Ability: the state of being competent. Competent adj. 1) adequately qualified or capable; 2) effective. It was generally accepted that an anaesthetic trainee who passed the Fellowship of the Royal College of Anaesthetists (FRCA) exam and spent the required amount of time in approved training posts would obtain a Certificate of Completion of Training (CCT ) that entitles admission to the specialist register and, for example, go on to become a consultant. Occasionally, remedial action was necessary, and methods for identifying this need varied considerably between regions and were poorly validated. In recent years, it has been increasingly recognised that time spent training does not automatically equate to the ability to do the job (i.e. competence). The introduction of competency-based training in anaesthesia occurred in the late 1990s, along with changes in the specialist registrar (SpR) training programme, and an increase in the length of SpR training from four to five years following the Calman reforms. All anaesthetic trainees are now trained in this way and an understanding of these basic principles should help to maximise your training opportunities and avoid any potential pitfalls.

TRAINING

Anaesthetic training can be broadly summarised as follows:

- the recommended minimum duration of training is normally seven years
- two years of basic level training (CT1 and 2)
- two years of intermediate level training (ST1 and 4)
- three years of higher level training (ST 5-7)

The actual duration of training is not fixed to seven years, but will depend on individual needs and the rate at which the competencies are achieved.

The objectives of training are grouped into four stages of learning and, within these, they are organised by surgical sub-specialty or anaesthetic focus. In addition, there are a group of general outcomes that are listed separately as 'professionalism and common competencies in medical practice'.

TRAINING CONCEPTS: SPIRAL, BROAD-BASED FLEXIBLE AND EXPERIENTIAL LEARNING

The new curriculum is built around spiral learning where trainees return to areas they sub-specialize a number of times over the years allowing them to gradually build on their basic knowledge. Flexibility is maintained within the anaesthetic trainees who chose more specialise until their later years of training; this will allow the specialty to respond rapidly to the changing face of medicine.

Finally, practical skills are learnt through repetition and not all trainees are expected to acquire the same advanced skills. For this reason, advanced and higher competencies have evolved.

COMMON COMPETENCIES OF MEDICAL PRACTICE REQUESTED BY ALL DOCTORS

The trainee must also develop general professional knowledge, skills, attitudes and behaviours required of all doctors. Twelve domains have been identified covering professionalism and common competencies. These are as follows:

- Professional attitudes and behaviours
- Clinical practice
- Team working
- Leadership
- Innovation
- Management
- Education
- Safety in clinical practice
- Medical ethics and confidentiality
- Relationships with patients
- Legal framework for practice
- Information technology

For further information please see www.rcoa.ac.uk
THE ANAESTHETIC TRAINING PROGRAMME

FOUNDATION YEARS 1 & 2

Many doctors will pass through anaesthetic departments for a few months as part of their foundation training (FT) programme, but their numbers are necessarily limited by their inability to participate in on-call rota. Some of them may return to anaesthesia in the future having achieved relevant competencies during time in other specialties.

THE IMPORTANT ANAESTHETIC TRAINING MILESTONES....

✱ Initial assessment of competence (first 6 months).
✱ Initial assessment of competence in obstetric anaesthesia (within first 2 years).
✱ Primary FRCA examination (in years 1 and 2).
✱ Basic level training certificate (end of year 2).
✱ Final FRCA examination (in years 3 and 4).
✱ Intermediate level training certificate (end of year 4).
✱ Complete higher and advanced essential units of training.
✱ Advanced special interest units of training relevant to ultimate area of practice.

BASIC LEVEL TRAINING (CORE TRAINING YEARS 1 & 2)

This is divided into two parts:
✱ The basis of anaesthetic practice (normally three to six months).
✱ Basic anaesthesia (including three months of ICM) which is normally 18 to 21 months

The initial training of novice anaesthetists has remained similar to the previous format and is an introduction to the principles and practice of safe anaesthetic care. The basis of this training consists of the following units:
✱ Preoperative assessment including history taking, clinical examination and specific anaesthetic evaluation
✱ Premedication
✱ Induction of general anaesthesia
✱ Intra-operative care
✱ Postoperative and recovery room care
✱ Management of respiratory and cardiac arrest
✱ Control of infection
✱ Introduction to anaesthesia for emergency surgery

Trainees are expected to have achieved all of these minimum clinical learning outcomes and obtained the Initial Assessment of Competence before progressing to the remainder of basic level training. In practice, this will take between three and six months for most trainees. The formal Initial Assessment of Competence, leading to a compulsory certificate (IACC), must be completed satisfactorily to enable trainees to undertake anaesthetic activity without direct supervision. This usually occurs about three months into the training scheme, although the RCoA are keen to stress that the emphasis during basic level training is on competence not on time. Trainees arriving in the UK having worked elsewhere will still be obliged to pass this assessment before undertaking any solo work or participating in an on-call rota.

Basic anaesthesia training will normally last eighteen to twenty-one months and provide a comprehensive introduction to all aspects of elective and emergency anaesthetic practice. Basic level training competencies must be achieved in both anaesthesia and intensive care medicine (ICM) in order to obtain the Basic Level Training Certificate (BLTC), usually at the end of CT Year 2. These competencies include passing the Primary FRCA exam and all workplace assessments, demonstrating acceptable attitudes and behaviour, and spending a three-month block in ICM.

INTERMEDIATE LEVEL TRAINING (ST YEARS 3 & 4)

This period of training will normally last twenty-four months and is based on the principle of ‘spiral learning’; trainees are required to gain intermediate level competencies in all the units of training undertaken in basic level training as well as in important new, and often complex areas, of clinical practice e.g. anaesthesia for cardiac surgery. Intermediate competencies have been subdivided into seven essential units and three ‘optional units’. At the end of ST Year 4 trainees will receive an Intermediate Level Training Certificate (ILTC) having passed the Final FRCA, continued to demonstrate acceptable attitudes and behaviour, and passed all the required workplace assessments. Some local flexibility may be required in order for trainees to gain adequate exposure (usually one to three-month blocks) to the essential units; training across anaesthetic schools or deferment of specific named units may be considered.

The seven essential units of training are:
✱ Anaesthesia for neurourology, neuroradiology and neurocritical care
✱ Cardiothoracic
✱ Intensive care medicine
✱ General duties, which consists of:
  o Airway management
  o Day surgery
  o Critical incidents
  o General, urology and gynaecology
  o Head, neck, maxillofacial and dental surgery
  o Management of respiratory and cardiac arrest
  o Non-theatre
  o Orthopaedic surgery
  o Regional
  o Sedation
  o Transfer medicine
  o Trauma and stabilisation
✱ Obstetrics
✱ Paediatrics
✱ Pain medicine

The three optional units of training are:
✱ Ophthalmic
✱ Plastics/burns
✱ Vascular

HIGHER & ADVANCED LEVEL TRAINING (ST YEARS 5, 6 & 7)

After acquisition of the ILTC, as above, the primary aim now is “to produce trainees competent for independent professional practice in their chosen consultant career path.” The RCoA points out that training opportunity must be balanced with anticipated career vacancies. All trainees must undertake a generalist pattern of training within a broad and balanced programme, but this stage is designed to be more flexible and tailored than basic and intermediate level training programmes. In order to attain consultant status, every trainee must complete the full higher and/or advanced programme of training which will have included at least nine months of ICM (see above). At least one year should be spent undertaking general duties, and at least two of these three years must be spent in approved training or research posts within the UK. Up to one year may be spent either outside the UK in a prospectively approved post, and/or in full-time dedicated work in a single specialty area. Only one year of full-time research can count towards a CCT.

An example of a clinical programme may consist of:
✱ Higher training programme - three-month blocks in a
The five essential units of training are:

- Anaesthesia for neurosurgery, neuroradiology and neurocritical care
- Cardiothoracic
- Intensive care medicine
- General duties, which consists of the following sub-units, of which a minimum of four must be done by all trainees: [those marked with an asterisk are essential for all trainees]:
  - Day surgery
  - General and urology surgery
  - ENT, maxillofacial and dental surgery
  - Management of respiratory and cardiac arrest*
  - Obstetrics
  - Orthopaedic surgery
  - Regional
  - Sedation
  - Non-theatre
  - Transfer medicine
  - Trauma and stabilisation
  - Vascular
- Paediatric anaesthesia

The eight optional higher units of training are:

- Ophthalmic
- Pain medicine
- Plastics/burns
- Pre-hospital care
- Anaesthesia in developing countries
- Conscious sedation in dentistry
- Military anaesthesia
- Remote and rural anaesthesia

The five advanced units of training are:

- Anaesthesia for neurosurgery, neuroradiology and neurocritical care
- Cardiothoracic
- General duties, which consists of the following sub-units, the exact number undertaken will depend upon individual trainee choice in discussion with the TPD and other trainers:
  - Airway management*
  - Airway management
  - Anaesthesia for hepatobiliary surgery
  - Day surgery
  - General, urology and gynaecology
  - ENT, maxillofacial and dental
  - Orthopaedics
  - Ophthalmic
  - Regional
  - Sedation and sedation in dentistry
  - Transfer medicine
  - Trauma and stabilisation
  - Vascular
- Intensive care medicine
- Obstetrics
- Paediatric
- Pain medicine
- Plastics/burns

In order to achieve a CCT it is necessary to complete all training in a P nộiTIR-approved training programme, be registered as a trainee with the RCoA and complete the minimum training to a satisfactory standard.

HOW DO YOU KNOW IF YOU ARE COMPETENT?

Assessments...

Anaesthetic training requires a robust and validated assessment programme. Knowledge is assessed via the Primary and Final FRCA exams, but these also have the ability to look at trainee decision making skills. Trainee knowledge is also tested using WPBAs and simulation. The RCoA has developed a set of workplace-based assessments (WPBAs), which are blueprinted against the new curriculum; every learning outcome in the curriculum is matched to at least one possible assessment.

The anaesthetic WPBA tools used are:

- Anaesthetic Clinical Evaluation Exercise (A-CEX)
- Anaesthetic List/Clinic/Ward Management Assessment Tool (ALMAT)
- Acute Care Assessment Tool for ICM (ICM-ACAT)
- Direct Observation of Procedural Skills (DOPS)
- Case Based Discussion (CBD)
- Multi-Source Feedback (MSF)
- Clinical Supervisors end of unit Assessment Form (CSAF)

Skills, attitudes and behaviour are assessed using the above tools and documentation and an up-to-date electronic logbook should also be maintained. All of these are used to inform the ARCP (Annual Review of Competence Progression) process and allow trainee progression to the next year of anaesthetic training.

WHAT ARE THE MAIN PITFALLS?

The fact that documentation is of central importance to making competency-based training work cannot be overemphasised. Good organisation and awareness of what is required will make a potential headache much easier to deal with. It is better to ensure that all paperwork is up-to-date and complete before leaving a post, as chasing people, and paper, once you have moved on can be difficult. Incomplete paperwork may result in delays in completion of your training. This advice is particularly pertinent to trainees who transfer between deaneries and consequently, have assessments from more than one region, and also to flexible trainees for whom calculating training time and a subsequent CCT date accurately, can be more difficult. Trainees in LT/ FTAA or Fixed Term Specialist Training Appointment (FSTAA) posts will also need to ensure that all workplace assessments are correct and complete for their time in post to be taken into consideration towards a CCT. Accurate electronic logbook data are extremely important in these days of reduced case exposure, so that any gaps in training can be picked up and dealt with promptly. In the current climate an up-to-date portfolio containing evidence of education and training (courses attended, presentations given etc) is essential and will impress upon your trainers that you are well organised and motivated.

WHAT DO I DO IF I HAVE A PROBLEM WITH GAINING MY COMPETENCIES?

Problems are easier to solve if they are identified early and taken to the appropriate people. By following the above advice you should be able to spot any difficulties early. Your first port of call should be your educational supervisor or college tutor, and regular appraisal with them will be invaluable in this respect. If problems remain or are not dealt with to your satisfaction then your programme director or regional advisor should be able to help. The main thing is to be pro-active in
LESS THAN FULL TIME TRAINING

Getting that work-life balance right when starting a new family, supporting an unwell relative or possibly even training for a competitive sporting event can be difficult when faced with a 48 hour training week and all the pressures that training presents. There are many reasons why trainees may wish to train Less Than Full Time (LTFT) and this article will explain a little more about LTFT training.

Some form of working less than full time has been available within the NHS since 1979. At this time it was on an individual contract that was negotiated between the trainee and the trust in a very ad hoc fashion. It was not until 1993 that the possibility of training LTFT became nationally accepted and it has subsequently been written into EU law. The EU law (Employment Act 2002) now states that any worker with young children (<17 soon to become <18) can request part time working and that refusal must be for a sound business reason and given in writing.

There are currently over 3000 LTFT trainees in the NHS and some 232 of these are training in anaesthetics. The PMETB survey of 2008 found that 22% of core trainees stated they feel they will want to train less than full time in the future, so we are likely to encounter an increased demand for it. Some specialties appear to attract more LTFT trainees than others and anaesthetics has always been a popular specialty for LTFT training.

With demand increasing there is the inevitable pressure on the resources available for LTFT training. Currently 13 of the 25 schools of anaesthesia are restricting the percentage of work that can be undertaken on a LTFT basis for this reason1. It may be that in your region you have no choice in what percentage whole time equivalent you are allowed to work, for this reason.

All trainees are eligible to apply for LTFT training. Formally, those wishing to do so must demonstrate a well-founded individual reason (category 1 see below) and hold a NTN/SIT training post. If you do not hold one, it must be obtained first and it is worth noting that during your subsequent interview you are not obliged to declare any intention to train on a LTFT basis. The Conference of Postgraduate Deans (COPMED, www.copmed.org.uk) has agreed the following categories to serve as guidelines for prioritising requests for LTFT training. The needs of trainees in category 1 will take priority. These two categories are not exhaustive and all reasons will be considered. However, financial constraints may limit the number of successful applications and category 1 requests will be given priority.

Category 1
- Disability or ill health (this includes those on IVF programmes)
- Responsibility for caring (men and women) for children
- Responsibility for caring for ill/disabled partner, relative or other dependant

Category 2
- Unique opportunities for their own personal/professional development
- Religious commitment
- Non-medical professional development

Most schools of anaesthesia have information on their website informing trainees of how to apply, but the most invaluable source of information is fellow colleagues already training LTFT. Each deanery has an associate dean or another individual with a specific responsibility and budget for LTFT training. This associate dean for LTFT training should be contacted first and they will assess your eligibility for LTFT training, as specified by the categories listed above. They may want to see you for an interview and require a copy of your CV. Once you are confirmed by the associate dean to have a well founded reason for training LTFT they will write confirming this to you and to your anaesthetic flexible advisor.

Your anaesthetic flexible advisor will then discuss your proposed rotation to ensure it meets the RCoA requirements. Your rotation should reflect the balance of training your full time colleagues receive.

Once you have been allocated a LTFT training position it can be funded in different ways and the way in which you work will depend on this. Funding can be:

Supernumerary: an individual post is created for a named person who is placed as an additional trainee within a department

Job-share: where two trainees are put into one full time post. Here the trainees must be of the same ability and require the same clinical experience, i.e. both senior registrars requiring an ICM module. This does not create much flexibility for departments and is not favoured

Slot-sharing: where more than one individual working LTFT is placed within a training ‘slot’ in a department.

REFERENCES:

LIZ SHEWRY
Previous GAT Vice-Chair 2008-2010
SpR, Wessex
This allows funding to be given to two trainees at any stage of training to be placed on different rotas with different emphasis. Full time slot: it is also possible to work reduced hours in a full-time slot.

The impact of the European Working Time Regulations has made that those trainees working 50%; now work 24 hour week. This has raised concern amongst LTFT trainees, trainers and the RCoA regarding the acquisition and retention of clinical skills. Recently the London LTFT Training Group conducted a national survey of LTFT trainees. They received a 71% response rate and reported a correlation between hours worked and self-reported clinical competence. Those trainees working fewer hours felt their competence was lower, perhaps reflecting lower confidence levels in those trainees who work 24-28 hours. Clearly, many factors affect the development of clinical competence, and the interplay of these factors merits further investigation when training on a LTFT basis. The RCoA is currently reviewing whether they should set a recommended minimum number of hours of work for LTFT trainees. For now, the RCoA have issued a mission statement reflecting lower confidence levels in those trainees who feel like this at some point. There are definite disadvantages and hurdles to overcome when training LTFT. The hurdles are just different, not additional, when compared to training full time. Often identifying them early is the key and regular communication amongst your LTFT colleagues is invaluable.

Mostly I am grateful for the opportunity LTFT training has given me in being able to balance being a mother with being an anaesthetist. I have always loved working within the field of anaesthetics and feel privileged that I have been allowed to combine this with time for my family.

REFERENCES
1. London LTFT training Group. Training survey presented at the RCoA ‘making part time work’ seminar

USEFUL RESOURCES:
BMA General information on ‘flexible working’:
www.bma.org.uk/employmentandcontracts/working_arrangements/flexible_working

RCoA Less Than Full Time training page:
http://www.RCoA.ac.uk/index.asp?PageID=1486

GAT LTFT RESOURCE:
GAT’s LTFT committee member, Sarah Gibb, along with her colleague Stella Carey, have produced a new document entitled: “Less than Full Time Training in Anaesthesia: An A to Z Guide”. This is free to download from our website and gives detailed information about LTFT in Anaesthesia.

www.aagbi.org/professionals/trainees/training-issues/ ltft-training

Susan Williams
Previous GAT Committee LTFT Rep 2005-2011
SpR, Wales

APPLYING FOR TRAINING IN ENGLAND
Medical training and recruitment has undergone major changes following MMC. This handbook is updated biennually and so the following information may be out of date. To get current information about the application process look at the Medical Specialty Training (England) website www.mmc.nhs.uk. Several useful documents are available from this website including ‘Quick Guide to recruitment to medical specialty training in England in 2010’. An overview of recruitment from choosing a specialty to the application process.

The RCoA website (www.rcoa.ac.uk) contains excellent anaesthesia-specific advice (look under professional training>> recruitment).

CHOOSING A SPECIALTY
A careers advice service for doctors has recently been launched (www.medicalcareers.nhs.uk). If you have not been convinced that anaesthesia offers the best career choice for you, information is available on other specialties. The website has advice for doctors at various stages in their careers and useful links to other websites such as the Royal Colleges and MRCGP.

GAT has recently published a guide called ‘Who is the Anaesthetist?’. It contains advice about career choices aimed at medical students and foundation doctors (www.aagbi.org/professionals/trainees/gat-publications). If you would prefer to speak to a person then GAT has a stall at the BMJ Careers Fair held every October in London.

POINTS OF ENTRY TO ANAESTHESIA
Foundation doctors can apply to basic core anaesthesia training via two programmes: Core Anaesthetic Training (CT) and Acute Common Care Stem (ACCS) training. Core training comprises two years of anaesthesia whilst ACCS is a three year programme, including six months of intensive care medicine and 18 months of anaesthesia (the other year being a combination of acute and emergency medicine). Anaesthesia training is uncoupled; after completion of basic core training it is necessary to repeat the application process to enter a five year specialty training programme (ST1-7) that leads to the Certificate of Completion of Training (CCT). The ACCS route into anaesthesia may be appealing for those seriously considering a career involving intensive care medicine, since it provides the necessary complimentary specialties.

MAXIMISING YOUR CHANCES
Preparation is the key to being successful in your application. Information on the person specifications for CT, ACCS and ST posts are readily available online at www.mmc.nhs.uk. Review these to ensure you meet all the essential criteria and have addressed them in your application form. The Medical Specialty Training (England) website also gives details on the numbers of posts available and applicants to each deanery. You may wish to take advantage of these to guide the posts you apply for. Information on each the application process can be obtained from either an individual school website or the corresponding deanery website. Alternatively advice may be sought from the RCoA college tutor in your hospital or the regional advisers and training programme directors of schools you may wish to apply for.
THE APPLICATION PROCESS

Traditionally each deanery has advertised, shortlisted and interviewed for their training posts. In 2010 anaesthesia piloted national recruitment for CT2 and ST3 posts, co-ordinated by the West Midlands Deanery. These posts were advertised in the BMJ and on NHS Jobs. Applications were made via a central electronic portal administered by the co-ordinating Deanery. Applicants could apply to two units of application (UoA). Long listing was performed by the West Midlands Deanery to remove any applicants who were ineligible for appointment on the basis of GMC status, level of experience or standard of written and spoken English. Short-listing was performed by each of the two UoAs to which the candidate had applied and was conducted according to a nationally agreed standard. A common application form was used in 2010 and this was revised for 2011. National recruitment has been now adopted for all CT and ST appointments to anaesthesia. It is also likely that this will extend to schools in Scotland.

In 2010 all offers of appointment were made by the coordinating deanery through an electronic portal. For candidates unsuccessful in the first round a cleaning process occurred and some ST1 and Locum Appointed for Training (LAT) posts were offered. It is likely these LAT posts will remain under local control. First round fill rates for ST1 were high and not all UoA conducted second round interviews. Feedback was made available to all unsuccessful candidates.

Good Luck!

CLARE WILLIAMS
Previous GAT Committee member
Consultant, Cambridge University Hospitals NHS Foundation Trust

NIGEL PENFOLD
Head of School, Anglia School of Anaesthesia

APPLYING FOR TRAINING IN WALES

The Welsh training scheme covers a wide geographical area with rotations taking a trainee through a mix of district general and university hospitals. In addition, there are considerable opportunities for advanced training, teaching and research posts for senior trainees. The MMC Wales website gives current and up to date information on the vacancies and application process (http://specialty.walesdeanery.org/) with further links to MMC UK and the Gold Guide.

The Welsh School of Anaesthesia website gives in-depth information regarding career pathways, training, research and out of programme experience opportunities for Welsh trainees (www.welshschool.co.uk)...

SUCCESS

In 2010 all offers of appointment were made by the coordinating deanery through an electronic portal. For candidates unsuccessful in the first round a cleaning process occurred and some ST1 and Locum Appointed for Training (LAT) posts were offered. It is likely these LAT posts will remain under local control. First round fill rates for ST1 were high and not all UoA conducted second round interviews. Feedback was made available to all unsuccessful candidates.

Good Luck!

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THE TRAINING

CORE TRAINING (CT1 & 2)
This is usually provided within a single hospital or region of Wales i.e. North or South Wales. The first three months of training are supervised, usually supervised by consultants. During this period the trainees are required to pass the Initial Assessment of Competency following which unsupervised work is undertaken. Details of the above and the curriculum can be found under the Training in Anaesthesia section of the RCoA website.

The Welsh Deanery is currently undertaking a pilot programme of an automatic one year extension. The aim is to further consolidate the Core Training years with an opportunity to work in a complementary specialty (for example general medicine or paediatrics). However, this is subject to satisfactory ARCPs. During this time trainees are also required to pass the Primary FRCA before applying for run through training.

Acute Care Common Stem (ACCS) with Anaesthesia training in Wales consists of a three-year programme of four six-month placements in anaesthesia, intensive care medicine, acute medicine and emergency medicine, followed by a third year of anaesthesia. Similar to anaesthetic CT2 trainees, ACCS trainees will be given a year extension subject to satisfactory Annual Review of Competence Progression. All the three years of ACCS training are spent in one hospital.

INTERMEDIATE TRAINING (ST3 AND ST4)
During these two years trainees are required to complete units of training as outlined by the RCoA, pass the Final FRCA, have a satisfactory ARCP and obtain an Intermediate Level Training Certificate.

HIGHER TRAINING (ST5 TO ST7)
Apart from completing the units of training as per the RCoA guidance, trainees also have an opportunity to apply for 6-12 months of advanced training. This can either be in Wales, elsewhere in the UK, or abroad.

There is also an opportunity to do a 6 month research post or clinical lecturer in University Hospital of Wales or a clinical lecturer post in Abertawe Bro Morgannwg University. If eligible, LTFT training is supported by the Welsh School.

Post fellowship trainees are encouraged to attend a study day four times a year. These are organised by trainees and cover a wide variety of topics, including information on research, experiences of trainees who have worked out of programme or overseas.

The Junior Anaesthetists of Wales (JAW) is a closed online forum for all Welsh trainees from F1 to ST7 whereby trainees can discuss training and educational issues. There is also an annual meeting of trainees followed by a social event.

CURRICULUM CHANGES

The Welsh School adopted the 2010 curriculum fully in August 2011. Further information on vacancies, training and hospitals can be found at the websites mentioned below.

REFERENCES

www.mmawales.org
www.rcoa.ac.uk/index.asp?PageID=33
www.welshschool.co.uk
www.junioranaesthetistsofwales.org.uk
www.welshschool.co.uk/note/116

PONAM BOPANNA
SIR, Wales
APPLYING FOR TRAINING IN SCOTLAND

Despite devolution and the numerous administrative differences between the Scottish and English NHS, anaesthetic training is markedly homogeneous. The exams are the same and the Certificate of Completion of Training is equally valid to allow appointment to a consultant post anywhere in the UK. As in England, training has been decoupled, resulting in two core training and five specialty training years, with separate selection processes at these two stages. Postgraduate training and applications for specialty training in Scotland are overseen by NHS Education for Scotland (NES): www.nes.scot.nhs.uk

HOW MANY JOBS ARE THERE?

Approximately 55 core training (CT1) posts were appointed in Scotland in 2010, including 17 ACCS (anaesthetics) posts. This number has remained relatively constant over the past few years. Applications for specialty training (StR1) began in earnest in 2011 as Scotland will adopt the national recruitment process. The pressures of achieving a pass in the FRCA Primary within a two year window has meant that a significant minority of trainees have not been able to progress to StR3. In 2010, NES permitted those who have passed the MCEQ and have applied to take the viva to be appointed, although they must pass the OSCE/OSOA before they are allowed to take up an ST3 post. There are ongoing discussions regarding the introduction of a three year core-training contract in Scotland (as has been successfully introduced in Wales). If adopted, this would allow trainees the security of a three year post to pass the primary exam, while those who pass the exam within two years progressing to ST3 (although the instigation of this initiative has not yet been confirmed).

THANKS TO JOHN COLVIN AND OTHER MEMBERS OF THE RCoA BOARD IN SCOTLAND FOR THEIR HELP WITH THIS ARTICLE.

WHAT IS THE RECRUITMENT PROCEDURE?

It is anticipated that all timelines will be the same for Scottish recruitment as the rest of the UK. In 2011 invitation to interview was based on the short-listing score from the application form. Final ranking will be based on performance at interview only. This will conform to the arrangements in England and Wales. The highest ranked applicants will have first choice of deanery within Scotland. Lower ranked candidates offered a second or lower choice deanery can hold an offer in the hope of securing their first choice in the event of a higher ranked candidate refusing their offer, or accept/decline the offer made to them.

IS SCOTLAND GOING TO MOVE TO THE NATIONAL RECRUITMENT PROCESS?

Scotland will adopt the national recruitment process. However, a separate application is required through the SMIT website (www.scotmt.scot.nhs.uk) for a Scottish post and the offers process will remain devolved. Whether Scotland will count as one of the two choices of UoA available to applicants, or as an additional option, i.e. two UoAs and Scotland, has not yet been decided.

APPLICANTS FOR ST3 Posts WHO HAVE NOT PASSED THE FRCA PRIMARY EXAM

The purposes of achieving a pass in the FRCA Primary within a two-year window has meant that a significant minority of trainees have not been able to progress to StR3. In 2010, NES permitted those who have passed the MCEQ and have applied to take the viva to be appointed, although they must pass the OSCE/OSOA before they are allowed to take up an ST3 post. There are ongoing discussions regarding the introduction of a three year core-training contract in Scotland (as has been successfully introduced in Wales). If adopted, this would allow trainees the security of a three year post to pass the primary exam, while those who pass the exam within two years progressing to ST3 (although the instigation of this initiative has not yet been confirmed).

Thanks to John Colvin and other members of the RCoA Board in Scotland for their help with this article.

Mike Macmahon
GAT Committee member
StR, South East Scotland

APPLYING FOR TRAINING IN NORTHERN IRELAND

Political progress in the UK has lead to the devolution of some governmental powers to the Northern Ireland Assembly. An Executive Body was created in 1999 with eleven operational local government departments and one of these, the Department of Health, Social Services and Public Safety, has the responsibility to manage healthcare within the province. In the devolved setting, postgraduate medical training is managed by the Northern Ireland Medical and Dental Training Agency (NIMDTA). For anaesthetic training issues the Northern Ireland School of Anaesthesia is the usual source of information and referral

From 2011, both core training and specialty training in Northern Ireland are run via the West Midlands Deanery, the coordinating deanery for national recruitment.

Core training lasts two years, during which set competencies must be achieved before a candidate is eligible to apply competitively for a position at StR3 level. After successful entry to StR3, there will be a five year programme to allow completions of training. This is in line with RCoA recommendations that apply to the whole of the UK.

APPLICATION PROCESS

The application process will be subject to strict deadlines for receipt of applications. Northern Ireland participates in the national recruitment process administered via the West Midlands Deanery. For 2011, CT1 posts were advertised in November 2010 and StR3 posts February 2011. Further information can be found on both the West Midlands Deanery and RCoA websites. The Intrepid Pathway process is used, and information can be found at www.intrepidonline.co.uk

Important notes for the application process:

✱ A candidate cannot apply to more than one entry level per specialty
✱ Shortlisting will be performed based upon essential criteria. If these essential criteria are not met within the application the candidate will not be short listed
✱ Incongruent online application forms will not be considered for short listing
✱ The candidate must ensure eligibility to apply in Northern Ireland, including full GMC registration and being without Home Office restriction to work within the UK
✱ If applying for CT1 evidence of core competencies will be required in the form of a foundation programme portfolio

THE INTERVIEW PROCESS

Candidates who are shortlisted will be offered interviews. These interviews will be conducted by trained selectors against a competency set in the personal and job specifications, and last about 30 minutes. Candidates are scored and ranked from these results.

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The interview format may change as national recruitment evolves, but it has previously consisted of:

- Document check
- CV check
- Five minute unseen presentation based on topical issues not necessarily related to anaesthesia
- Three or four OSCE stations: usually one ALS station; one to test communication skills; one to test data interpretation e.g. simple electrolytes, blood gas analysis, X-ray or EEG findings
- Conventional interview questions: clinical and non-clinical

The same competencies are assessed for each applicant and each panel member gives an independent score. The aggregate of the scores from all panel members gives the final selection score.

More than one offer may be received through this process in which case you are encouraged to accept and reject offers in a timely manner to allow the training opportunity to be passed on. Once a training post is accepted, no other posts will be offered in that round of the selection process.

**TRAINING IN ANAESTHESIA**

The RCoA sets standards for training to CCT. These standards apply equally throughout the devolved nations. Training will be in the form of basic, intermediate and advanced level training as set out by the RCoA. Following review of the new curriculum for 2010, the GMC has advised that the fellowship examinations of the College of Anaesthetists of Ireland would no longer be acceptable as tests of knowledge for a CCT in anaesthetics in the UK from August 2010. Traditionally, many trainees underwent exams via the equivalent College of Anaesthetists of Ireland, owing much to geographical convenience. As such, trainees can no longer undertake the Irish examination for a UK CCT. Both the GMC and the RCoA are currently reviewing the College of Anaesthetists of Ireland exam content to see if it can be mapped to the new 2010 curriculum, and if so, may accept equivalence at a future date. The 2010 curriculum update was fully implemented for CT1s in August 2010 and August 2011 for all other trainees.

**REFERENCES:**
1. www.nimelta.gov.uk
2. www.hscrecruit.com
4. www.rcoa.ac.uk
5. www.intrepidonline.co.uk

- **PAUL JOHNSTON**
  Previous GAT Vice-Chair
  Consultant Anaesthetist, Northern Health and Social Care Trust

- **ORY MAGUIRE**
  StM, Northern Ireland

**APPLYING FOR TRAINING IN IRELAND**

Training in anaesthesia is the responsibility of the College of Anaesthetists of Ireland. It is structured over a seven-year time frame that is subdivided into basic specialty training (BST) and specialist registrar training (SpR).

**BASIC SPECIALTY TRAINING**

This initial two year training is organised by regional training schemes in four areas of the country: Eastern, Southern, Western and North Western. Entry to the programme involves interviews that are held twice a year. Details on applying for the BST are available from the College of Anaesthetists of Ireland. During BST the trainee will generally rotate between two to four hospitals. The minimum time spent in any one centre is six months. An initial competency assessment is performed after two to three months of training. The assessment reflects the skills which should normally be acquired by this stage and which are needed before undertaking the extra responsibility of on-call duties. The College recommends that this assessment is undertaken before a trainee can administer anaesthesia without immediate supervision or when a trainee has newly arrived in Ireland. On completion of the scheme and having passed the primary part of the fellowship examination, trainees are eligible to apply for the SpR training scheme.

**SPECIALIST REGISTRAR SCHEME**

The basic premises of SpR training are that it should:
- be a minimum of five years’ duration
- include formal six monthly assessments by way of InTraining Evaluations (SPiRES)
- be closely monitored and supervised
- be flexible to allow for individual trainee interests and career objectives

SpR training is divided into:
- Intermediate anaesthetic training, SpR Yrs 1 – 3
- Advanced anaesthetic training, SpR Yrs 4 / 5

Rotations are structured to ensure exposure to the sub-specialties listed below and to meet, as much as possible, the career objectives of individual trainees. Sub-specialty training is organised in a modular format.

- Paediatric and neonatal anaesthesia
- Anaesthesia for vascular surgery
- Anaesthesia for cardiac and thoracic surgery
- Anaesthesia for neurosurgery and neuroanaesthesia
- Anaesthesia for plastic and maxillofacial surgery
- Anaesthesia for ambulatory surgery
- Management of burns patients
- Acute and chronic pain management
- Intensive care medicine

SpR training also includes further exposure to subspecialties experienced in BST training (e.g. obstetrics, regional anaesthesia, ENT, ophthalmic surgery, genitourinary surgery, orthopaedic surgery, general surgery).

Entry to the SpR scheme is by competitive interview. These are held twice a year and are advertised on the College of Anaesthetists of Ireland website (www.anaesthesia.ie). On securing a place on the scheme, trainees will be assigned a SpR year 1-3 rotation. This includes 6-12 month posts in accredited training hospitals around Ireland. During the rotation, trainees spend on average 12-18 months in hospitals outside of Dublin. Details of accredited training hospitals are available on the website. There is provision to take a year out of clinical anaesthesia for either full-time research, working in anaesthesia abroad or working in another relevant specialty. Trainees progress to advanced anaesthetic training (SpR Year 4 & 5) following an interview at the end of SpR Year 3. The final two years of training include exposure to cases of higher complexity with increased responsibility on-call and exposure to models of good practice in terms of departmental organisation and status. On satisfactory completion of the training scheme, the trainee will receive a Certificate of Specialist Training (CST) and will be competent to take up a consultant post in anaesthesia. Most recipients of a CST undertake further training in Ireland or more commonly abroad to develop sub-specialty interests and expertise.

Further details on training in anaesthesia in Ireland can be found on the website www.anaesthesia.ie.

- **ABIGAIL WALSH**
  SpR, Ireland
WHERE TO GO?
The days of choosing your destination by proximity to the beach are gone. If you come back with a fellowship in regional anaesthesia, ICM, transplant, etc, then you are going to set yourself apart, so think about destination and work. Specific countries are discussed in the GAT publication ‘Organising a Year Abroad’.

PLUS POINTS
★ New and exciting
★ Good on CV
★ Meet new people
★ Perform work/research not available in your deanery
★ ‘Try before you buy’ if you are thinking of moving overseas permanently

NEGATIVES
★ Can be expensive
★ Can be difficult to organise
★ You may be a long way from friends and family
★ Lots of paperwork!

WHAT TO DO NOW
★ Ask colleagues where they went
★ Research what you want to do and where you want to go
★ Ask your regional advisor and training program director (remember this is a sales pitch; they do not have to say ‘Yes’ and by doing so they will lose a senior trainee, so be ready to persuade them as to why they should let you go)
★ Start early, it always takes far more time and effort than you think
★ Try to direct any questions/enquiries to a named person at the hospital in which you are interested as generic emails are easy to ignore
★ Think about money, insurance, pensions, housing and tax (and many more). Please get advice before you go or you may come home to a nasty headache

WHILST YOU ARE THERE
★ Keep a logbook
★ Take photos as you are bound to be asked to give a presentation on your return
★ Plan your job for your return to the UK and stay in contact with your training programme director via email as post allocations and rotations do change
★ After all the hard work of set up, getting there and the work, remember to enjoy yourself whilst you are there. You’ll be amazed how fast the time flies. And remember, many overseas departments will be interested in British-trained anaesthetists joining their dept on a permanent basis, so work hard!
★ Thanks to Claudia Moran at the RCoA for her valuable input.

FURTHER READING
Organising a Year Abroad - Out-of-programme advice from the GAT Committee 3rd Edition; Dr Adam M Paul - www.aagbi.org/sites/default/files/organising_year_abroad09.pdf

Adam M Paul
Previous GAT Committee member
Consultant, Royal Infirmary, Edinburgh

THE NON-EU TRAINEE
Since I started anaesthetics training in the UK in 2008 as an Australian on a work permit, it has become extremely difficult for non-EU nationals to undertake employment as a doctor in training here. The main hurdle is obtaining a visa. This is a very complicated area and this article should not be taken as authoritative or comprehensive. Anyone interested must read the UK Border Agency website (www.ukba.homeoffice.gov.uk).

According to the current guidance, for a non-EU national who has not studied or worked in the UK already, there now appears to be no obvious route to a visa that permits employment as a doctor in training. Such employment is specifically excluded under various relevant visa categories such as the highly skilled workers (Tier 1 General) route and the Youth Mobility Scheme. Doctors who qualified from a UK medical school, or who have already been employed as a doctor in training in the UK, may be exempt from this exclusion.

Another important step is GMC registration, including the Professional and Linguistic Assessments Board (PLAB) exams. Again, this is quite complicated and you must consult their website (www.gmc-uk.org).

Of course there are many issues involved in moving to work in the UK for example, getting a National Insurance number, opening a bank account, and many more, but none of these are insurmountable.

For me, training in the UK has been very positive and it has been definitely worth pursuing, despite the obstacles. In my experience, once the bureaucratic barriers are overcome, foreigners are treated much the same as any other trainee. Although Australia’s healthcare system is similar to the NHS, I have still learnt a great deal from experiencing UK-style anaesthesia and intensive care.

Thomas Smith
Australian Academic Clinical Fellow, Oxford

OUT OF PROGRAMME TRAINING
Most people will still refer to CPD (Out of Programme Experience) but this is no longer correct and it has been rebranded OOPET (Out of Programme Training/ Research) – this may sound pedantic but as paperwork has changed very rapidly in this field over the past few years it is worth getting it right so that you can search for the most up-to-date information (and so that when you have your chat over coffee you can gauge how long ago it was ‘Dr Smith’ really was a fellow at St Elsewhere!).

The chance to work out of programme for an extended period is one that should be grabbed with both hands (I am biased as I did it!). Times are changing and with the reduced hours and reduction in trainee numbers the option to take a year out of programme for further training or research is being eroded as deaneries are loath to lose a senior trainee. However, with a very competitive job market, something different on your CV will seem all the more attractive to employers. Moreover, with the threat of post-CCT non-consultant posts still hanging over us, I would suggest that the chance of strengthening your skills and widening them should be grabbed.

WHEN TO GO?
Post fellowship or post-CCT will allow you to get the most from it and to choose a fellowship that will add value as you will know where your interests lie.
ANAESTHESIA TRAINING AND THE ARMED FORCES

BACKGROUND

The Defence Medical Services (DMS) recruits doctors at all stages of training, from cadets at university through to accredited consultants. The entry process remains stringent and places for medical officers in acute specialties remains very competitive. Each of the single services have specific entry requirements and initial training, but once accepted into anaesthesia training runs under the umbrella of the Department of Military Anaesthesia, Pain and Critical Care (DMAP&C).

DMAP&C is not only responsible for anaesthesia training, but is also the lead for operational deployments, research and all innovations in equipment and techniques related to anaesthesia, pain management and intensive care medicine. The Defence Consultant Adviser in Anaesthesia, Pain and Critical Care and the Defence Anaesthesia Specialty Board run the specialty on a day-to-day basis. Also included in the team are the two defence regional advisers and programme directors in anaesthesia and intensive care medicine. There are single service anaesthesia consultant advisers and the Department of Military Anaesthesia, Pain and Critical Care oversees academic endeavour.

PATH TO A CONSULTANT

Once a trainee has made the decision to pursue a career in anaesthesia, there is a very clear path to follow. The application for specialist training is performed in the same manner as for civilians and currently the interviews take place in one of seven deaneries with which the Defence Speciality Training Board run the specialty. All trainees are directly compared and benchmarked against their civilian counterparts and are involved in the interview process ensuring candidates are directly compared and benchmarked against their civilian colleagues. Successful candidates will be offered a place in one of seven deaneries with which the DPMDC has links.

Anaesthesia training follows the same path as for civilian trainees, under the auspices of the RCoA, with a small number of exceptions. Firstly, it is expected to continue to develop core military skills, such as leadership and team working. This includes being able to provide military trauma anaesthesia using military protocols. Apart from these minor differences the core competency framework, assessment and examinations are the same as for any anaesthetist in training.

Military anaesthesia has been formally recognised as a specialist area by the RCoA and there is a military module in training for senior trainees. This has been incorporated into the latest CCT syllabus 6 and is designed to be flexible to allow the incorporation of new developments, while providing a framework for maintaining knowledge and skills. During times of conflict many of the competencies will be attained on deployment, but it is also designed to be deliverable in more peaceful times and is part of the process of maintaining the corporate memory of lessons learned. A detailed account of completing deployed aspects of the training has been recently described and specific components consist of:

- The ability to deliver and organise military pre-hospital care during casualty retrieval. This section addresses issues such as casualty triage and military triage categories, aeromedical transfer, the operation of the Medical Emergency Response Team-Enhanced (MERT-E) and military casualty handover matrices. Trainees are expected to show competency with various specialist pre-hospital equipment such as the field cyclicoxygenator kit, military chest drums, rapid infuser pumps, the combat application tourniquet (CAT). This section also covers knowledge of the intravenous rapid access devices available and the use of novel haemostatic techniques.

- Principles of in-hospital resuscitation and field anaesthesia - Current trauma scoring systems, data collection and UK military audit projects are studied as well as gaining working knowledge of the Sunshine General’s policy, via Defence Instruction Notice (DIN) on massive transfusion in UK hospital fields. This includes using blood and thawed plasma in a 1:1 ratio with early use of crystalloids and platelets guided by the use of rotation thromboelastometry (ROTEM®). Trainees are made aware of processes involved in the obtaining of and transfusion of blood and blood products. They also become familiar with concept of damage control resuscitation (DCR)5 and damage control surgery.6 Finally they are introduced to trauma anaesthesia and analgesia.

- The management of anaesthesia and critical incidents using field surgical equipment - Competencies in the Tropical Anaesthetic Apparatus, field anaesthesia machine and the other specialist theatre equipment such as the backup operating theatre ventilator, field suction apparatus, oxygen concentrators and infusion pumps are covered in this section.

- Field critical care and aeromedical evacuation - Intensive Care and Critical Care Air Support Team (CCAST) equipment and the procedures involved in transferring a critically ill patient are covered in this section. The role of field critical care in DCR is also included.

- Battle casualty rehabilitation - The casualty reception process in the UK, the short- and long-term rehabilitation processes, the principles and problems of chronic pain management for battlefield casualties and follow up of patients at the Defence Medical Rehabilitation Centre.

- Deployed military hospital management - This will involve a working knowledge of how the field hospital functions, including major incident plans, how medical communication processes work within UK and allied forces. This includes review of Geneva Conventions and other legal obligations pertaining to the treatment of casualties during conflict.

- Attitudes and behaviour - Looking at teamwork, communication skills and leadership and the ethical challenges and non-medical influences on hospital activity.

During training, opportunities exist to develop specialist interests with potential for off rotation training in the UK and abroad, provided they complement the role of the military anaesthetist. This includes areas such as intensive care, pre-hospital care, pain management and acute trauma. Overseas fellowships are used to focus areas of training in areas relevant to military medicine and competition to gain these highly sought after places is keen. Defence funds are available to support study allowances and financial help with the FRCA Primary and Fellowship.

Additionally, during training there is a period of collaboration following which successful trainees are awarded an operational tour prior to attaining a Certificate of Completion of Training (CCT). There are also annual meetings of the Triservice Anaesthetic Society (TSAS) and the Society of Triservice Anaesthetists in Training (STAT). These academically focused meetings provide an opportunity to get the latest military updates, as well as compare notes with other military anaesthetists (consultants and trainees) across the country. Once a CCT has been obtained, trainees sit an Armed Services Consultant Advisory Board (ASCAB). The ASCAB is the military version of a consultant appointment interview. It is conducted in the same way that a civilian appointment is and is approved by the NHS. Following this comprehensive interview, the trainee is a fully-fledged DMS anaesthetic consultant and member of defence anaesthesia.

All trainees undertake mandatory annual military training to compliment their clinical skills. Keeping fit is a requirement and annual testing is undertaken (for the RAF this is twice a year, unless you perform markedly above the standard when it reverts to annually). Compulsory training includes refreshers training of basic military skills such as weapons handling, fire fighting, first aid, dinghy drills, helicopter escape and chemical, biological, radiological, and nuclear training. In addition before a deployment all attend a hospital simulation exercise (HOSPEX), which is undertaken in a mock field hospital setup.

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from the arrival in the helicopter by the pre-hospital decision making, but also the ‘journey’ of a patient different to that experienced in the course of routine. They may also be required to transfer deployed, anaesthetists have duties in the operating procedures and the actual equipment that will be used increasing realism. This training is required, because while the CCAST team. Casualties are simulated by live actors and the human factors required for defence Medicine, the anaesthetic training, as members of CCAST. This compliments other RAFMS specific training for aeromedical evacuation duties. CCAST teams are deployed and are on standby to repatriate critically ill patients from anywhere in the world, in what is essentially a fully equipped flying ICU. Recent developments mean that there is now a RAF anaesthetists’ career path that also allows pre-hospital emergency medicine training as a subspecialty in order to provide appropriately trained doctors for the MERTE service currently supporting operations in Afghanistan. RN trainees may have the opportunity to deploy on an aircraft carrier or the primary casualty receiving ship RFA Argus. Again this depends on prevailing military operations. Anaesthetists also take an active role in management within the field hospital with full participation in clinical governance and management issues specific to working in a field environment. Senior anaesthetists are often selected to become deployed medical directors, advising commanders on medical matters and assisting in the overall medical management strategy. Weekly Joint Theatre Clinical Case Conference (JTCCC) meetings occur using telephone conferencing. This system links deployed field hospitals with the Royal Centre of Defence Medicine, the Defence Medical Rehabilitation Centre, the on-call CCAST team and other areas of the DMS involved in patient care and evacuation. This feedback system allows deployed clinicians to track the ongoing care and outcome of patients treated in the field unit and also provides for data collection. This is an unparalleled learning opportunity for clinicians and the DMS to aid in future management of patients. Outputs from this and Defence Anaesthesia Lessons Learned are fed back into training areas such as MOST and MERTE to ensure regular updates to training can occur as concepts and practice evolve in real time. RESEARCH
Defence anaesthesia trainees with an interest in anaesthesia are encouraged to undertake military directed research. The Defence Professor in Anaesthesia and Critical Care leads the academic department based at the Royal Centre for Defence Medicine with a team of RCoA-appointed senior lecturers and foundation senior lecturers. Any trainees wishing to undertake higher degrees are encouraged and compete for limited places. Trainees will be expected to complete significant projects before moving on to a higher degree and local research and audit is expected. SUMMARY
A career in military anaesthesia is exciting and challenging, demanding a high level of expertise, initiative and flexibility. It gives the unrivalled opportunity to be part of a team that has recently been shown to provide standards of medical care that are world-leading. It is not for everyone, but talk to those who are part of it and you may be surprised that it might just be for you! REFERENCES:
1 The CCT In Anaesthetics IV: Competency based higher and Advanced Level (Speciality Training (ST) Years 5, 6 & 7) Training and Assessment A manual for trainees and trainers Interim edition: January 2007 Amendment 1 August 2008

SURGEON LIEUTENANT SIMON MERCER
Royal Navy
LIEUTENANT COLONEL THOMAS WOOLLEY
Royal Army Medical Corps
GROUP CAPTAIN NEIL MCGUIRE
Royal Air Force

HOSPEx tests not only the team’s clinical skills and decision making, but also the ‘journey’ of a patient from the arrival in the helicopter by the pre-hospital MERTE, through the emergency department, operating theatres and ICU, with evacuation back to the UK, via the CCAST team. Casualties are simulated by live actors from commercial firms such as ‘Amputees in Action®’ to increase realism. This training is required, because while deployed, anaesthetists have duties in the operating theatres, the intensive care unit and are members of the trauma team. They may also be required to transfer critically ill patients via helicopter or fixed wing aircraft. Anaesthetists are also key members of MERTE.

Another mandatory pre-deployment training course is the Military Operational Surgical Training Course (MOST). This runs for a week at the Royal College of Surgeons and is a team-training course with a focus on team resource management. There is a combination of cadaveric scenario based exercises with the trauma surgeons and the opportunity to practice during high fidelity simulation some of the typical cases that will be encountered whilst deployed. This course allows the opportunity to familiarise with standard operating procedures and the actual equipment that will be used on deployment. The use of non-clinical skills is very important when deploying to an environment that is very different to that experienced in the course of routine NHS work and the human factors required for defence anaesthesia have recently been described.

OPERATIONAL DEPLOYMENTS
When a trainee undertakes an operational deployment they do so under the supervision of a defence anaesthesia consultant. Currently this training is out of programme, but work is continuing to review this. Operational deployments vary, but are usually to a field hospital in an operational area. For the Royal Navy (RN) trainees this may be in support of a seaborne operation. Likewise for the Royal Air Force Medical Service (RAFMS) trainees there may be opportunities to deploy in support of an Aeromedical Staging Unit. For the most part, however, anaesthesia and critical care trainees come under the Triservice umbrella and work together in field units.

RAF trainees are supervised, as an integral part of their anaesthetic training, as members of CCAST. This compliments other RAFMS specific training for aeromedical evacuation duties. CCAST teams are deployed and are on standby to repatriate critically ill patients from anywhere in the world, in what is essentially a fully equipped flying ICU. Recent developments mean that there is now a RAF anaesthetists’ career path that also allows pre-hospital emergency medicine training as a subspecialty in order to provide appropriately trained doctors for the MERTE service currently supporting operations in Afghanistan. RN trainees may have the opportunity to deploy on an aircraft carrier or the primary casualty receiving ship RFA Argus. Again this depends on prevailing military operations. Anaesthetists also take an active role in management within the field hospital with full participation in clinical governance and management issues specific to working in a field environment. Senior anaesthetists are often selected to become deployed medical directors, advising commanders on medical matters and assisting in the overall medical management strategy. Weekly Joint Theatre Clinical Case Conference (JTCCC) meetings occur using telephone conferencing. This system links deployed field hospitals with the Royal Centre of Defence Medicine, the Defence Medical Rehabilitation Centre, the on-call CCAST team and other areas of the DMS involved in patient care and evacuation. This feedback system allows deployed clinicians to track the ongoing care and outcome of patients treated in the field unit and also provides for data collection. This is an unparalleled learning opportunity for clinicians and the DMS to aid in future management of patients. Outputs from this and Defence Anaesthesia Lessons Learned are fed back into training areas such as MOST and MERTE to ensure regular updates to training can occur as concepts and practice evolve in real time.

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Most anaesthetists in training should now be using some form of logbook to record their experience. This does not prove competence but it does enable trainers and college tutors to see what a trainee has done and if there are any gaps in their training. However, keeping a personal record of details about patients has significant implications. There are both professional and legal obligations regarding clinical records. Anyone keeping a logbook must be aware of these if they are not to fall foul of the GMC or the Courts.

**ACTS OF PARLIAMENT**

There are two Acts of Parliament relevant to the keeping of logbooks, the Freedom of Information (FoI) Act 2000 and the Data Protection Act (DPA) 1998. The essence of the FoI Act is that patients have the right to know what is recorded about them. It is important therefore that records are factual and accurate. The provisions of the DPA can be summarised by its eight principles. In abbreviated form, these are that personal data shall:

- be processed fairly
- be obtained only for one or more specified and lawful purposes
- be adequate, relevant and not excessive
- be accurate, and where necessary, kept up to date
- not be kept for longer than is necessary
- be processed in accordance with the rights of data subjects
- have appropriate technical and organisational measures taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data
- not be transferred to a country or territory outside the European Economic Area without adequate protection

**IMPLICATIONS**

Firstly, a logbook must be accurate. Significant inaccuracies could be regarded as fraud, which would have serious consequences. That said, it is probably the penultimate principle that causes most difficulty. Everyone will be aware of the news stories about the losses of personal data incurred by various Government departments. When personal data is lost by an organisation it can be very difficult to blame an individual, but if an identifiable anaesthetist loses their logbook and the personal data of one or more identifiable patients gets into the public domain then that anaesthetist could be in serious trouble. The logbook database must therefore be kept physically secure and be regularly backed up to ensure against data loss or corruption. Access must be controlled by at least a password. The use of encryption software is recommended.

Some of this can be difficult in practice. For example, if the database is kept on a USB stick it can easily be mishandled, and encryption software is not always user friendly. One solution is not to record any unique patient identifiers in the logbook so that if the data falls into the hands of a third party it is meaningless.

The Joint Informatics Committee (JIC) of the RCoA and the AAGBI has debated the need to record unique patient identifiers. It has been agreed that it must be possible for a college tutor to verify a trainee’s logbook by identifying individual patients beyond all reasonable doubt. The NHS number and date of birth can identify a patient uniquely, but so can a hospital number and age. The former would allow anyone in the NHS to identify the patient, so is inherently less secure than recording hospital number and age, which would only permit someone with access to that hospital’s computer systems to identify the patient. The JIC has received conflicting professional advice from the Information Commissioner and another regulatory body regarding this problem and, in the absence of any legal precedent, currently recommends that the recording of hospital number and age provides sufficient safeguards while meeting the requirements of college tutors.

Finally, anyone keeping a logbook should consider the need to register as a data controller under the DPA.

**REFERENCES**


**FURTHER READING**

The Care Record Guarantee www.nigb.nhs.uk/ guarante


How to maintain an anaesthetic logbook. Dr A McIndoe and Dr E Hammond, Bulletin 51, Royal College of Anaesthetists, 26/13, September 2008. www.logbook.org.uk


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**LOGBOOKS – A TRAINEE’S OPINION**

iGasLog 1.2

iPhone/iPod Touch/iPad

This had emerged recently as a real favourite, even for those technophobes amongst us. Its ease of use and speed of data input, coupled with the instant access of the iPhone, (found in the majority of anaesthetists’ pockets) account for this success. It also appears to keep data relatively safe (provided you don’t lose your iPhone in that it doesn’t crash and lose all the info). On the downside, it is difficult to back-up data onto a PC hard drive. This can be done though (for details see YouTube video). The reports, whilst including all essential information are visually unattractive. There is little flexibility in the programme to allow for specialist areas or custom data collection. However, it is not cheap, at £17.99 (via iTunes Apps).

iGasLog 2.0 will have all the good features of the 1.2 version, plus automatic web-based backup, separate data entry fields for pain and ICU cases and even the facility for collecting tutor and Dr E Hammond, Bulletin 51, Royal College of Anaesthetists, 26/13, September 2008.

www.logbook.org.uk


HandiBase

For PDAs, iPhones and other smartphones

This ‘generic’ database can be used on many smartphones
and portable devices. For the enthusiastic logger it provides the flexibility to custom make a logbook with the desired additional information. The LSORA logbook can short-cut a lot of this customising and provide a tidy HandiBase platform fairly easily (see below). It costs between £5 and £15, and is not as pleasant to use as its competitors, but probably provides the most flexibility.

**USB MEMORY STICK LOGBOOK**

This appears an excellent concept, especially as most theatres have a PC available. The downsides are that memory sticks are all too easy to lose, and many trusts are in the process of banning all non-encrypted memory sticks. Un-encrypting the disk may add a few more precious minutes to the procedure! It also lacks the additional benefits of the more advanced logbooks available online. Available via www.logbook.org.uk.

**WEB-BASED LOGBOOKS**

The London School of Regional Anaesthesia (LSORA) logbook: as one would anticipate, the real attraction of this free logbook is the ability to record the detail and outcomes of regional procedures. It can be integrated with HandiBase for use with portable devices. The reports it produces are pleasant, RCoA compatible, and in addition it will construct CUSUM curves for the all reports it produces are pleasant, RCoA compatible, and more (secure) places the data is backed up the better.

An interesting way of presenting the data, and after all, the take some of the tedium from inputting cases, provide a tidy timeline of the procedures. This would be impressive data to produce in addition it will construct CUSUM curves for the all procedures. This system of assessment for all trainees is called the Annual Review of Competency Progression (ARCP).

### ANNUAL REVIEW OF COMPETENCY PROGRESSION (ARCP)

The system of assessment for all trainees is called the Annual Review of Competency Progression (ARCP). The ARCP replaces the old RITA system, but the only thing they have in common is that they are annual, taking place towards the end of each year of training.

The ‘rules’ and expectations of the assessment process are detailed in the Gold Guide, as are all aspects of training. The most relevant part is section 7, pages 54-45 where assessment is covered. What follows is a summary of the process:

Most regions conduct their ARCPs slightly differently, and interpretation of the Gold Guide varies between deaneries. Over time, I am sure these discrepancies will be ironed out as trainers become more familiar with the process.

ARCP is fundamentally a documentation exercise to show that the trainee is progressing at the appropriate rate through specialty training. The decision of the panel is made based on the evidence provided by the trainee and educational supervisor.

The ARCP is annual, and is composed of three elements: appraisal, assessment and annual planning. The appraisal should be both an educational appraisal with the educational supervisor, and a NHS appraisal covering areas of good medical practice. The outcomes from these should feed in to the ARCP process. The assessment is coordinated by the educational supervisor and trainee to look at workplace based assessments, MfP, logbook details, as well as the ‘newer’ style assessments such as DOPS, Anaes-CSE, AIAMAs and CBIs. In addition, evidence of professional development from a summary of the trainee’s portfolio is considered. These are collated and a summary of all of these assessments is usually provided to the ARCP Panel for consideration as evidence. The annual planning should take place after the ARCP assessment outcome is known and will involve the trainee, educational supervisor and programme director. This is to provide the trainee with the most appropriate training for the next year.

The ARCP panel will consist usually of at least three members, usually either the Dean, the STC chair, the specialty school representative, or similarly experienced trainers. The possible outcomes from the ARCP have changed considerably to RITAs. They are now a numbered outcome and are detailed below. An important part of the process is that the information leading to the outcomes is assessed by an outside agency for 10% of the trainees. This can, for example, be the lead for ARCP in a neighbouring deanery.

**OUTCOMES FROM ARCP**

**Satisfactory outcome:**

1. Achieving progress and development of competencies at expected rate
   
   This is, thankfully, the most common outcome.

2. Unsatisfactory outcomes:
   
   1. Specific competencies required, no additional time needed
      
      Certain competencies are missing but have an opportunity still exists to achieve them. It empowers the trainee to ‘insist’ on allocation to the appropriate attachment to gain these competencies. The ‘rules’ and expectations of the assessment process are detailed in the Gold Guide, as are all aspects of training. The most relevant part is section 7, pages 54-45 where assessment is covered. What follows is a summary of the process:

   2. Inadequate progress, additional time required
      
      Training number is withdrawn.

   3. Inadequate progress, additional time required
      
      Training number is withdrawn.

   4. Other outcome
      
      Training number is withdrawn.

   5. Unsatisfactory outcome
      
      Training number is withdrawn.

   6. Gained all competencies and can be awarded CCT
      
      Awarded at the final ARCP.

   7. FISTA or LAT outcome
      
      This has a summary of competencies achieved so far.

   8. Out of programme
      
      Issued when out of programme.

These outcomes are very prescriptive in nature and offer little in the way of interpretation. Obviously the vast majority of trainees will achieve outcome number 1. However, there will be some that require additional time and/or support, often for failure to obtain the exam at the appropriate time. The section of the Gold Guide for this states, “If there is an unsatisfactory outcome the deanery requires a specific educational agreement to be drawn up to address the deficit in training. The effectiveness of the additional training is assessed by the ARCP panel and if unsatisfactory the trainee will be asked to leave the programme.”

If a trainee is ‘asked’ to leave the programme he/she has the right to appeal before a panel that usually includes the Dean, a consultant from another specialty (with ARCP experience), specialty representative local and one from outside the region and a trainee representative. They are allowed a further time to company them in the meeting, but not legal representation. The trainee prepares and submits their evidence, the specialty theses. The panel will then sit in judgement of the case and decide the outcome.
If asked to leave the training programme the employer will try to find the trainee alternative employment within the organisation. If this is not possible their contract will likely be terminated. The Gold Guide makes good bedtime reading; it will certainly aid sleep at 108 pages long. However, it governs your training and so specialty trainees need to know about it.

**GARY LEAR**  
Consultant in Anaesthesia & Intensive Care, City of London Teaching Hospitals NHS Foundation Trust

**CAROLINE HARRELY**  
SR, North Deanery

### The FRCA Examination

The trainee anaesthetist aims to pass the two-part examination, set and supervised by the RCoA to obtain the FRCA. After recent concerns regarding eligibility to take the FRCA examination consists of up to 18 stations over an hour and 50 minutes, of which only 16 count towards the result. Up to two of the stations may be used to introduce and validate new questions; these stations will not be identified to the candidates, but will count towards the final mark. The stations may cover: resuscitation, technical skills, anatomy (general procedure), history taking, physical examination, communication skills, anaesthetic equipment, monitoring equipment, measuring equipment, anaesthetic hazards and the interpretation of medical images (X-rays). One or more of the stations may evolve the use of a medium fidelity simulator.

#### The SOE

The SOE is conducted as two sessions of 30 minutes each, although these two sessions count as a single SOE examination. Two examiners mark the questions independently and there is no closed marking. The answer to each question is given a numerical score by each examiner (Fail = 0; Borderline = 1; Pass = 2). The candidate’s overall score is the total marks awarded by all the examiners for all the questions. Maximum score 48; pass mark 37. If a candidate fails either the SOE or OSCE section then they need only to re-sit that section within two years. The maximum number of attempts is four.

**Preparing for the Primary FRCA**

#### The MCQs

The primary MCQ examination consists of 90 questions in three hours. There are three sections of questions on physiology and biochemistry, pharmacology, physics and clinical measurement, but these subsections need not be passed individually. From September 2011, the number of MCQ questions has decreased from 90 to 60 and 10 ‘single best answer’ questions (SBAs) have been added. The SBAs include questions from the standard subsections and samples of these will be available on the College website. There is no negative marking in the exam; therefore there is no benefit in not answering a question. This is a pass or fail examination and a pass is valid towards the OSCE for two years. The maximum number of attempts allowed at the MCQ is five. The MCQ exam is currently held at five different locations throughout the UK.

#### The OSCE

The OSCE examination consists of up to 18 stations over an hour and 50 minutes, of which only 16 count towards the result. Up to two of the stations may be used to introduce and validate new questions; these stations will not be identified to the candidates, but will count towards the final mark. The stations may cover: resuscitation, technical skills, anatomy (general procedure), history taking, physical examination, communication skills, anaesthetic equipment, monitoring equipment, measuring equipment, anaesthetic hazards and the interpretation of medical images (X-rays). One or more of the stations may evolve the use of a medium fidelity simulator.

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### Preparing for the Primary FRCA

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the MCQs. This will give you a clear idea of how to approach questions. It is extremely important to be clear and succinct. You will fail the exam if you do not answer the basics, where as you will not if you cannot remember trivia.

THE FINAL FRCR
The Final FRCR consists of two parts, the written and SOE. The SOE is held only in London. Both the written and SOE are pass or fail examinations. If only the written is passed that will stand and only the failed SOE must be re-taken. A maximum of four attempts are allowed at the written exam. A pass in the Primary FRCR permits eligibility to sit the Final for up to 10 years.

THE WRITTEN EXAMINATION
The Final FRCR written examination consists of two parts and stands alone; it must be passed before moving onto the oral parts of the exam. The exam questions are mapped to the RCoA intermediate level curriculum. These written examinations are held in March and September each year, to allow time to apply for the SOE in June or December accordingly. A pass in the written is valid towards the SOE for two years and six attempts at the Final exam are permitted. Both exams carry equal weight and closed marking is not used (e.g. 1, 1, 2, 2, 2). There are two subsections to the exam: the MCQ paper and the SAQ paper.

THE MCQ PAPER
The MCQ examination consists of 90 multiple-choice questions in three hours: 60 true/false and 30 single best answer questions. 20 T/F questions in clinical anaesthesia 20 T/F in applied basic science (including clinical measurement) 15 T/F questions in intensive care medicine 5 T/F questions in pain management

THE SAQ PAPER
The Short Answer Question paper has 12 compulsory questions on the principles and practice of clinical anaesthesia, to be answered in three hours. Unlike before, papers will not be reviewed for candidates performing particularly badly in isolated questions. All questions are marked out of 20 in accordance with the marking guides for each question. No longer will 10% of the marks be allocated for clarity, judgement and the ability to prioritise, but marks will no longer be deducted for serious errors.

THE SOE EXAMINATION
The Structured Oral Examination of the Final FRCR exam is a stand-alone section and can only be attempted after passing the Final FRCR written section. There are two sub-sections to the SOE examination comprising:

Clinical anaesthesia: This is of 50 minutes duration, comprising ten minutes to view clinical material, 20 minutes devoted to three questions based on the clinical material and 30 minutes devoted to three questions on clinical anaesthesia unrelated to the clinical material. It is followed by:

Clinical science: This is of 30 minutes duration consisting of four questions on the application of basic science of anaesthesia, intensive care medicine and pain management.

There is a maximum of six attempts at the SOE. Candidates who fail the SOEs more than once can request a guidance interview. Two examiners mark each part of the SOE and both examiners mark every question independently. There are 10 questions, two marks are given for a pass, one mark for a borderline performance and 0 marks for a fail, giving a maximum total score of 40 marks with a pass mark of 12.

PREPARATION FOR THE FINAL FRCR
The observations made regarding the MCQs and SOEs for the Primary exam are valid for the Final exam, with the caveat that there is an emphasis on clinical medicine, anaesthetic management of patients with co-morbidities and common problems in intensive care. The clinical SOE in the Final exam evaluates your clinical judgment based on your knowledge i.e. what an anaesthetist does in everyday medical practice. The emphasis is on safe and competent clinical care of patients undergoing anaesthesia, hence the quote “don’t change your daily practice for the exam” is valid. The clinical science SOE is a scaled-down version of the Primary SOE, with an emphasis on clinical application of the drugs, equipment and anatomy with relevant to regional anaesthesia, and medical statistics.

“Do not answer what has not been asked, and answer all that has been asked” The SAQ is an assessment of your ability to organise thoughts and your time management when dealing with scenarios from everyday clinical practice. With 12 SAQs to endure in three hours, the average time for each question is only 15 minutes. It is worth spending a couple of minutes planning the answer – content and layout (tables, labelled diagrams) to achieve decent answers. This leaves you only 10–12 minutes to write an answer, therefore use short and snappy titles, bullet points with content (tables, labelled diagrams) to achieve decent answers. The SAQ is a pass or fail examination. If only the written is passed that will stand and only the failed SAQ paper.

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CONCLUSIONS
The FRCR examination is an essential requirement for career progression in anaesthesia and is a challenging task that requires a solid six months of revision to cover the vast syllabus. This is an understandably stressful time, made easier by planning and starting early. Plan the sitting a year ahead to have adequate revision time, collect revision resources, book the courses that you want to attend (most good courses are oversubscribed) and organise study leave and life in general! Remember there is no rationale for a trial run.

REFERENCES AND USEFUL WEBSITES

LIZ SHEWRY
Previous GAT Vice-Chair 2008-2010
Spli, Wesses
CORE TRAINING

During the first year the trainee may also undertake basic level intensive care medicine, followed by obstetric anaesthesia competencies in year two.

ACUTE COMMON CORE STEM (ACCS)

Acute Care Common Stem (ACCS) is a three year training programme and is an alternative core training programme. A parent specialty must be chosen from anaesthesia, emergency medicine and acute medicine on entering ACCS. It is the only entry point to emergency medicine training. It is possible to change parent specialty after starting training, but the trainee must reapply competitively for the new post.

There are several routes of entry into ACCS training programme:

- Entry into ACCS Year 1 from F2
- Entry into ACCS for trainees with a combined total of less than 18 months experience in any of the four ACCS component specialties at SHO/CT1/CT2 level
- Entry into ACCS from core/higher training in a non-ACCS specialty

The first two years of the programme involve rotating through emergency medicine, general internal medicine, anaesthesia and intensive care medicine, with six months spent in each. The third year is spent in the parent specialty and, in the case of anaesthesia, is the equivalent of CT2 in anaesthesia.

The ACCS programme provides a broad base of clinical skills and experiences. It also permits a better understanding and appreciation of the other specialties with which you will be closely working. If you are minded to undertake intensive care medicine as a dual-CCT then the ACCS programme allows you to gain complementary specialties in a pre-planned and structured manner rather than trying to 'slot' them in later. This is proving more difficult with the reduction of stand-alone jobs recognised for training.

With regard to anaesthesia examinations, it is expected that trainees will have passed the FRCA Primary MCQ assessment prior to entering CT2 anaesthesia (i.e. by the end of the first 2 years ACCS). Like core training in anaesthesia, the FRCA Primary examination must be

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passed before entry into ST3 anaesthesia training.

The RCoA has issued advice on examinations: “25% of ACCS (Anaesthesia) trainees will not start their anaesthetic module until the final 6 months of the 2-year ACCS course and therefore are not obtaining the Initial Assessment of Competence in Anaesthesia (IAC) until 22 months into their 2-year ACCS training. This could limit the opportunities such trainees have to sit the Primary FRCA Examinations. To address the problem Council has agreed to allow any registered trainee to apply to sit the Primary FRCA MCQ Examination as soon as they start an approved training post in anaesthesia or ACCS. This replaces the previous regulation that a trainee must have passed the IAC before applying to sit the MCQ Examination. However, College Tutors are strongly recommended to advise their trainees not to attempt the MCQ before they have obtained their IAC.”

There are, of course, WPAs for each subsection of ACCS which vary from specialty to specialty. The 2010 curriculum for ACCS is overseen by the Intercollegiate Committee for Acute Care Common Stem Training (ICACST) and their national training website at http://www.accsuk.org.uk is extremely helpful.

DEVELOPING YOUR CV FOR ST3
You’ve completed your core training and you’ve got the Primary FRCA exam. Now all you have to do is get that ST3 post. Other candidates will have similar qualifications and experiences, so how do you stand out enough to be shortlisted? A good, well-balanced curriculum vitae is the first step. With national recruitment you submit your details via an online template. Having a good paper curriculum vitae will form the basis of any online application process and be invaluable throughout your career.

There is no correct style and layout for your perfect CV. Write your CV several months ahead of the application. Having several colleagues proof read it is vital. They can identify any weak points, layout blunders and spelling mistakes whilst giving you enough time to rectify these deficiencies. College tutors will also be able to advise which elements score points on the long-listing scoring systems.

GENERAL POINTS
 Ensure you have the minimum specifications and tailor your CV to the advert.
 Spend time on the design and layout. A well presented CV, with clear headings, stands out from the competition.
 Spelling. Nothing looks as incompetent as poor spelling and grammar.
 Fonts. Be conservative and stick to easy on the eye fonts such as Arial or Times New Roman, with a size that is legible e.g. 11 or 12 point.
 Use a laser printer with good quality, white paper. 100g/m² paper looks and feels more professional than standard 60 or 80g/m². Stay away from patterned or coloured paper and card.
 If you are not skilled at using a word processor then either ask a friend or sweet-talk a secretary. There are companies that will design and type up a CV for a fee.

CONTENT
The content of your CV for this application should reflect what you have achieved over the previous years. From the start of your anaesthetic career, look to maximise opportunities that will improve your CV.

A summary of what you enjoy outside of work. For example, sport shows that you have commitment and a team spirit.

A logbook summary: as well as a CV you may have to include a summary of your logbook. It is tempting to include everything you have ever done in your career. Some applications may require this. However, this may make it too long and hide some of your career highlights.

A well written CV gives you over the first hurdle by getting you shortlisted for a ST3 post. It will form the basis for the interview questions. Make sure you can talk about all the items included in your CV.

This has been my personal opinion on CVs. I have submitted many CVs over the years to different specialties with varying success. I hope what I have learnt from my mistakes helps, and that you are successful.

NICHOLAS LOVE
GAT Chair 2011-
ST3, Oxford

**Index page:** if your CV is long.

**Personal details:** including contact details, GMC and training numbers.

**Qualifications:** include all exams attempted.

**Professional memberships**

**Employment history:** include a brief summary of experience and duties.

**Prizes:** enter local, regional or national competitions.

**Publications:** these can be sub-categorised into either papers, posters, abstracts, presentations and letters or into local, regional, national and international. Presenting an audit at the GAT Annual Scientific Meeting looks good on your CV.

**Research:** a brief summary of any research you may have undertaken.

**Audits:** completing the full audit cycle and showing how your audit changed practice makes you stand out. Audits can also be used for presentations at either a regional, national or international meetings.

**Teaching experience:** teaching does not just involve becoming an instructor for ALS. Show evidence of local teaching by being the lead at tutorials and lectures. Evidence of multidisciplinary teaching shows that you are involved in all aspects of anaesthesia. There are also various Train-the-Trainer courses.

**Management experience:** showing that you take an interest in helping to run your department looks great on a CV. Identifying and making changes to the department really makes you stand out from other candidates.

**Courses and Continued Professional Development:** minimum courses include ATLS, ALS and APLS.

**Other notable achievements:** achievements outside of medicine should be included as it shows that you are a well-balanced, rounded person.

**Hobbies:** a brief summary of what you enjoy outside of work.
STREET 3-7

COURSES FOR ST3 - ST7

Study leave budgets are being reduced, FETR-compliant fixed rotas make getting study leave time difficult and yet attending courses is important for several reasons. Early in training courses may be goal-focused, such as for exams, but later in training attendance at update days and specialist meetings allows trainees to develop specialist interests, meet peers and seniors and allow networking. This is an area where advice from your fellow trainees and consultants is useful; ask which meetings they have been to and find out if they were worth attending. This section cannot give you a list of the courses you must attend as there are no fixed rules, but by thinking about the different types of courses available you can plan how to spend your precious money and time.

EXAMS

The ST3 and ST4 years are focussed towards attaining the Final Fellowship of the Royal College of Anaesthetists (FRCA) exam. Revision courses are offered within hospitals, deaneries, by the RCoA and other institutions. (FRCA) exam. Revision courses are offered within hospitals, deaneries, by the RCoA and other institutions. The StR 3 and 4 years are focussed towards attaining the FRCA exam. Revision courses are offered within hospitals, deaneries, by the RCoA and other institutions. The FRCA exam. Revision courses are offered within hospitals, deaneries, by the RCoA and other institutions. (FRCA) exam. Revision courses are offered within hospitals, deaneries, by the RCoA and other institutions.

Skills. Anaesthetists should be 'appropriately trained and assessed' in advanced life support. For this reason it's advisable that all trainees maintain Adult Life Support (ALS) provider status until appointed to a consultant post. Depending upon the organisation for whom one works, in-house ALS training may be considered sufficient to meet this 'appropriately trained and assessed' status.

SPECIALIST INTERESTS

After passing the Final FRCA, attention turns to developing a specialist interest and polishing one's CV. Depending on the subspecialty involved, certain courses and qualifications become appropriate, see table for examples. Advice and recommendations on this can be gained from the relevant sections of the RCoA's curriculum. Membership of specialist societies and attendance at their meetings is also encouraged within the curriculum. Other societies allied to anaesthetic specialties often run interesting courses for example, attendance at a Royal College of Obstetrics and Gynaecology meeting might give the obstetric anaesthetist new perspectives.

Subspeciality

Courses

Obstetrics

Obstetric Anaesthesia
Simulator Course
Multidisciplinary Obstetric Emergency Course
Newborn Life Support

Paediatrics

Advanced Paediatric Life Support
Training in Child Protection
Newborn Life Support

Cardiothoracic anaesthesia

Transoesophageal Echocardiography Accreditation

ICM

Ultrasound/Echo course

MANAGEMENT

The importance of management training is being increasingly recognised with several deaneries offering in-house management training or fellowships. It is advisable for all trainees to gain an understanding of the practical workings of the NHS before applying for consultant posts as questions on management and service provision are common at interview. Management courses are run frequently by GAT, the AAGBI and the Association of Anaesthetists in Management (AiM). Please see the GAT seminars section of the AAGBI website (www.aagbi.org/professionals/trainees/gat-seminars) for details.

EDUCATION

With the increased use of workplace based assessments ever more anaesthetists are expected to assess trainees. It is appropriate for potential assessors to understand the design and aims of these assessment tools and in fact many hospitals expect assessors to hold some form of certification. Training in assessment is available at a local, regional and national level with the RCoA regularly running courses in how to teach and assess.

For those people who are particularly interested in education, a postgraduate qualification might be appropriate. Several institutions offer postgraduate certificates, diplomas and masters-level degrees in medical education. These require a significant time and financial commitment but are well worth it if a career as an educator appeals to you.

SIMULATION

The use of simulation in medical education has boomed over the past few years, with many deaneries investing in a high-fidelity simulator centre. Courses vary from basic anaesthetic emergencies and crisis management to specific courses on obstetric, paediatric or airway emergencies. Many simulation courses are multidisciplinary and provide opportunity to build non-technical skills (ANTS) as well as clinical ones. Simulation is being used increasingly as an assessment tool so familiarity with this medium might be good for several reasons.

With the increased use of simulation goes an increased need for teaching faculty. Post-FRCA trainees are often encouraged to train to become faculty, another valuable experience for those interested in education or assessment.

CONSULTANT INTERVIEW PREPARATION

As with passing exams getting the consultant job of your dreams depends on thorough preparation. Consultant interviews practice can often be gained within individual hospitals but formal courses are available that include advice on how to prepare your CV, lectures on common interview topics and questions and mock interviews. GAT runs a seminar on the consultant interview several times a year; it is always well attended and receives excellent feedback (www.aagbi.org/professionals/trainees/gat-seminars).

CLAUDE WILLIAMS

Previous GAT Committee member
Consultant, Cambridge University Hospitals NHS Foundation Trust

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DEVELOPING YOUR CV FOR…. AIRWAY / HEAD AND NECK

Anaesthesia for maxillo-facial, dental and ENT surgery, together comprising the 'head and neck' specialties, is increasingly being identified in job descriptions as a specific area of anaesthetic practice. These specialties present perhaps the widest range of patients and manifestations of surgery, varying from fit and healthy young people undergoing functional and aesthetic procedures, to the elderly and compromised undergoing complex operations for cancer. Major cases typically demand anaesthesia to deal not only with the haemodynamic accuracy required by such things as free-flaps but also the ability to deal with intermittently stimulating bony procedures in an area of the body where regional block techniques have traditionally been somewhat unsuitable and where there are quite complicated airway techniques. One consultant in any anaesthetic department with some interest in these fellowships in advanced airway management of between three and 12 months duration are available to the senior anaesthetic trainee. Possibilities on these fellowships include, as with any other, the concept of advanced difficult airway anaesthesia for complex major surgery. As the airway is shared, surgeons take a particular interest in your skills and if you are involved in the management of major head and neck reconstructive surgery then this interest extends further. A sense of belonging always seems to develop in head and neck theatre teams. Once identified as someone with difficult airway skills you might be called upon to assist other members of your department with complex cases; a situation which calls for a cool head and an agreed plan of action. Your support will also be needed by nursing staff in pre-operative assessment and sometimes by the multidisciplinary team caring for patients with head and neck cancer. Not only can you provide support but there also exists the possibility to shape services.

Aside from direct clinical work there is still much to do. Airway equipment requires organising and maintaining up-to-date, trainees and other members of the department require airway training, guidelines and protocols must be written and airway practice requires auditing. It is also important to maintain your own skills through local, regional or national airway courses and through attendance at the annual meeting of the Difficult Airway Society (DAS). Some regions have also established their own airway groups whose meetings provide a good forum to discuss current airway issues.

It can therefore be seen that in head and neck anaesthesia your working life will never be dull.

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BARIATRICS

The term ‘bariatric’ originates from the Greek root ‘bar’ meaning weight, and the suffix ‘air’ meaning treatment. It therefore refers to the physiological, dietary, medical, and surgical treatment of the obese patient. It is not a polite substitute for the word ‘obese’! This trend looks set to continue.

Bariatric surgery has developed over the last 30 years. The main procedures are adjustable gastric bands, gastric bypass and intragastric balloons, the majority of which are carried out laparoscopically. NICE guidelines recommend bariatric surgery for all people with a BMI of >35 and those in which non-surgical interventions have failed with a BMI >40 or 35-40 with obesity-related co-morbidities. An Office of Health Economics report estimated there are between 31,000 and 140,000 people in England who qualify for bariatric surgery. However due to a reluctance of core primary care organisations to fund surgery, only 1067 procedures took place in England in 2009-2010. Currently over 50% of bariatric surgery is carried out in the private sector. The reluctance to fund surgery may be short-sighted as it is estimated that 17% of the US health budget goes toward treating obesity related illness. Surgery can prevent the onset, or even reverse, obesity related pathology such as hypertension and diabetes. In the right patient, a gastric bypass pays for itself in three years, and a gastric band in 18 months. Bariatric anaesthesia has developed alongside the surgery as a sub-speciality. The safety record of bariatric surgery (gastric bypass mortality 0.5% and laparoscopic band 0.1%) is partly due to the allocation of experienced anaesthetists to the lists. In truth, any major case-competent anaesthetist could be a bariatric anaesthetist, however there are a few areas that require specific attention. These include management of obstructive sleep apnea with the condition being a risk factor for perioperative care; assessment of cardiovascular function with awareness of obesity-related pathologies, positioning to avoid airway at risk and surgical problems, a knowledge of pharmacokinetics in the obese and appropriate anesthetic techniques. The Society of Bariatric Anaesthetists (SOBA) is a new AAGBI affiliated society started in late 2008. The aims of the society are to educate and support anaesthetists involved in bariatric anaesthesia, to facilitate research and practice development, to contribute guidelines for the training and revalidation curricula, to develop a database to improve patient safety, and to encourage national and international links with like-minded groups.

The SOBA Committee recognises the significance of training in bariatric anaesthesia to two trainee representatives appointed to it annually.

SOBA provides a valuable source of information and also a discussion forum via its website at www.soba.uk.com. The annual cost of SOBA membership is £25, which is tax deductible. If you are planning on attending any of the meetings, this is more than recouped in the reduced fee for members.

SOBA runs two educational meetings a year aimed at the consultant or senior trainee embarking upon bariatric practice. They are usually held in December in London and in Manchester.

There is a SOBA session at the Annual Chichester Bariatric Surgery and Anaesthesia meeting. This includes a trainee poster and presentation competition. The five best abstracts are submitted for publication in Anaesthesia. SOBA plans to expand on this next year, and run a joint session with the European Society of Perioperative Care of the Obese Patient (ESPOCP). This is a golden opportunity for anyone interested in bariatric anaesthesia, or obese patients, to present at an international meeting.

There are several bariatric fellowships around the country available as additional or out of programme training. Currently they are at Luton and Dunstable, Taunton, The Whittington, and Chichester. SOBA’s aim is to facilitate and encourage the expansion of these positions. Consultant posts have recently been advertised ‘with an interest in bariatric surgery’. With the prospect of revalidation looming, SOBA has contributed to the RCoA’s matrix for continuing professional development defining core, intermediate and higher skills expected of anaesthetists. We have also had input into the new curriculum, and will be involved in developing practice guidelines in the near future.

The SOBA database is in the beta-testing phase, the ultimate aim is to link it with the National Surgical Database with the aim of it being a powerful source of information to improve patient outcomes and to aid commissioning. The database is available to members via the website and trainees are welcome to use it and to provide feedback.

In summary, why is bariatric and SOBA relevant to GAT members? Like it or not, for the foreseeable future, you will be anaesthetising an ever-enlarging population. SOBA can provide an educational forum for the expression of your research. For those of you interested, we can help you find or set up a bariatric fellow position. Please visit www.soba.uk.com for more information.

CLARE NIGHTINGALE

Treasurer, Society of Bariatric Anaesthetists UK
Consultant, Buckinghamshire Healthcare NHS Trust

CARDIOThorACICs

Before considering entry to any sub-specialty of anaesthesia, it would be wise to consider what the shape of that sub-specialty might be in 20 years time. After decades of increasing capacity for cardiovascular surgery, we may now have past the peak. In my own unit, there is currently no waiting list for cardiac surgery and, compared to this year when we were contracted to undertake next year has dropped by more than 10%. Coronary artery bypass grafting (CABG) currently makes up the great majority of all adult heart surgery and this reduction reflects a drop in the number of patients presenting for CABG surgery. Several affiliated society started in late 2008. The aims of the society are to educate and support anaesthetists involved in bariatric anaesthesia, to facilitate research and practice development, to contribute guidelines for the training and revalidation curricula, to develop a database to improve patient safety, and to encourage national and international links with like-minded groups.

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assisted thoracoscopic surgery (VATS) is considerably metastases are increasing. Moreover, because video be for GUC that in ten years time, 50% of adult heart surgery might of their original surgery. Indeed, some have estimated congenital heart disease (GUC because of heart surgery. Many of these grown-ups with Furthermore, increasing numbers of children with sclerotic aortic stenosis and our aging population is therefore likely to significantly increase the number of reasons why there will still be cardiothoracic surgery in the presence of impaired left ventricular function. In my opinion, the answer is no, as there are a number of reasons why there will still be cardiothoracic surgery in 20 years time. The evidence base continues to indicate that CABG surgery is prognostically better than angioplasty for the treatment of certain patterns of CAD, in particular triple vessel and left main CAD, especially in the presence of impaired left ventricular function. In addition, age is directly related to the incidence of sclerotic aortic stenosis and our aging population is likely to significantly increase the number of these patients. It is unlikely that percutaneous aortic valve implants will be appropriate for all, many patients will require surgical aortic valve replacement. Furthermore, increasing numbers of children with congenital heart disease are surviving to adulthood because of heart surgery, and this is a growing problem. Moreover, congenital heart disease (GUCH) will require revision of their original surgery. Indeed, some have estimated that 5% of aortic valve surgery may be for GUCH. In thoracic surgery, the surgical excision of both primary lung tumours and isolated pulmonary carotidies are increasing. Moreover, because video assisted thoracoscopic surgery (VATS) is considerably less of a surgical trespass than open thoracotomy, it enables operation on sicker patients who might have been declared inoperable in the past. Therefore, whilst the case-mix may be considerably different in the future, I have little doubt that there will plenty of patients requiring the skills and expertise of cardiothoracic anaesthetists to ensure the future career of anyone now entering this sub-specialty.

So, having established that there is a future in cardiothoracic anaesthesia, what will attract many junior doctors? The RCAn 2010 Curriculum for a CCT in Anaesthetics indicates that of 501 consultant jobs advertised in 2008, 25 (5%) were for cardiac anaesthesia, cardiothoracic anaesthesia or cardiac intensive care medicine. According to the 2009 Association of Cardiothoracic Anaesthetists (ACTA) Training and Workforce Survey, there were a similar number of consultant cardiothoracic anaesthetist appointments in 2009. The same survey also estimates that there will be 80 consultant vacancies in cardiothoracic anaesthesia in the next five years and 40 of these will be within the next two years. However, these estimates do not tally well with the number of consultants approaching retirement age. To take the most conservative view point and assume that all consultants will take retirement at age 65, the numbers would be 20 in the next five years and six over the next two years. Given the current downward trend in the number of adult patients requiring cardiothoracic surgery, compared to the deepest ever recession, not all of these vacancies arising from retirement might be reappointed. However, against these downward forces, the reduction in service commitment by trainees as a result of the European Working Time Regulations and the decrease in trainee numbers will force changes in consultant working practice that may necessitate maintenance of the current number of consultant cardiothoracic anaesthetists. At this time, the uncertainties, it is difficult to accurately predict the number of consultant appointments in cardiothoracic anaesthesia in future years.
not possible, then evidence that you are moving in that direction with, for example, attendance at one of the TOE courses run by undergraduate medical schools. Evidence of clinical experience is essential for your CV. Both FACA and the Society of Cardiovascular Anaesthesiologists (SCA) also run annual conference courses in TOE and there are an increasing number of meetings in the UK devoted to TOE. Attendance at these courses and meetings would strengthen your CV. Registrar's papers are now a regular feature in all the UK cardiothoracic centres, but experience in other countries, such as the USA, Canada or Australia, will add to your CV. Whilst this may be possible as an out of programme experience for training during CCT training, it seems more likely that working abroad will be a post-CCT experience.

Your future consultant colleagues on the interview committee will only have shortlisted you as they expect that, with the exception of paediatric cardiac anaesthesia and some super-specialised techniques, on appointment, you will be capable of giving cardiothoracic anaesthesia. What will they then be looking for is the added value that you will contribute to the department, and over and above your clinical skills. Teaching and management experience are two common areas that may be valuable to a department and hospital, and that does not mean supervising junior colleagues and running a trainee rota. Like TOE, some formal qualification such as a Certificate in Medical Education would be ideal for teaching, but perhaps unrealistic for everyone to achieve during training in anaesthesia. However, evidence of interest should be demonstrated by attendance at teaching or management courses.

Consider participating in UK or international courses if you are in an academic centre. Problem based learning is a good way into undergraduate teaching, as it is now an important component of the undergraduate curriculum in many medical schools. Because it is taught in small groups, a large number of tutors are needed. Again, ask your senior colleagues if they would be interested in sharing their teaching commitment in this area or have suggestions for other appropriate teaching.

Without doubt, paediatric cardiac anaesthesia is a super specialisation. Currently, there is considerable debate as to what training should be required for a consultant in this area and what to which you are applying is planning to set up a similar service. For example, the pandemic of H1N1 virus has sparked a renewed surge in paediatric anaesthesia. Although cold and unique, even trans-thoracic echocardiography (TT ECHO) as a treatment for life-threatening respiratory failure and, world-wide, there are only a limited number of centres offering experience with ECMO. Undoubtedly, valuable training will be gained in all the UK cardiothoracic centres, but experience in other countries, such as the USA, Canada or Australia, will add to your CV. Whilst this may be possible as an out of programme experience for training during CCT training, it seems more likely that working abroad will be a post-CCT experience.

In conclusion, if you are interested in a career in cardiothoracic anaesthesia, you should maximise the duration of your exposure to cardiothoracic anaesthesia and ICM during your intermediate and higher CCT training. Then, ideally, you should spend the year of your advanced training in cardiothoracic anaesthesia and ICM. Post-CCT experience in cardiothoracic anaesthesia on your CV, to show that you have obtained sufficient clinical exposure seems increasingly likely to be a prerequisite. Certainly, TOE accreditation or evidence that you are moving towards accreditation is essential for your CV. Evidence of academic achievement, educational abilities or management experience would then become important on your CV to make you stand out as an applicant for a consultant post in cardiothoracic anaesthesia. Although we live in a changing world, and unlike appointments in adult cardiac anaesthesia, newly appointed consultants may well not be able to hit the ground running, especially with infrequent patients with congenital heart disease requiring complex surgery, and may need mentoring during the early stages of their consultant careers. Given the complexities and lack of necessity as to the training requirements, anyone interested in a career in this area should seek out specialist advice early in their career to know how to develop the relevant experience and hone their CV to paediatric cardiac anaesthesia. The CCT in Anaesthetics Curriculum also advises that pre-CCT training for such posts has to be arranged on an individual trainee basis in conjunction with the medical secretary and training committee to ensure it complies with the requirements of a training programme leading to CCT.

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Without doubt, paediatric cardiac anaesthesia is a super specialisation. Currently, there is considerable debate as to what training should be required for a consultant post. Clearly, anyone who is going into paediatric cardiac anaesthesia needs to have a sound training in both cardio and paediatric anaesthesia. Furthermore, experience of specialist and unlike appointments in adult cardiac anaesthesia, newly appointed consultants may well not be able to hit the ground running, especially with infrequent patients with congenital heart disease requiring complex surgery, and may need mentoring during the early stages of their consultant careers. Given the complexities and lack of necessity as to the training requirements, anyone interested in a career in this area should seek out specialist advice early in their career to know how to develop the relevant experience and hone their CV to paediatric cardiac anaesthesia. The CCT in Anaesthetics Curriculum also advises that pre-CCT training for such posts has to be arranged on an individual trainee basis in conjunction with the medical secretary and training committee to ensure it complies with the requirements of a training programme leading to CCT.
with on a 23-hour basis. Furthermore, only a minority of patients require a hospital stay of longer than 48 hours. It seems that the

I enjoy the variety from anaesthesia in an environment that is harder to keep absolute control. Intensivists have a reputation for a broad medical knowledge, good communication skills and an ability to act quickly and appropriately under pressure. Personally, my advice is to consider the implications, but not to let concerns about private practice deflect you from your ambition.

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It was a wonderful insight into how the members are nurses, and six months are spent on this advanced unit of training. Training in day surgery forms part of the essential training units in the CCT in anaesthetics higher level training and is one of the options for advanced level training. Details can be found on the RCoA website. These documents provide guidance to trainers and trainees and are useful for those wishing to expand their training within day surgery. The advanced level training document states that “Advanced training in anaesthesia for day surgery should be delivered in centres with a dedicated day surgery team and with a dedicated director/lead clinician who has a substantial commitment to the role”. It goes on to say: “It is recommended that between three and six months are spent on this advanced unit of training.” Whilst mastery in clinical skills will be achieved, much of the benefit gained from this unit of training will be expanded day surgery. The more common question of how is a career in intensive care different to one in anaesthesia?”

The more important difference is obvious. You have the ground (such as the underlying theme of physiological safety) yet can be very different from anaesthesia. Intensive care is a more complex environment in which it is harder to keep absolute control. Difficult rationing and limitation decisions occur more frequently than in anaesthesia. You have a more central role in the hospital and interact with consultant colleagues (medics for example) that you rarely need to in anaesthesia. This offers great potential for your career down the line. Intensivists have a reputation for a broad medical knowledge, good communication skills and an ability to act quickly and appropriately under pressure. Personally, I enjoy the variety from anaesthesia in an environment that compliments and enhances my anaesthetic skills. It is rare to be bored in ICN.

WHAT ARE THE NEGATIVES? The common cautions are the pattern of work and the implications for private practice. You are probably more likely to be called at night as an intensivist than as an anaesthetist, although of course this depends on local arrangements. In years gone by this led to the reputation that ICN is harder work and that intensivists ‘burn out’. The recent emphasis on job planning has changed, and now intensivists have more time allocated outside normal working hours. As this counts as ‘time and a half’ they get more non-clinical time during the week. The issue of private practice is more variable. Most good intensive care units have continuity of consultant care during a typical week. This means that you are less likely to be available on a regular day, week in week out. If you are planning private practice with a surgeon who will not tolerate your absence then ICN might not be consistent with that kind of relationship. You will also probably have to let them choose when you can take your annual leave so you may want to think twice about this ambition! Anything short of this extreme practice is still consistent with ICN as most consultant groups have worked out ways to achieve both consultant continuity and exposure to private practice if that is what they want. My advice is to consider the implications, but not let concerns about private practice deflect you from your ambition.

INTENSIVE CARE MEDICINE

WHY DO YOU WANT TO DO INTENSIVE CARE?

Happy and successful intensivists will give you many different answers to this and each are as valid as the next. Perhaps a useful approach is to ask the question “how is a career in intensive care different to one in anaesthesia?”

I suspect that these ideals are some way from being met and that provision of training time within the day surgery arena often proves difficult. However, continued pressure from trainees will help ensure that suitable time is allowed for such attachments. Given the importance of training, surgery outlined at the start of this article, I suspect this will be an increasingly important area for hospitals around the UK.

I hope that I have provided some useful insights within this article, however if you require further information or feel that I have left a question unanswered then please contact me via BADS or by email (ian.jackson@york.nhs.uk).

IAN JACKSON Consultant Anaesthetist Clinical Director of Theatres, Anaesthesia & Critical Care, York Teaching Hospital NHS Foundation Trust
intensive care continues to expand as a specialty, and recruitment will continue to reflect this.

The existing programs require that anaesthetists gain some training in medicine including unscheduled acute care. This concept is almost certain to remain.

Complimentary training is provided in ACCS programs. Anaesthetists who have not done ACCS have sometimes found such posts difficult to come by. Trainees are strongly advised to check the latest training arrangements on the Faculty of Intensive Care Medicine website as the nature of handbooks is that they can be out of date soon after publication (www.ficm.ac.uk). In the meantime it is reasonable to say that those wanting to do ICQM should not pass up an opportunity to gain their complimentary specialty experience.

SO HOW SHOULD YOU DEVELOP YOUR CV FOR ICQM?

When you look at a trainee applying for an ICQM post I am trying to answer three questions: do they want to do intensive care, will they be good at it and are they better than their contemporaries? The first is most important, so is the second, and the third is a comfortable third. In other words, it doesn’t matter how good you are on paper if you cannot reassure the appointments process that you have an enthusiasm and aptitude for ICQM. The first two are vital, and the third is the clincher.

Although assessing enthusiasm can be subjective a few themes are reliable. The most important is that there is no substitute for evidence of enthusiasm spread over a period of time. You appoint someone for a year in the hope that they contribute to the unit through publication, teaching and organisation within that time. At interview everyone says they will do so, but it is easier to believe them if they have delivered something similar every year. Without doubt, enthusiasm is everyone’s unit and a candidate’s manner can convey, but enthusiasm without resultant achievement is a worrying sign.

Aptitude is in my opinion more difficult to assess than enthusiasm. Here, those involved in the appointment process are tempted, but unable, to use their personal experience of the candidate. It is reassuring to see a trainee who has succeeded in an area of particular interest in one area and points are given for those that have excelled, but this evidence needs to be presented in the CV. A common misunderstanding here is that aptitude is communicated through the references. These are important, but they only have the power of veto as they are usually read after the decision has been made. If you have done well enough to warrant a good reference then you need to communicate your achievement through your application; the reference is too late. If you are in doubt how then ask your referee who will appreciate the problem.

Because aptitude is difficult to assess, I often try to imagine how the trainee would fit into an ICU. Trainees that tend to fit in well are good communicators who understand the subtleties of a team of strong characters working in an intensive environment. I try to imagine you seeing them leading a ward round, prioritising multiple priorities at night, controlling the team during a difficult admission and keeping you appropriately informed. If you can’t imagine them doing this, you are worried that training will be difficult.

Often it comes down to personal fit— are they better than their competitors? Again credit is given for achievement over time. Have they initiated projects and been proactive in their own development? Completion is obviously important too. A bare CV with a flurry of recent projects described as “in progress” is a common but worrying sign.

At consultant interview you look for a clinical or para-clinical unique selling point (USP) that the unit is after, and to an extent this is true at trainee level. At least some achievement in each of teaching, publication, audit and management is important but if you can have a clear special interest in one area it reassures the panel that you are on the right track. Going on courses and staying up to date with mandatory qualifications such as life support courses is important but it does not score you points. In other words, the ability to book study leave is taken as read rather than as a positive. Becoming an active instructor on a course is different; you have been selected, have undergone formal teacher training and have demonstrated material to an audience in an environment in which you are comprehensively assessed. This is far more impressive and a great start for a para-clinical interest.

So what practical steps can you take to improve your CV? Examine your achievements and prioritise those that are proactive, complete and spread over time. If you know which clinical and para-clinical USP you are aiming for, try to show that you are on the correct course to achieve them by consultant interview. Above all choose your future audits, teaching, publications and management activities so that they have relevance both to intensive care and your interests. Join the Intensive Care Society (the membership numbers are significant). Put your best points at the top of the early pages (and hide others low down on later pages). Avoid abbreviations that are not explained (it makes the reader feel ignorant). A single typo error on your CV immediately disproves your application that is used to predict future performance. People want to appoint keen, capable, proactive and reliable trainees who have a clear idea where they are trying to go. If your CV reflects these attributes you will get the job.

LEADERSHIP AND MANAGEMENT

Management can be a dirty word amongst trainees. All too often our encounters with ‘the trust’ involve administrative problems or encounters with bed managers, but as you progress through to completion of CCT and eventual substantive post your appreciation of what management truly involves changes and evolves. It can be seen as irrelevant to our day to day jobs but nothing could be further from the truth, very often it is the ‘fast paddling feet’ that keep the hospital swan moving forward, whilst largely unseen. Furthermore, management and leadership skills are part of the higher training curriculum for all anaesthetists trainees and increasingly are asked for at consultant interview; after all, everyone will be ‘seen’ as a leader and have to manage many aspects of care and, if only indirectly, influence major spending decisions and strategic changes for the future.

The NHS is evolving, indeed the recent white paper ‘Equity and Excellence’ has been described as “evolutionary” by Andrew Lansley, Secretary of State for Health, and “evolutionary, like fish to man” by Sir David Nicholson, NHS CEO and Chair of the new NHS Commissioning Board. The Health Bill proposed huge changes to how the NHS is run. Departments will need
they will continue in some form. More forward looking trusts of these secondments is not clear, there are strong signals that advisor programs and being run across all of the strategic health authorities but it a more involved experience clinical leadership, schemes are competitive market of the shrinking consultant job market. For tick the management boxes, although beware of thinking that where there is an opportunity to spend a short period of time ‘left behind’ in the rapidly changing environment of the future. Office’ components of consultants’ working lives, something as an observer. This will give you some insight into the ‘back departmental committees, or by attending consultant meetings experience can be as a trainee representative on trust or as consultants. The nature of our sessional commitments about it: managing competing demands between different surgical specialties on an emergency list already encompasses elements of time management, communication skills, crisis management, conflict management and team working. There are many opportunities to get involved as a senior trainee. Writing the on call rota for six months can be an enlightening experience and can demonstrate the challenges of managing the competing demands of 8-10 people, as well as avoiding the temptation to bias or favouritism. Other ways of gaining experience can be as a trainee representative on trust or departmental committees, or by attending consultant meetings as an observer. This will give you some insight into the ‘back office’ components of consultants’ working lives, something every consultant needs to be involved with if they are not to be ‘left behind’ in the rapidly changing environment of the future.

Many trusts may offer leadership modules for higher trainees where there is an opportunity to spend a short period of time developing skills and seeing leadership in action. It may also be the case that you are on a course designed to tick the management boxes, although beware of thinking that this will be ‘all you need’. Everyone else will have done this too, so you’ll need more to make yourself ‘different’ in the competitive market of the shrinking consultant job market. For a more involved experience clinical leadership, schemes are being run across all of the strategic health authorities but it remains to be seen how long the Health Bill will affect the future of these courses. Nationally, there are clinical advisor programs and Darts fellowships but whilst the future of these secondments is not clear, there are strong signals that they will continue in some form. More forward looking trusts are also developing leadership programs, or even ‘staff colleagues’ to develop the multidisciplinary leadership needed for the future. As the financial and structural changes start to take effect in secondary care it is likely that there will be changes to rota structures and composition. Offering well thought out critical appraisal of proposed changes, both positive and negative, is another way in which management and leadership skills can be gained and demonstrated. Even better is to gain and build the skills required by the Care Quality Commission, or build a multidisciplinary team with your nursing colleagues to meet the challenges of critical illness patients as trainee doctors’ numbers drop. Understanding the structure of the trust is a good first step. Most, if not all, trusts will have their senior management structure on their intranet or website, ask your clinical director (departmental lead) to run through it and who best to meet and follow to learn more. The bottom line is that organisations within the NHS must find ways of maintaining or enhancing the quality of care with a clear eye on the bottom line. Financial incentives and penalties are some of the levers being used in an attempt to drive up Quality, Innovation, Productivity and Prevention (QUIPP) within the NHS. To survive in the modern NHS as a consultant, you will need to be familiar with the basics. For those who wish to take things further, there are plenty of opportunities to do so, and it is increasingly being looked upon as a very desirable characteristic.

Whilst these changes are most acute in the English NHS, the pressures to enhance value are present in every country in the UK. Whilst the market may be a feature of England, the pressures are as acute across the whole health care world. There has been a recent review of leadership opportunities in BMJ Careers which can be found at http://careers.bmj.com/careers/advice/view-article. html?id=20010165. A good book to read for further information is ‘Clinical Leadership: Bridging the divide’ edited by Stanton, Lemur and Mountford and available from Quay Books.

Things to do:

- Find a mentor to talk you through and aid your journey; many consultants already have an interest or experience in management and will be willing to help.
- Read up on the management structure of your own trust and get to know the senior management team and their roles.
- Spend time with senior management. They are usually very amenable to a clinical staff who want to learn more about their roles. The CEO or MD will often be delighted to have the stimulation and challenge that ‘naive’ observers bring to their everyday work.
- Keep abreast of medical policy, in particular the changes associated with the health bill and how the NHS is funded. The ‘New NHS’ will be fundamentally different.
- Become a trainee representative on either the consultant committee or as part of clinical governance. Look to becoming a rep to a regional or national society or professional association or college, they have opportunities to grow.
- Take a lead role within a department.

Courses:

- Information about these courses has been taken from their websites.
- King’s Fund Management Course for Specialist Registrars See: http://careers.bmj.com/careers/advice/view-article. html?id=20010165 for a review of this course in BMJ Careers. A five day intensive course that will prepare participants for that crucial consultant interview and help with the significant learning curve of their first consultant role.
- Clinical Management and Leadership, Keele University
A three day course intended for specialist registrars in their penultimate or final years of training, although they may be of interest to SpRs earlier in their careers. They are specific to each specialty. For anaesthesia look at http://www.keele.ac.uk/eml/coursesandprogrammes/ specialistregistrars/anaesthesia/

Prepared to be a consultant, Sheffield Hallam University

These two day management courses are designed for final year specialist registrars of any specialty, and others who are eligible to apply for consultant roles.

THOMAS DUNCAN
MRA Student
StR, Oxford

JONATHAN FIELDEN
Medical Director
Consultant, Royal Berkshire NHS Foundation Trust

MEDICAL EDUCATION

Whilst ‘doctor’ means ‘teacher’, this is not a role traditionally embraced by all doctors. With the decreased training time available due to the EWR there is an increasing focus on the quality of training, teaching and the learning environment.

CURRICULUM

Annex G of the RCoA 2010 curriculum describes basic, intermediate and high/advanced competencies in learning and teaching. This lays out clearly the skills and attributes all anaesthetic trainees should achieve. The challenge remains; if you want to stand out as a medical educator what can you do in addition to these required standards?

BEING AN EFFECTIVE LEARNER

Teaching begins with learning; some educationalists believe that there is no teaching but rather the facilitation of learning. Whilst some readers might not agree with this, for all of us, our first experience of education was as learners and this experience must necessarily inform our views and opinions. We know who the inspirational teachers are and by thinking about their teaching style, attitudes and behaviours we may be able to mirror these qualities in our own teaching style. Likewise we can avoid the mistakes of the poor ones!

TEACHING OPPORTUNITIES

Within medicine and anaesthesia there are a huge range and variety of teaching opportunities. The courses and qualifications described later are costly, but getting involved in teaching on a practical level costs no money, just your time. Teaching may be formal or informal, organised or opportunistic. It is important to gain experience in all these different settings and to maintain a record of your teaching activity. If you supervise a more junior trainee this can be recorded within the RCoA logbook, you can reflect upon teaching sessions in your portfolio and powerful evidence is to collect feedback from those you teach.

a) Local teaching sessions

Many hospital departments run regular teaching sessions, which may be led or facilitated by a consultant but often involve trainees preparing and delivering content. If such teaching does not exist within your department why not suggest it? The content is often exam focused but depends upon the needs of trainees in a department.

All trainees will spend some time at a teaching hospital; depending on local arrangements medical students will have an anaesthetic, ICU or acute care attachment. As a more junior trainee you may be allocated other trainees on your list, a little preparation can help others to develop. There are always medical students, student ODPs and paramedics in theatre. These people are often desperate for someone to give them some time, show them things and answer their questions (just remember to use your notes). This is both rewarding and fun.

b) Regional study days

In addition to local teaching, regional study days are also common. These may be run by one hospital in a deanery or rotate around departments. Seek out your college tutor and volunteer your services to help organise one of these days, help is usually very greatly received and a bit of initiative is very impressive.

c) Deans’ opportunities

Training is overseen by deans and many will appoint a trainee representative. If you are interested in education this is a way to get involved in the organisation of training at a higher level. Arrangements vary between deaneries so again, speak to your college tutor. Observing at interviews may feel like it falls into the category of management but an interview panel is trying to select trainees who will fit in with their training programme and show potential to learn and develop. If you see yourself as college tutor, programme director or regional advisor in the future it is these people that run the interview panels.

d) In-theatre teaching

Anaesthetic teaching takes place in theatre, even as a new trainee you have skills and knowledge that you can help others to develop. There are always medical students, student ODPs and paramedics in theatre. These people are often desperate for someone to give them some time, show them things and answer their questions (plus you can make a bit of money). Anaesthetists are popular as teaching faculty on regional study days. Senior trainees are usually able to assess other trainees once they themselves have been suitably trained. This training is often available in-house but is also available at the RCoA.

f) Resuscitation courses

Anaesthetists are popular as teaching faculty on resuscitation courses. The usual way into this is to be selected when completing a course as a candidate, those with potential are selected if performance has been sufficient. If you are interested in gaining instructor status make this known to the course director before the course, they may have helpful hints to aid your selection. Once selected it is necessary to complete the generic instructor’s course and commit to teaching a certain number of times per year. Details can be sought from the Resuscitation Council (www.resus.org).

Alternatively the ALERT course is run in-house by many hospital resuscitation departments. This course is taught to many medical students and nurses and involves recognition and treatment of unwl people, just where the skill of the anaesthetist lies. Speak to your resuscitation officer to see if your help is needed.

e) Simulation

Once you have gained your Primary and then your Final FRCA you may be able to teach on exam revision courses. These may be run within your department or region. Acting as faculty and an examiner is a good way of keeping your own knowledge fresh.

WORKPLACE BASED ASSESSMENTS

The way in which trainees are assessed and appraised has changed over the past few years, with the introduction of training portfolios and workplace based assessments. Senior trainees are usually able to assess other trainees once they themselves have been suitably trained. This training is often available in-house but is also available at the RCoA.

‘HOW TO TEACH’ COURSES

In addition to gaining training in assessment there are a variety of teaching courses available. These are available within many deaneries and may be free, or cost up to £500 per module. The RCoA runs a series of events
The Society of Anaesthetists as Educators. Annex C of the 2010 curriculum states that attendance at a ‘How to Teach’ course is expected at the higher level of training. Now that this is mandatory the issue still remains of how to stand apart. For that you may need a higher level teaching qualification.

TEACHING QUALIFICATIONS

Qualifications in medical education range from a postgraduate certificate to diploma and on to masters level and beyond. These qualifications are available at several institutions. Dundee runs a distance learning course focused on anaesthesia whilst most other courses are directed at healthcare in general and include contact days. Distance learning probably fits with most people’s working life but there are advantages to courses with contact days. The course I undertook included contact days learning with trainees from other medical disciplines, dentists, vets and other healthcare professionals. Continuing education is an area that was identified in complimentary disciplines allow for joint teaching, observation and importantly feedback. Qualifications with fixed terms also focus the mind and a deadline might make some people more productive. These qualifications represent a significant financial and time investment but as with many things if you see this as worthwhile investment in your career you need to make some long term plans.

QUALIFICATIONS

Qualifications range from a postgraduate certificate to diploma and on to masters level and beyond. This reflects the increasing expectations of training. The term ‘expert’ is widely misunderstood. It absolutely does not mean this person knows more about anaesthesia than you do. It means this person has a degree of experience and knowledge in the particular circumstances which pertain to this case. The standard of care which the practitioner needs to have achieved to avoid being found negligent is that which is ‘accepted as proper by a responsible body of medical men skilled in that particular art’ (the well-known Bolam test), and it is the expert’s job to represent the views of that responsible body to the highly intelligent but medically naive lawyers and judge.

What do you need to be an expert? From the point of view of the curriculum vitae, you only really need to show that you maintain a clinical practice in the field under scrutiny and, ideally but not critically, that you have been doing so successfully for some time. It is much more important to have the right skill set and personal traits for this sort of work.

To stand apart. For that you may need a higher level teaching qualification. The legal process is relentlessly logical, and you will need to be as well. You need to be as well.

Ability to write to deadlines

Time factors can be critical when submitting reports or comments.

Ability to write clearly and concisely

Try explaining the relationship between vasoconstrictor setting, MAC, end-tidal and arterial volatile agent concentrations to a lay person who is interested in anaesthetic awareness (if you think you’re hard enough).

A logical mind

The legal process is relentlessly logical, and you will need to be as well.

A thick skin

The lawyers for whom you are preparing a report will try very hard to pick holes in it, but this is nothing compared to what can happen in Court when the opposing barrister gets his teeth into you.

Complete control of your temper

See above.

Knowledge of your limitations

Nothing diminishes an expert’s standing more than when they stray outside their area of expertise (not that this stops obstetricians from giving opinions on anaesthetic practice at the smallest opportunity).

A degree of anal retentiveness

When every comma counts, as it does in legal argument, then slapdash is not a good look.

If these are your strengths, then all well and good. If not, there is equal good, if not better, income to be had at the private hospital down the road, and you already know that you’re a good anaesthetist!

While it used to be acceptable to learn on the job, nowadays some form of training is, understandably, considered useful. Bond Solon, a legal training firm, run a very expensive one-day courses in respect of writing, courtroom skills and civil law and procedure. Alternatively, AVMA (Action against Medical Accidents’) and the Academy of Experts also provide training, usually for a somewhat lower fee.

Once trained, how do you get your first cases? Unless you are fortunate enough to find yourself on AVMA’s recommended list (no, I’ve no idea how I got there), your best bet is to attach yourself to the coat-tails of an established expert. Ask them for a few cases to study and to prepare mock reports; they may well recommend you when they are offered a case with too short a deadline, an increasingly frequent occurrence as the workload builds up.

Don’t ask me though – I don’t need the competition.

REFERENCES

1 www.bondsolon.com/expert-witness-courses
2 www.avma.org.uk
3 www.academy-experts.org/courses/expert_training.htm

NEUROANAESTHESIA

Are you looking for a dynamic and rapidly advancing sub-specialty where your anaesthetic technique can have a real impact on both operative conditions and patient outcome? Where advanced airway skills, multi-modal pain management and the monitoring of the challenging and complex cases are required on a regular basis? Do you enjoy bringing physiology and pharmacology to life whilst working as part of a dedicated team who manage critically ill patients? If so, neuroanaesthesia and/or neurocritical care may be the career choice for you.

WHERE WOULD I WORK?

Most neurosurgical units are based within 39 teaching hospitals in major geographical centres of the UK and Ireland. These are as central as tertiary centres within a set geographical area. Working at such centres, most neuroanaesthetists will also have sections where they carry out non-neuroanaesthetic lists or work in intensive care. As with other sub-specialities, the training in neuroanaesthesia and neurocritical care has become increasingly standardised following the introduction of competency based training. There are now intermediate, higher and advanced training modules, details of which...
can be viewed on the Neuromuscular anaesthesia Society of Great Britain and Ireland (NAGB) website (www.nagbi.org.uk).

TRAINING
If neuromuscular anaesthesia has appealed during your basic training then express an interest to your programme director at an early stage so they can arrange a placement for your advanced training.

INTERMEDIATE TRAINING
Requires between one and three months spent at a specialist centre building on competencies and skills obtained during basic training (CT1 and CT2).

HIGHER TRAINING
Requires between one and three months spent becoming more independent in managing a range of cases for neuroanaesthesia.

ADVANCED TRAINING
Should be for six to 12 months, with at least one month in neurocritical care. Trainees are encouraged to gain experience in more than one such centre. Many national and international centres offer such opportunities and for those wishing to pursue research, educational objectives or further study at an overseas institution the Neuromuscular anaesthesia Travel Fellowship is available to members of the NAGB. This is an annual grant and is awarded to any trainee or consultant with an interest in neuromuscular or intensive care. The grant will be to facilitate visits in Great Britain and Ireland or abroad. Visits should include research, study or learning. The award is up to £2500 and allocated towards travel and accommodation and subsistence. Of this, a maximum of £1250 will be awarded per applicant. More information can be found in the Resources section of the NAGB website. It is also recommended that those wishing to specialise in neuromuscular anaesthesia and neurointensive care complete three months of neurointensive care as part of their general intensive care training. For jobs with a major interest in neuroanaesthesia, it is recommended that training should include a minimum of six months higher/advanced training in neuromuscular anaesthesia and Step 2 training in intensive care medicine including three months of neurocritical care. For a post with a major interest in paediatric neuroanaesthesia, an individual advanced training programme will need to be prospectively agreed and early discussions with the Royal College of Anaesthetists training department and medical secretary will be essential.

HOW DO I DEVELOP MY CV?
You should get involved with any ongoing projects in neuromuscular anaesthesia or critical care. You might do this in various ways such as presenting topics on neuromuscular anaesthesia at journal clubs or getting involved with critical incident reporting. You could discuss relevant morbidity and mortality cases that occur in your neurosurgical unit. You should read the relevant journals and other topical subjects from the AAGBI glossies and RCoA bulletins. These might give you a simple idea to audit and may lead to implementing change in your department. Anything leading to service improvement or improving the patient pathway are currently very ‘in’ and could double up as management projects too. Above all, you should be proactive and keep your eyes open for any interesting cases that could be written up and published. Often the simplest ideas are the best. Apply for local and national prizes because you are interested and experienced in all aspects of neuroanaesthesia. A few days spent in another centre looking at a specific area can be a very efficient use of your study leave. This will require a small amount of planning on your part but should be quite easy to arrange, and has the advantage of being free! Look on the training section of the NAGB website where you will find information about what other neuro centres have to offer. Here are a few suggestions that will make it clear that you are serious about your neuromuscular training:

- Improve your advanced airway skills: teach on a local airway course and make friends with a respiratory physician or max fac team to increase your exposure to fiberoptic intubations. Don’t forget to document these cases in your logbook.
- Ensure you have a broad experience of surgical and interventional cases including major orthopaedic spinal surgery such as scoliosis repair.
- Spend some time in an X-ray department which performs interventional radiology for aneurysms, abscesses and strokes, this is a very specialised but fast expanding area.
- Ensure you have done some paediatric cases even if this is not your intended area of practice; time spent broadening your training is never wasted.

ADDED POINTS TO AIM FOR ON YOUR CV
Demonstrating that you are an effective teacher should be relatively easy to do. Offering to organise pre- and post fellowship study days on neuromuscular anaesthesia will make you popular in your department. Often the simplest ideas are the best. Apply for local and national prizes because you are interested and experienced in all aspects of neuroanaesthesia. A few days spent in another centre looking at a specific area can be a very efficient use of your study leave. This will require a small amount of planning on your part but should be quite easy to arrange, and has the advantage of being free! Look on the training section of the NAGB website where you will find information about what other neuro centres have to offer. Here are a few suggestions that will make it clear that you are serious about your neuromuscular training:

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FURTHER INFORMATION:
1. www.nagbi.org.uk
2. www.das.uk.com
3. www.snc.org.uk
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OBSTETRICS

WHY SHOULD I CONSIDER A CAREER IN OBSTETRIC ANAESTHESIA?

Whilst the surgical repertoire changes, (minimally invasive cardiac surgery, endovascular repair of thoracic and abdominal aneurysms, etc), and arguably becomes less exciting for some anaesthetists, obstetric anaesthesia is increasing in complexity thereby presenting us with exciting challenges. Women with complex medical problems, who would never have achieved a successful pregnancy in the past, now appear regularly on the labour ward. The rising caesarean section rate, home births in hospital, the obesity epidemic and the challenge of working with our multidisciplinary obstetric colleagues are part of what makes life on the labour ward so totally different to the structured life of the operating theatre. If, however, you enjoy medicine/obstetric medicine and miss patient (and their next of kin) contact, all human life, its most vulnerable, is to be found on the labour ward.

PERSONAL SPECIFICATION

✱ Able to work as part of a multidisciplinary team.
✱ Will include seeing selected women antenatally and contributing to the care of women during labour, delivery and post-partum.
✱ You cannot be an excellent obstetric anaesthetist without a good understanding of what your obstetric colleagues are getting up to! Learn how to read that CTG, be able to interpret the foetal blood gases, STAN and etc.
✱ Communicates effectively with mothers, partners, medical colleagues and midwives.
✱ Skilled in regional anaesthesia/anaesthesia for labour and operative deliveries, and perhaps on some occasions providing effective general anaesthesia for a caesarean section.
✱ Remains calm under pressure, and can manage challenging situations and make rapid decisions.
✱ Suitably skilled to recognise and treat the sick parturient on the labour ward and liaise with intensive care.
✱ Teacher, trainer and provider of up-to-date guidelines for the labour ward and information for mothers.
✱ Committed to research and audit.
✱ Can work without a routine, sometimes at unsocial hours.
✱ Recognises and enjoys the alternative lifestyle to that provided in a windowless operating theatre.
✱ Willing to humbly accept praise, gratitude and even champaigne for relieving pain and safely supporting a woman through a difficult delivery.

TRAINING

Obstetric anaesthesia is a basic core topic in anaesthetic training and as such all trainees will spend a significant proportion of their early training-on-call years dealing with pregnant women. After all, women represent half of the population and caesarean section is the most frequently performed operation in the UK. However, a career in obstetric anaesthesia does have something extra. In the first instance a trainee contemplating a career in obstetric anaesthesia should arrange to spend at least six months as an obstetric fellow in their senior training years. The RCoA sets the standards for anaesthetic training in the UK. Senior trainees contemplating a sub-specialty career should access the document: The CCT in Anaesthesia IV: Higher and Advanced Level Specialty Training Year 5, 6 & 7. The RCoA also provides practical information on out of programme training/ research (OOPR). Arguably, of all the sub-specialities obstetric anaesthesia provides the most fascinating opportunities for out of programme training, be that in the developed (especially Australia, the United States and Canada) or developing world. However if you choose to go to a developing country it may have training implications. These positions are rarely advertised, often require a thorough internet search and/or a useful contact. You may find that one of your obstetric anaesthetists consultants can put you in contact with colleagues abroad.

Excellent training and research information (e.g. Guidelines for Obstetric Anaesthesia Research) is also available on the website of the UK-based Obstetric Anaesthetists’ Association (OAA) (www.oaa-anaes.ac.uk). The OAA has a global membership of more than 2300 members and aims to promote the highest standard of anaesthetic practice in the care of the mother and baby. In addition the OAA has excellent links with its fellow organisation in North America, the Society for Obstetric Anesthesia and Perinatology (SOAP) (www.SOAP.org) and many other countries around the world. Try to attend one of SOAP’s annual meetings, which are wonderfully stimulating and are usually held in a very attractive US venue. You should certainly demonstrate your interest in obstetric anaesthesia by becoming a member of the OAA, which offers preferential rates for trainees, and you should aim to present a paper or a poster at one of its annual meetings during your trainee years. The lucky trainee winner of the oral presentation wins a cash prize. Membership of the OAA also includes the specialist journal, the International Journal of Obstetric Anaesthesia. In addition, do not forget that the website of the college of our obstetric colleagues: www.rcog.org. It provides excellent information much of which is of interest to anaesthetists.

Working in a specialist unit or a large busy unit with a reputation for guiding trainees in research, audit and their ultimate conclusion, an oral or a written presentation at a meeting, will serve you well. You should also aim to involve yourself in the teaching and administrative side of your local maternity service e.g. lecture on anaesthesia in labour at an antenatal class. You may also aim forHonours at a Maternal and Child Health Matters or an Obstetric Risk Management meeting. Not only will this be educational but will prepare you for that consultant interview.

Becoming involved in obstetric research can be difficult, e.g. suitable obstetric patients do not often turn up between 9 and 5, and there are ethical constraints and it may be difficult to complete the research in the course of a fellowship. However if the opportunity presents, grab it! Audit is somewhat easier than research in obstetrics and you should certainly aim to complete at least one audit project during your fellowship. Our sub-speciality is actively involved in the Centre for Maternal and Child Enquiries, previously the Confidential Enquiry into Maternal and Child Health (CEMACH), an obstetric audit that is the envy of our colleagues worldwide.

THE FUTURE

One thing is certain: it is unlikely that women will cease to reproduce! In fact the workload seems to go on increasing, the 10% caesarean section rate of the 1980’s is today nearer to 30%. What may change is how the workforce will be deployed. The current eight to nine hour consultant anaesthetist cover on the labour ward may soon become 12 hours (as many of the obstetricians are now doing) and ultimately 24 hours. The European Working Time Regulations and the continuing shortage of midwives will continue to impose additional safety and ability to deliver an efficient and safe maternity service. But become an obstetric anaesthetist because you do not fear the unexpected and enjoy a challenging career.
In the operating theatre the anaesthetist performing any local anaesthetic block is responsible for checking the consent form with the patient especially with regards the laterality of the eye to be operated on in accordance with stringent guidelines, hence vigilance and attention to detail is essential. A certain degree of manual dexterity is advantageous in performing regional ophthalmic blocks. Good and effective communication skills are vital both in assessing the patient and in communicating with the surgeon to ensure optimal operating conditions.

The ophthalmic anaesthetist has a key role in the following areas:

- Preoperative patient assessment, to assess patients and manage existing medical conditions prior to surgery
- Provision of local anaesthesia typically sub-Tenon (blunt needle technique) or peribulbar (sharp needle technique) blocks
- Provision of general anaesthesia when appropriate
- Administration of intravenous sedation for some underlying complex procedures under local anaesthesia
- Patient monitoring throughout the operation
- Management of any perioperative complications including maintenance of haemodynamic stability and cardiopulmonary resuscitation
- Teaching and training of other staff
- Participation in audit and research projects
- Development of the ophthalmic anaesthesia service for the future

TRAINING IN OPHTHALMIC ANAESTHESIA

Over recent years, the trend has been for ophthalmic surgery and anaesthesia to be undertaken on a case basis and an increasing number of procedures are carried out under local anaesthetic. To facilitate this anaesthetic provision, an understanding of the relevant orbital anatomy, physiology and pharmacology is essential, together with the more clinical aspects of patient care including experience in day case anaesthesia. All trainee anaesthetists with an interest in ophthalmic anaesthesia should complete competency-based assessment of knowledge, skills, attitudes and behaviour in ophthalmic anaesthesia in accordance with the 2010 RCoA Curriculum for a CCT in Anaesthetics.

The training in ophthalmic anaesthesia is delivered in optional units at both intermediate and higher levels within schools of anaesthesia. Currently, ophthalmic surgery is undertaken in a range of settings including general hospitals, isolated ‘stand-alone’ units and large single-specialty centres. All such settings must have appropriate staffing levels, skill mix and facilities.

Some supra-regional tertiary referral units such as the Birmingham and Midland Eye Centre offer advanced training modules in ophthalmic anaesthesia. Such training provides specialist training opportunities for a senior trainee to gain further knowledge and experience in:

- General and regional anaesthesia for the range of ophthalmic surgical procedures including cataract, strabismus, glaucoma, vitreoretinal, ocularplastic and corneal transplant surgery
- Anaesthesia for elective and emergency ophthalmic surgery
- Preoperative ophthalmic patient assessment
- Audit and research
- Levels of service provision in ophthalmic anaesthesia including staffing requirements, equipment, support services and facilities
- Gaining insight into guidelines and protocols in ophthalmic anaesthesia as the joint report by the Royal College of Anaesthetists and the Royal College of Ophthalmologists
- Ophthalmic anaesthetists who intend to work regularly with children will need appropriate training in paediatric anaesthesia in addition to specialist experience in ophthalmic anaesthesia. Any trainee who wishes to develop an interest in ophthalmic anaesthesia must make this known to their training programme director at the earliest opportunity so that this may be facilitated.

IMPRESSING YOUR CV

The British Ophthalmic Anaesthesia Society (BOAS) organises an annual scientific meeting in the UK which provides useful specialist continuing education and professional development. This annual event is also an excellent opportunity for trainees to submit case reports and the results of audit or research work for verbal or poster presentation. Both the journals Anaesthesia and British Journal of Anaesthesia publish articles and original research relating to ophthalmic anaesthesia. In addition, reading the journal Ophthalmic Anaesthesia, which is published by BOAS, gives useful background information as it covers issues of topical interest and current new areas of development in ophthalmic anaesthesia. Attendance at specialist ophthalmic regional anaesthesia workshops such as those organised by the AAGBI and the Middlesbrough video-conference on local anaesthesia for ophthalmic surgery will provide trainees with additional experience to further enhance and refine their local anaesthetic techniques.

FURTHER INFORMATION

Obstetric Anaesthetists’ Association www.oaa-anaes.ac.uk
Centre for Maternal and Child Enquiry (CMACE) www.cmace.org.uk
Managing Obstetric Emergencies and Trauma (MOET) www.alsg.org/index.php?id=33
Royal College of Obstetricians and Gynaecologists www.rcog.org.uk
Society for Obstetric Anesthesia and Perinatology www.soap.org

GERALDINE O’SULLIVAN
Consultant, Guy’s & St Thomas’ NHS Foundation Trust

OPHTHALMICS

Anaesthesia for ophthalmic surgery is a recognised sub-specialty of anaesthetic practice. A broad spectrum of patients will be encountered, ranging from premature neonates to the very elderly who, because of their age, frequently require optimisation of concomitant systemic disease prior to surgery. Ophthalmic surgery is also commonly required for ocular manifestations of systemic disease and in ‘syndromic children’, hence a relatively high proportion of patients are seen with relatively uncommon medical conditions, making this a sub-specialty that presents the opportunity to encounter a wide range of disease conditions. Pre-operative patient assessment is particularly important for these reasons and is now commonly performed prior to surgery. During consultations, decisions are also made about appropriate patient selection for day surgery and choice of local or general anaesthesia.
Combining paediatric anaesthesia with adult intensive care medicine is usually obtained through several years of experience, which is becoming increasingly centralised; some deaneries have the scope to offer an advanced training programme in paediatric anaesthesia, and if yours does not then you will need to explore the feasibility of taking time out of programme and competing for a fellowship post, either in the UK or combined with the opportunity to go abroad. Overseas fellowship positions (commonly in Canada, the USA and Australia) require early application as there are often waiting lists, and must be prospectively approved by your regional advisor with any other out of programme position. If it turns out not to be a realistic option, then another consideration is one of the increasingly popular post-CCT fellowships. If you consider all your options in advance, discuss them with the appropriate people and prepare properly, the choice could be all yours.

Achieving your ultimate aim is a question of identifying it, declaring it, getting the relevant and important people on your side and listening to their advice and direction. Ensure you cover the basics well in advance, and then any exciting extras you can add will be truly beneficial. If paediatric anaesthesia interests you then go for it – it is an immensely challenging and rewarding field, which is becoming increasingly centralised; some district general hospitals have reduced their paediatric workload with a resulting impact on the more traditional role of anaesthetic jobs ‘with an interest in paediatrics’. However, these things often come full circle and you will be future development opportunities within your Regional Managed Clinical Network, something else about which you and your local paediatric anaesthetists may be able to inform you. An early insight into these longer-term issues should enable you to consider fully any conflicts of interest between sub-specialisation and geographical location that may arise, and how many people can say that about their day job?
PAIN

What is it like to be a consultant in pain medicine? Is it better to see the big picture, and what is the future of acute pain? How much pain training do I need to do before advanced pain training? Do I have to sit an examination?

Pain medicine has superseded the term ‘pain management’ as pain develops into a specialty in its own right. It ‘describes the work of specially qualified medical practitioners who undertake the comprehensive management of patients with acute, chronic and cancer pain using physical, pharmacological, interventional and psychological techniques in a multidisciplinary setting’.

The Faculty of Pain Medicine at the Royal College of Anaesthetists was launched in April 2007 and is the ‘professional body responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain in the United Kingdom. It supports a multidisciplinary approach to pain management informed by evidence based practice and research’.

There are several categories of fellowship of the Faculty which are explained on the Faculty website. Trainees who are interested in a career in pain medicine should seek a post in advanced pain training with a view to becoming a fellow by assessment. Successful applicants can then use the postnominals FFPMRCA. Details of the competencies required and application forms are available on the Faculty website. Successful applicants will also find guidance about advanced training in pain medicine for anaesthetists. The Faculty continues to work hard to set standards and to ensure consistency of training, which is a process that is evolving slowly. This work will continue. Watch the website for the publication of ‘best practice’ guidance for different topics such as ‘Compendium for Spinal Cord Stimulation’. Upcoming ones include Paediatric Pain and Cancer Pain. The current Dean of the Faculty is Professor David Rowbotham. There is a contact address for the Faculty if you have any queries, and there is always a trainee representative on the Board to whom you can address your questions. The Faculty and deaneries work closely together, and you may find regional pain training initiatives emanating from the deaneries, such as the All England Academy of Anaesthetists and the Pain-London Pain Training Advisory Group, which is a sub-unit of the Academy of Anaesthesia.

The pain medicine curriculum is now finalised. It was developed with reference to the excellent publication of the International Association for the Study of Pain: Core Curriculum for Professional Education in Pain, third edition, editor J Edmond Churthem. The subject matter is wide ranging, from transmission of pain transmission (science of understanding of psychological aspects, interventional techniques, pharmacotherapies, and pain in particular syndromes such as the very young and old). The curriculum covers knowledge of acute, chronic and cancer pain management. An entrance examination to the Faculty is under development by the Faculty and should be initiated in 2012. Passing this examination will be compulsory in the future for those wanting to become fellows of the Faculty, although this does not affect the award of your CCT. It is strongly advised that all pain trainees keep a logbook; a logbook that has been developed for pain medicine trainees is now available on the Faculty website.

It is possible to seek a career in pain medicine without doing advanced pain training? I would advise against it, unless you are followed by an advanced pain training college and are good at a holistic approach to patient assessment, and the pharmacokinetics of analgesic and adjunct drugs; ward work is more to do with the prevention of chronicity, diagnosis of neuropathic pain and the judicious use of strong opioids. There is no room for paternalism; you must keep an open and enquiring mind. The Faculty website will also include information about the Good Pain Medicine practice guidelines that will be published includes a description of the knowledge, skills and attributes required by a pain doctor for revalidation.

Most schools of anaesthesia offer compulsory pain modules as a part of anaesthetic training, at a basic and an intermediate level. These vary in length from one to three months. To develop your CV in pain you should do a bit more than just turn up at your allocated clinic.

FELICITY HOWARD

Previous GAT Chair

Consultant Paediatric Anaesthetist, University Hospital of Wales

The GAT Handbook 2011-2012
In summary, pain medicine is an interesting and compelling career, in a field that is rapidly developing and gaining greater recognition, and there is now a dedicated Faculty to support training and uphold standards. It requires an in-depth medical knowledge, a combination of scientific and psychosocial skills, dedication, team working ability, and perseverance. Once understood, it can be a most rewarding career, potentially patient groups may include:

- Burns (resuscitation, intensive care management and transfer)
- Breast surgery (reconstruction following cancer, cosmetic surgery)
- Skin cancer (excision and reconstruction, management of metastasis)
- Head and neck (oral cancer reconstruction, craniofacial surgery)
- Children (cleft lip and palate, hypospasias, ear anomalies, congenital anomalies)
- Hand and upper limb surgery (hand trauma, degenerative conditions such as arthritis)
- Lower limb trauma reconstruction
- Microsurgery for bone and soft-tissue reconstruction and free tissue transfer

HOW TO DEVELOP YOUR CV

Desirable qualities are an attention to detail and meticulous anesthetic technique. The ability to balance an extremely varied workload and a capacity to foster good working relationships as part of a multidisciplinary team make this specialty a particular challenge. If you have an interest in plastics and burns, let your training program director or clinical lead know early on. Training doesn't have to be in a dedicated block; it could be performed piecemeal over time. Some larger centers may offer dedicated blocks and one year fellowships either as OPRE or post-CCT positions. Here at Broomfield, we have four post-FRCA fellowships. The RCoA provides general guidance and the Association of Burns and Reconstructive Anaesthetists (ABRA) is helpful in providing a syllabus, but it may be possible to put together an interesting module yourself which would look far better on your CV.

The AAGBI and RCoA bulletins provide useful CPD topic guidance. The National Burn Care Group is a useful resource and provides guidelines on treatment which are endorsed by RCoA. Demonstrate commitment by presenting at journal clubs and morbidity and mortality on relevant cases you have seen. There are regional and national meetings as well as ABRA offer a trainee prize. The specialty is often underrepresented at departmental level so offer to run some specific pre and post fellowship teaching sessions, an interesting area may be the choice of fluids and how they may affect survival, the choice of fluids and how they may affect survival.

Audit activity is made easier as
our surgical colleagues are only too keen to have an anaesthetist’s collaboration. There are a number of collaborative areas to make a contribution to research and development such as pain relief following burns or the effects of anaesthesia on grafts. You cannot be an excellent anaesthetist without knowing what the surgeons are up to, therefore it is vital to work closely with and attend some local surgical teaching sessions so that you know the difference between a TRAM and a DIEP flap! The British Association of Plastic and Reconstructive Surgeons (BAPRAS) have twice yearly scientific meetings. A small local surgical seminar is run. There is a BAPRAS annual meeting which requires a good opportunity to submit a poster for a prize; this is not oversubscribed and you should have a good chance of winning. The British Burns Association (BBA) meets annually during the spring for a multidisciplinary meeting and is another excellent meeting to aim for with either a poster or oral presentation. If the study budget allows, there is always the European Burn Association meeting.

Teamworking and the capacity to remain focused during long lists are essential. A background in paediatrics or intensive care would be useful for a list but is particularly relevant if you are going to be working in a tertiary referral unit for reconstruction or major burns resuscitation. Similarly, plastics and burns patients have often suffered trauma so it is useful to update your APLS and ATLS courses. Patients requiring head and neck surgery, those with face and neck scarring from burn injuries or congenital deformities are often transferred so make sure your transport skills are up to date in this area. Take the initiative, be proactive and demonstrate interest and expertise.

THE FUTURE

The speciality is a small one and many departments will be looking for candidates with an active interest. The number of consultant posts has increased in the last twenty years and plastics and burns anaesthetists have become an essential part of the ATRA. This shows that plastic and burn surgery is an exciting and innovative speciality which you could become part of. Good luck!

USEFUL WEBSITES

www.rcOA.ac.uk
www.abra.org.uk
www.britishburnassociation.org.uk
www.bapras.org.uk

■ SIMON LAW
SpR, Oxford

■ PATRICIA RICHARDSON
Consultant, St Andrews Centre for Plastic Surgery and Burns, Broomfield Hospital, Chelmsford

PRE-OPERATIVE ASSESSMENT

The field of pre-operative assessment (pre-assessment) and optimisation is a rapidly changing environment. As little as a decade ago, it was commonplace for patients undergoing high-risk, complex surgery with life-threatening co-morbidity to be seen by a surgical house officer a week before surgery, and then seen on the ward by an anaesthetist the night before. This left very little time for necessary investigations and management plans to be instituted, let alone for an unpressured discussion of risk/benefit and truly informed consent. Thankfully, things have moved on. However, it is still in its infancy, and systems for pre-operative assessment vary greatly from trust to trust.

WHAT DOES PRE-OPERATIVE ASSESSMENT INVOLVE?

Exposure to pre-operative assessment can be quite variable as a trainee. Obviously the basics are fundamental to all anaesthetic practice. However, the whole process of pre-assessment is much more complex. Most trusts now have consultant sessions in a pre-assessment clinic. This gives an opportunity to optimise the patients prior to surgery, assess their physiological reserve (for example using cardiopulmonary exercise testing) and to give some estimation of the risks involved in the whole peri-operative period. This requires not only a good knowledge of the various surgical procedures undertaken, but also the medical management of the common co-existing conditions encountered. Developing good working relationships across all the specialties is therefore essential.

Often a more significant role is the management of the patient’s respiratory status as a whole. As many disciplines are involved, structures need to be in place to ensure good communication, and in most centres the anaesthetist has become an integral part of the medical team. Many hospitals now undertake nurse pre-assessment for the majority of patients, and they need to have good, evidence-based, robust guidelines upon which to act. Developing such documents and ensuring all colleagues agree to them can be challenging!

IMPROVING YOUR CV

If you have an interest in pre-assessment, it is important that you make your wishes known to your nro coordinator. Most trainees spend only a few sessions as a ‘supernumerary’ in clinic, and consequently have limited exposure. If you wish to attend, the more responsibility you will be able to take on. Make sure that you record clinics attended in your logbook. There are also numerous conferences and seminars available to those wishing to pursue an interest. Many of these are multidisciplinary, providing a good insight into the many facets of a pre-assessment service.

Pre-assessment skills often overlap with those in other areas of anaesthetic practice. The management skills often associated with day surgery will be of benefit, and any evidence of an interest in management will be helpful. Similarly, a background in intensive care or cardiothoracic anaesthesia can be useful in familiarising yourself with the management of the common co-morbidities encountered.

CPX testing in the UK is beginning to move from an area of research interest into established practice outside of the main teaching centres. As well as providing information as to how best to optimise patients peri-operatively (both in terms of direct interventions and also allocation of resources e.g. critical care), it provides useful objective information to guide the patient consent process. CPX sessions are, in most centres, now led by anaesthetists, with many consultants having sessions dedicated to its use. If there are any opportunities within your training region, arrange a number of visits to the CPX clinic. This will provide you with excellent opportunities should you wish to pursue this in the future.

CPX training can also be undertaken in a number of centres around the world. This will also provide opportunities to see how else pre-assessment can be structured. For example, often all patients are seen in a pre-assessment clinic by an anaesthetist. Therefore a period spent working abroad as part of out of programme
experience will often provide opportunities which are currently rare in the UK. I first developed my interest during my first year of training in vascular and transplant anaesthesia, so developing pre-assessment skills can often go in tandem with gaining other clinical skills.

Finally, if you are interested in a consultant post involving pre-assessment, make it known to the trust at an early stage. Many departments are looking for candidates with an interest in this area, and job plans can often be created to accommodate this.

**FURTHER INFORMATION**

1 www.pre-op.org
2 www.spaq.org

**DAVID EARL**
Past Chair, The Preoperative Association
Anesthetic Lead for Preoperative Assessment, Harrogate and District Foundation Trust.

**REGIONAL**

**WHY SHOULD I DEVELOP MY SKILLS IN REGIONAL ANAESTHESIA?**

The ability to locate, image and block a central or peripheral nerve or structure is not just a skill that regional anaesthetists utilise. In fact almost all anaesthetic sub specialties utilise, to some degree, regional or local anaesthesia either as a sole anaesthetic technique or for post-operative pain management.

With an ageing population with increasing co-morbidities, in many instances regional anaesthetic techniques provide the safest method of anaesthesia. Developing ultrasound guided visualisation techniques provide the safest method of anaesthesia.

Recent developments in ultrasound guided visualisation techniques provide the safest method of anaesthesia. Many departments offer advanced training modules in regional anaesthesia, entry to which is competitive.

**IMPROVING YOUR CV**

There are many opportunities to develop your CV further in this field. As regional anaesthesia is a generic skill associated to many specialties it can be useful for those who are in training and set to decide a specific career path as this skills are readily transferrable to other areas. For others regional anaesthesia is more than just a passion and offers a rewarding, skill-based career path. Below are some of the opportunities that are available to trainees to further their interest and add valuable consultant interview shortlisting points to their CV.

**ESRA DIPLOMA IN REGIONAL ANAESTHESIA**

The European Society of Regional Anaesthesia (ESRA) started a Diploma in Regional Anaesthesia in 2006. This two-part (MCQ and VIVA) examination initially had a low uptake (four applicants in its first year) and also received criticism for its easy (low) standard. Times have recently changed and with 80 delegates last year (90% of these were from the UK) and an improved examination standard, this has become a popular method for UK based trainees to demonstrate their continuing enthusiasm for regional anaesthesia (and for more exams!).

**FELLOWSHIP PROGRAMMES**

High profile academic centres for regional anaesthesia (New York, Vienna and Toronto) offer competing out of programme fellowships. Many trainees are seeking time abroad out of programme with the added value of seeing a different country as well as being trained by some of the world’s leading experts (Hadzic, Marhofer and Chan respectively). This can be a valuable experience and add lines to their CV in the process. Recently Regional Anaesthesia UK (RA-UK) has started an Abbott-sponsored RA fellowship programme. These fellowships vary from four to six months in duration, are run by the very best experts in the field here in the UK, and have proved both popular and successful to date.

**SOCIETY MEMBERSHIPS**

By joining ESRA you will automatically gain membership of RA-UK and also receive the Regional Anaesthesia and Pain Medicine journal. The main European meeting in held in September each year with the RA-UK meeting around May each year.

**PUBLICATIONS AND RESEARCH**

Many trainees struggle to participate in a regional based research project and hence subsequently fail to get published in this area. Both the RA-UK and ESRA accept poster and verbal presentations at their annual meetings. By attending one of the ESRA annual meetings many trainees can get several posters (including completed audit cycles), sit the diploma examination and receive expert lead tuition on a cadaver or ultrasound workshop. Not bad for one meeting!

**AUDIT**

Naturally, along with all the helpful lines in this handbook from each of the specialties, a solid ‘loop closed’ patient seeking audit in regional anaesthesia would be expected.

**NEW DEVELOPMENTS: ULTRASOUND AND CATHETER TECHNIQUES**

Interest in ultrasound guided regional anaesthesia (USGRA) has increased in the last few years. Ultrasound machines have become more powerful, cheaper and more portable. Augmented by the growth in the evidence base, many trainees are expressing an interest to be trained in this technique. This is currently a very popular area. Training in USGRA is also becoming standardised by the presence of national courses and published recommended training pathways.

Catheter techniques provide the added reward of continuous post operative pain relief and also the chance to perform ambulatory surgery and reduce in-patient duration of stay.

In summary, regional anaesthesia has and continues to provide a heavily skill based option in which trainees may excel. Combined with the recent advances in ultrasound and peri-neural catheter techniques, this should provide trainees with plenty to boost their skills and also CV in the process.

**WHAT DOES REGIONAL ANAESTHESIA TRAINING INVOLVE?**

Regional anaesthesia is one specialty in anaesthesia where training starts very early in your career. As a junior trainee regional anaesthesia can be used on a wide range of theate lists from orthopaedics and trauma to general surgery. Common early blocks include femoral, fascia iliaca and more recently TAP (transverse abdominus block) later progressing to more complex-deep blocks (infracaudal) and blocks with close proximity to vital structures (supracaudal).

Regional training involves a degree of self directed learning. Refreshing your anatomy and pharmacodynamics of local anaesthetics is essential to successful regional anaesthesia. Increasing enhanced recovery has made the use of both appropriate regional blocks and local anaesthesia essential for early mobility and recovery. It is vital during regional anaesthesia training to put regional anaesthesia in context and regular sessions with the acute pain service to follow up and troubleshoot postoperative problems are just as important as the block itself. Withholding the acute pain services can have a further training opportunities where rescue blocks can be used for failed or difficult postoperative analgesia.
The use of ultrasound with regional anaesthesia and enhanced recovery have renewed enthusiasm for regional techniques with new technology and didactic skills can pose a challenge for regional trainers and trainees alike. It is important not to become over-focused on just needle technique. An ultrasound (US) block can be split into four phases from US image generation and device to optimisation, interpretation and only finally needleling and block performance. It must be remembered that the first two are equally important. As a trainee I also feel it is useful to be competent in both US and non-USS techniques. Recent evidence suggests that the use of both modalities may be safer.

Regional training requires a daily mindset, practice scanning can be carried out on any list, on yourself and colleagues. You do not need to wait for a dedicated regional list for example on-call cover of emergency lists will often present cases requiring regional anaesthesia. Be proactive and look for any interesting blocks in a neighbouring theatre that you can observe or perform.

UK CCT in anaesthesia offers a wealth of regional anaesthesia training. At the end of training you can become proficient in a variety of blocks that will allow anaesthesia and anaesthetists for the majority of procedures. If you want further training advanced training modules exist around the country allowing training in technically advanced training modules. At the end of training you can rotate to other centres such as Glasgow Royal Infirmary, rotate to other centres such as主城区 or teach new anaesthesia techniques to your theatre assistant. A sub-specialty exam (national or European) may be required, however there are a few things which are common across several different training areas.

Wherever you get your dream job, it is healthy to be open to new developments, present your case for a regional anaesthetist offering a good quality of service, and a high standard of care. Recent evidence suggests that the use of both modalities may be safer.

**CONSULTANT CAREER IN REGIONAL ANAESTHESIA**

**Where can you work as a consultant in regional anaesthesia?**

One of the many good things about regional anaesthesia is that, in contrast to centralised subspecialties such as neuro, cardiac, transplant or vascular, regional anaesthesia can be used equally in teaching and district centres, allowing a greater degree of flexibility when targeting a potential consultant job. Any hospital, whether it is a district or a teaching hospital, can become a regional anaesthesia centre with your help, you can either build or join a team and put your hospital on the national/international map.

**What can a job as a regional anaesthetist offer you?**

- Satisfaction of making a difference to your patient offering superior anaesthesia compared to morphine PCA.
- Opportunities for service development, enhanced recovery, audit, research and training.
- Teamwork with your surgeon, the acute pain service and physiotherapist.
- What will the job require from you?

**Knowledge, skills and attitude** as any other job are required, however there are a few things which are required in initial training for a successful career of a regional anaesthetist, such as:

- Good technical skills.
- Keeping up with the new developments (CPD), through meetings, courses, workshops, books and software etc. A sub-specialty exam (national or European) may be required, however there are a few things which are common across several different training areas.
- Learning how to cope with a failed block or difficult regional case in theatre.
- Good communication skills. Successful regional techniques require communication with your surgeon and theatre staff (particularly for awake cases). Your surgeon may start the consent process for a regional technique in the preoperative clinic setting. You will need to be a confident communicator to take consent for, and perform regional anaesthesia, particularly in the nervous patient. It is important that any regional technique is an experience that a patient would be willing to have again.
- Good management skills of your surgical lists, regional blocks may require ‘cooking time’. It is often the responsibility of an anaesthetist to rearrange the list in such a manner that there are no unnecessary delays.
- Being a good trainer to your theatre assistant. A well trained assistant is vital for success and safety, whether it is a patient with fractured neck of femur in a reasonable position for a spinal or understanding the importance of negative aspiration and incremental injection of local anaesthetic.

Successful regional technique requires a combination of understanding the importance of negative aspiration and incremental injection of local anaesthetic.

**Where to work as a consultant in regional anaesthesia?**

As a trainee I also feel it is useful to be competent in both US and non-USS techniques. Recent evidence suggests that the use of both modalities may be safer.

Wherever you get your dream job, it is healthy to be open to new developments, present your case for a regional anaesthetist offering a good quality of service, and a high standard of care. Recent evidence suggests that the use of both modalities may be safer.
more comprehensive information on the opportunities for trainees interested in pursuing transplant as a sub-specialty. At present, UCAE has a web-based learning resource, the Liver Transplant Anaesthesia and Critical Care Forum (LTACF), which is now run collaboratively as the Anaesthesia/CCM section of a redeveloped International Liver Transplantation Society website (www.ihts.org). This contains tutorials and discussion forums on all aspects of liver transplantation, in addition to giving links to upcoming meetings.

**HEMANTHA ALAWATTEGAMA**
Consultant in Transplant Anaesthesia, Cambridge University Hospitals NHS Foundation Trust

**VASULAR**
Vascular anaesthesia is a challenging sub-specialty which involves essentially three operations, each of which may be performed electively or as an emergency: aortic aneurysm repair, carotid endarterectomy and lower-limb revascularisation procedures. Vascular patients have significant cardio-respiratory co-morbidity so there is a significant morbidity and even mortality of the procedures; it is not a specialty for the faint-hearted! In recent years there has been a trend towards endovascular repair of aortic aneurysms instead of open repair, and these take place in the endovascular suite or radiology department. A national screening program for men over 65 is likely to mean that more AAA procedures will take place. Vascular surgery currently occurs in both teaching and district general hospitals. However, there are plans to move all vascular surgery into larger, central hospitals and medical funding and pay and conditions vary in Australia and New Zealand. The current GAT provides a model for this.

**WHAT TRAINING IS REQUIRED?**
There is no formal training program in vascular anaesthesia. However, trainees wanting to pursue a career in vascular anaesthesia are well-advised to spend as much time as possible with the vascular anaesthetists. It is not for everyone, but can be very rewarding. Some teaching centres offer vascular fellowships or advanced training modules in vascular anaesthesia which are highly recommended. In addition, there are several centres abroad which are particularly suitable including centres in North America (University of Michigan, Duke University etc) and Australasia. Research and/or audit projects are obviously recommended for boosting your CV in this respect.

**WHAT DOES WORK AS A VASCULAR ANAESTHETIST INVOLVE?**
Vascular anaesthetists would expect to have one all-day vascular surgery list a week in their job plan. This list may include both open and/or endovascular operations. In addition to this, there may be cross-cover for colleagues who are away on leave in a ‘flexi’ session. All patients undergoing aortic aneurysm repair need to have a preoperative assessment by a vascular anaesthetist so a pre-assessment clinic may be part of the job plan as well. Most hospitals undertaking vascular surgery do not at this stage have specific vascular anaesthetists on call rota however this could change in the future as larger centres are formed. In addition, many anaesthetic intensive care consultants take a vascular surgery list as part of their job plan.

**MARK STONEHAM**
Consultant, Oxford Radcliffe Hospitals NHS Trust Chairman, VASGBI

**OVERSEAS TRAINING**

**AUSTRALIA AND GASACT**

**WHAT IS GASACT?**
Like all worthwhile representative bodies, the anaesthetic trainees of Australia are represented by an acronym. GASACT, the Group of Australian Society of Anaesthetists Clinical Trainees, the Australian equivalent of GAT, is the trainee body of the Australian Society of Anaesthetists (ASA). We are smaller than GAT and are structured a little differently, but our aims are similar: to act on behalf of anaesthetic trainees. GASACT is represented by a committee comprised of members from each state in Australia. From the bigger states there are two delegates on the GASACT Committee. Collectively, we act as a voice for Australian trainees, at state and national levels amongst the ASA and also through collaborations with other trainee bodies, including the New Zealand Society of Anaesthetists, Australian and New Zealand College of Anaesthetists (ANZCA) Trainee Committee and the Australian Medical Association Council of Doctors in Training (AMA CDT).

Unlike GAT, we are a relatively new group, but like GAT, our activities include advocacy, and running trainee courses and conferences albeit on a smaller scale. Inspired by the activities of other trainee groups including GAT, in 2010 GASACT ran its inaugural Trainee Congress, a one-day event which was combined with the ASA National Scientific Congress in Melbourne. In Australia, many of the advocacy issues affecting trainees are championed through the Australian Medical Association. Issues such as sole working hours, pay and conditions for junior doctors are negotiated on a state-wide basis. There are seven states and territories and medical funding and pay and conditions vary in different state jurisdictions. GASACT takes a limited role in negotiating these issues, but as mentioned, has a good relationship with the trainee body of the AMA and works with the AMA to further causes affecting anaesthetic trainees.

**ANAESTHETIC TRAINING IN AUSTRALIA**
Anaesthetic training in Australia and New Zealand is relatively well regarded, but differs from that of the UK in its length and structure. The body responsible for education, training, and Continuing Professional Development in Australasia is the Australian and New Zealand College of Anaesthetists. The College of Intensive Care Medicine has recently become an independent college, with its own training program. There are undergraduate and postgraduate basic medical degrees with varying models in Australia. The initial 12 months of postgraduate training is spent as an intern and is hospital-based, with mandatory rotations through general medicine, surgery and emergency medicine. A further 12 months of pre-vocational medical education and training is required before approved training in anaesthesia may commence. Many trainees do more than these minimum two years of postgraduate resident years, and it is common to do a year as an anaesthetic or critical care resident before entering the anaesthetic training program.

Anaesthesia training itself is five years in duration and is composed of two years basic and three years advanced training. There are two major exam hurdles: the Primary exam, undertaken during basic training, and the Final exam, for which you are not eligible until you have completed basic training, including passing the Primary exam (or being exempt in the case of some trainees migrating from UK) and undertaking a total of 36 months of accredited training, of which at least 24 months must have been in clinical anaesthesia. The Primary exam has an infamously low pass rate and consists of two subject areas, which may be attempted together or separately: physiology including clinical measurement, and pharmacology including statistics. Both subject areas comprise a written paper (MCQ and SAQ) and, if successfully negotiated, are followed by a 20-minute viva session.
The Final exam comprises MCQ and SAQ papers and two medical vices, followed by, if successful, eight anaesthetic vices. Both exams have two sittings a year. There is also a modular system covering areas of clinical experience and other components of the curriculum that need to be completed – twelve modules in total (NIl the College has been undertaking a curriculum review and redeveloped program with some changes due to be implemented in 2012).

**WORKING IN AUSTRALIA DURING YOUR ANAESTHETIC TRAINING: WHY? GO!**

Many poms journey to Australia or New Zealand during their training years. I undertook some research amongst some of them that I know to find out what the common reasons are for coming, and some of their thoughts and comments on the transition.

*This is what I found: reasons are predictably multifactorial and centre around the themes of CV-polishing, change-of-scene, weather and lifestyle, training environment or opportunities and positive reports from others. Lots of people stay and don’t go home, so there must be something good!*

A common theme is that the job market is becoming increasingly competitive in the UK. Work experience in a different country shows that you have initiative to undertake and follow through with the big task of moving countries, welcoming change and being able to adapt and adjust to a new environment, people and culture. Hopefully, this makes a candidate an attractive addition to any anaesthetic department.

Some trainees expressed that they found the NHS a frustrating place to work – still under-resourced, unsatisfied staff, too busy to deliver the optimum treatment to patients in a timely manner, or were frustrated with UK training schemes being somewhat constraining or inflexible, and not allowing for much individuality.

The hours in Australia used to be good compared to the UK after a campaign for safe working hours produced an improvement in many notas a few years back, although the difference is perhaps not so marked now that the European Working Time Directive has come into effect.

Brits like Australian cities. Also, Australia and New Zealand are similar to UK: similar culture, language, etc. There are established, although perhaps informal, links between some centres in the UK and Australia and many trainees in the UK know a colleague who has been to Australia or New Zealand before. Beware however, that different cities and states are often dissimilar, and vary in terms of their regulations, pay and conditions and certainly experience different climates.

Warning: not all parts of Aus have good weather and offer the iconic beach lifestyle that we are known for. Of the cities, Melbourne is probably the most similar to European cities. It has abundant good coffee and a cosmopolitan buzz, but it is not as warm as the more northern states, and not as colourful as Sydney. Western Australia, Queensland and New South Wales probably have the best sun and beach lifestyles on offer, if that’s what’s drawing you. It might pay to be clear on what you want to do for your first year, or so you can go to the beach every day! But previous trainees have found their weekly shopping more expensive.

**ORGANISING A YEAR IN AUSTRALIA**

There will be some paperwork. A lot of paperwork. It is expensive. A figure proposed is £1000 (in paperwork alone) which covers application fees, credentialing, witnessing of documents, etc. Allow at least six months.

1. **When do you want to come?**

   Australians have a provisional fellowship year in their final year of training, designated advance training year 3. For UK trainees, you should probably be at ST5 level or above, and have your FRCA. The Australian academic year runs January or February through the calendar year. Many postings in Australia can work on six with rotations, a six start date in July or August may be possible.

2. **Which state do you want to come? Which city? Which hospital?**

   You will need a ‘sponsorship contract’ before you can get a visa (has been visa 457, although this may change). Ask if this can be handled by human resources in Australia.

3. **Australian Medical Council**

   Overseas trained doctors must be credentialed with the Australian Medical Council to practice as a medical practitioner in Australia. This can be complicated, expensive and time-consuming. You will need lots of copies of forms and credentials, which may have to be sent backwards and forwards to the UK for verification.

4. **Medical registration**

   There is now a national medical board. This makes things a little easier if you plan to work in more than one place, as previously each state/territory had a different medical practitioner’s board. See www.medicalboard.gov.au.
5) English certification

6) Medical indemnity cover

This can be obtained once you get here and some have noted that it may be cheaper in Australia than U.K.

7) Finances

It is recommended that you see an Australian accountant soon after you get here to facilitate your tax return, maximise tax deductions and advise on salary packaging advantages.

Many UK trainees have been to Australia before you and this may make the transition process smoother. In some places hospital administration and human resources staff will be familiar with the processes required and may be able to advise you.

Broadening your experience can be very valuable both personally and professionally. It can be quite limiting only working in one rotation for the whole of your anaesthetic training and a trip abroad can be exciting and challenging. Australia is well-known for its laid-back attitude, its sporting culture, its outback geography with large areas of low population density and huge distances. Medical training takes place within only 17 medical schools across Canada (three are Francophone within the province of Québec, the others are either bilingual or Anglophone). While some programs allow entry into medical school after two or three years of undergraduate studies, the majority require a full undergraduate degree, typically in the sciences, but sometimes from as disparate disciplines as music and political science.

There are currently 16 anaesthesiology training programs within 16 medical faculties. In 2010, there were 116 anaesthesiology training positions available and these included 10 dedicated positions for International Medical Graduates. Anaesthesiology is a five-year training path in Canada. Throughout this time, trainees are called ‘residents’ and proceed through postgraduate years one through five. Training across the anaesthesiology programs tends to provide a dominant focus on education and a secondary one on service provision. Trainees are both enrolled as postgraduate students within their respective faculty of medicine and employed by their academic healthcare organisation, aka hospital. Most anaesthesiology programs provide strong clinical teaching environments. Separate from the usual activities of academic clinical departments (grand rounds, mortuary & morbidity rounds, local conferences etc), anaesthesia training programs provide a comprehensive curriculum to residents with formal teaching at least weekly.

Over the five years, anaesthesia residents must complete minimum requirements for training as follows: a 12-month basic clinical year, 12 months in adult anaesthesiology, three months in paediatric anaesthesiology, two months in obstetrical anaesthesiology, one month of chronic pain management, 12 months of internal medicine training (six months internal medicine subspecialties and typically six months of ICU). Most training programs exceed these minimum requirements in anaesthesiology and ICU by a stretch. We are also given six months of elective time. Residency culminates in taking the RCPSC Final exam which marks the end of their fifth year. This is inevitably a harrowing and stressful task, but most residents are successful on their first try.

I’m sure one can see many similarities and differences between this and training in the UK or Ireland. At a more granular level, the focus on education in Canadian programs cannot be overstated. As residents, our typical workload mirrors that of our consultant teachers. We are assigned to their lists and work with them (or with them!). We cover call no more than one in four days, including no more than two weekends per month. Call is usually 14-24 hours long depending on the rotation and the program. In most centres, regardless of your level of training, you are permitted to do a case entirely independently (i.e. without direct available support). Consultants typically have to be in the hospital for all case starts, even if you’re in the last day of your training! Typically, residents cannot run their own lists and their consultant must be exclusively available to the list being run by the resident. This reflects two issues: the first is the understanding that anaesthesia training programs see education as trumping ‘service’. Second, this reflects the Canadian medicos-legal environment and the level of vigilance that the profession has evolved towards in Canada. Training culminates in taking the RCPSC Final exam which marks the end of their fifth year. This is inevitably a harrowing and stressful task, but most residents are successful on their first try.

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Training is five years, with two years of basic training and three years advanced training. The earliest one can apply to get on to training is from PGY3 (dependent on securing a job at an accredited hospital). In Canada, residency training is administered by the Australian and New Zealand College of Anaesthetists (ANZCA). One applies directly to the college after securing a job in an accredited hospital. In NZ, there are no ‘non-training jobs’ for registrars. The college holds the view that if you are performing the same duties as a trainee at the same department, you are entitled to be a trainee with the college. In NZ, all new registrars are the equivalent of more senior SHOs in the UK/Ireland and one may become a junior registrar as early as the third postgraduate year (PGY3), though usually in PGY4.

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Introduction to anaesthetic practice
Critical care and medicine
Head and neck and complex airways anaesthesia
Major surgery, abdominal and emergency anaesthesia
Neuroanaesthesia
Obstetrics and gynaecology anaesthesia
Orthopaedic, trauma and regional anaesthesia
Paediatric anaesthesia
Pain medicine
Vascular, thoracic and cardiac anaesthesia

WORK ENVIRONMENT, SALARY, TAXATION AND MEDICAL INDEMNITY

Rostering practices and supervision are generally very good within the NZ anaesthesia fraternity, with some variation from department to department. The vast majority of trainers will be granted leave for courses and all for exams. Compared to the UK, the working environment here may be perceived as 'laid back'. The vast majority of consultants are supportive and approachable. There are no hierarchical boundaries in communication between anaesthetists and nurses or other allied health staff.

The current annual salary of a second year registrar (usually PGY4 or 5) in the five major cities of Auckland, Wellington, Christchurch, Hamilton and Dunedin is NZ$94,000 to NZ$103,000, depending on hours worked. All other areas pay a 'non-urban' rate, which is 2% higher. This salary includes all rostered overnights and nights. Your annual salary increases by NZ$5,000 to NZ$6,000 per year with each year of practice. Additional rostered duties (i.e. if a colleague is sick or away on annual leave) are paid at a minimum rate of $60 per hour.

The NZ tax rate is a graduated system of taxation. The highest marginal tax rate of 33% applies past the NZ$70,000 threshold. For example, the total income tax on a NZ$95,000 salary is NZ$22,270 or effectively 23.4%.

Although medical indemnity insurance is compulsory, annual fees (reimbursed by the DHBs) are kept low by NZ legislation that prevents patients from taking direct legal action against medical practitioners. Cases of medical negligence are referred to the Health and Disability Commission and recommendations may range from an apology to dismissal of the registrant. Affected patients will be classified as having a ‘treatment injury’ and their welfare will be handled by the Accident and Compensation Commission. Criminal practice will however attract the attention of the police.

WORK ENTITLEMENTS

All district health boards (DHBs) currently employ junior doctors under the Multi-Employer Collective Agreement (MECA) which is negotiated between the Resident Doctors Association (RDA, effectively our union) and the DHBs. The RDA was formed 25 years ago during a time when it was thought the New Zealand Medical Association wasn’t effectively defending the interests of junior doctors. Although the junior doctor workforce is highly unionised (98%), it is not compulsory to join the RDA. Non-RDA members retain the option of negotiating their own contract with individual DHBs.

Most DHBs will still offer you the MECA and you pay a negotiation fee equivalent to one year’s subscription to the RDA. The RDA-DA members (including those doctor on a work visa) the following:

- Paid meals while on duty
- 30 days (i.e. six weeks) of annual leave
- Full reimbursement of the cost of your Annual Practising Certificate from the medical council
- Full reimbursement of annual medical indemnity insurance fee
- 12 weeks of paid study leave for the duration of your specialty training

Full reimbursement of all costs of specialty training (textbooks, college fees, exam fees, course fees, travel & accommodation for courses/travel)

The RDA is currently in negotiation with the DHBs to renew the MECA. The last two MECA renewal negotiations (i.e. since 2005) have resulted in strike action at various hospitals throughout the country. This has been primarily in response to DHB efforts to alter clauses that determine run descriptions and rostering practices. The DHBs view these as restrictive to service delivery whereas the RDA views them as protective for safe working environment. Any major changes will unlikely have much impact on rostering in anaesthesia as departments on the whole are very good at looking after their trainees.

APPLYING FOR A JOB

The working year in NZ starts in the final week of November for interns, HOs and SHOs and two weeks later (early-mid December) for registrars. Jobs for the next working year are usually advertised in April or May although many departments welcome enquiries throughout the year. Applications are made to individual DHBs – contact details can be found at www.healthcareers.org.nz/mo under the ‘Current RMOs apply now’ tab. Not all anaesthetic departments in NZ are accredited for training by ANZCA. To view the list of accredited departments, go to http://www.anzca.edu.au/trainees/hospital-accreditation/new-zealand-hospitals.

REGISTRATION

Graduates of medical schools accredited by the GMC or Irish Medical Council will be eligible for registration after their FR or inter year spent working under the jurisdiction of that council. Doctors without British/Irish medical degrees who have worked for three of the last four years in the UK/Ireland and have full (unconditional) registration with the GMC or Irish Medical Council will also be eligible. The ‘ provisional general scope of practice’ registration category that is awarded to the two groups above allows you to enter into vocational training in anaesthesia in NZ. Some applicants may need to sit an English test depending on their background. For more information and to register, contact the Medical Council of New Zealand via www.mcnz.org.nz.

WORK VISAS

These are issued by the New Zealand Immigration Service (www.immigration.govt.nz) and can be obtained by applying to the nearest NZ High Commission or Embassy. Alternatively, you may arrive in NZ earlier on a holiday visa to apply at the NZIS office here if all your documents are in order and you’ve allocated enough time, but speak to your nearest NZ High Commission or Embassy before doing this! Your prospective employer will issue a supplementary form to support your application.

NAV SIDHU
Deputy Trainee Representative
New Zealand Society of Anaesthetists (NZSA)
THE CONSULTANT POST

THE INTERVIEW

When the going gets tough, the tough get going and, let’s face it, it’s tough out there. There are just not enough jobs for everybody and competition has stepped up a notch recently. You owe it to yourself to be as prepared as possible for the all important consultant interview. The process, however, hasn’t changed very much over the last few years. The same rules apply, it’s just that you have to be highly competitive. The process starts months, if not years, before, with the most important decision, what you want out of life and what you want out of work. Think about how that can be best achieved in your consultancy. This needs to be coupled with some early and focussed CV development. Be quite deliberate about getting the right evidence on your CV, about getting that evidence to be consistent. So for instance, you’re a surfer with an interest in education in one of those fabulous places on the UK south coast, well that’s going to be highly competitive, so start early. Aside from work-life balance though, remember that all consultants in all hospitals, so read on for some things you can do to help yourself adjust to the changes, as well as a few pitfalls to avoid.

1. Start with the basics

As a trainee you will have become an expert in the practicalities of rotating between hospitals, but you may also be used to temporarily ‘making do’ with less than ideal circumstances. This should be the last time you have to sort out these small but important issues, so tick each one off as soon as possible. If you are new to the hospital this will help you feel more in control. A few tips:

- ID badge & security pass – these will still only be available between 09:00 and 09:15 on a Thursday when the computer says “yes”!
- Car parking – well done if your hospital still has a parking bay! Let’s hope you can continue to use this for as long as you can.
- Computer access – trust email address (may be

TEN TOP TIPS FOR YOUR FIRST YEAR AS A CONSULTANT

Congratulations! You have gained your Certificate of Completion of Training (CCT), played the consultant interview game and won. Now that you have secured your position you may be filled with apprehension about actually doing the job. It is only natural to feel like this, especially if you have obtained a post in an unfamiliar hospital, so read on for some things you can do to help you adjust to the changes, as well as a few pitfalls to avoid.

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THE GAT HANDBOOK 2011–2012

THE GAT HANDBOOK 2011–2012
mandatory for intra-hospital communication), passwords for clinical portal/pathology/padiology etc.

- Coffee – where can you get it and where do your colleagues go to drink it?
- Meet the ODP/paraesthetic nurses for the theatres in which you will be based – they may even write down your particular preferences for difficult cases.

2. Departmental orientation

A formal departmental induction should cover all of these:

- Your secretary – this may be someone allocated to you or a communal service. They will be invaluable in helping you to settle in and you will gradually realise a greater need for them than you ever had as a trainee.
- Find your desk/office/pigeon hole – again, these are often communal.
- Rotas – find out when they are written and sent out. Ensure you are clear about the mechanism of booking leave and enjoy the novelty of being able to plan much further ahead.
- Work out the best way for people to get hold of you, both in and out of the hospital. Also decide when and how you would like to be contacted on-call so you can lay some early ground rules with your team. Find out how you can get hold of the on-call team yourself and/or provide a designated colleague as back-up early.
- Find out which departmental meetings you are expected to attend.
- Are there any local societies (including private practice groups) that you are expected/invited to join?

3. Trust orientation

Aside from the above, the greatest changes you will notice in the trust which can be very reassuring:

4. The Consultant Contract and job planning

The Consultant Contract is something you will have heard much about but paid little attention to as a trainee. The British Medical Association (BMA), produces a New Consultant Pack for each devolved nation which is worth requesting. Check your contract against this prior to signing. The AAGBI have recently produced guidance for working as a consultant but the best advice is to know your personal entitlements. The BMA can help you with any queries you may have.

You should receive a job plan when you start; these often change and may bear little resemblance to what you do on a daily basis. It is extremely important to keep a record of what you actually do each day in both your clinical (especially flexible) and non-clinical sessions, so that when your job plan is up for discussion you have evidence to back up any requests or issues that you have. This requires commitment on your part but will make the whole process much easier for you in future.

5. Consultant work patterns

These are surprisingly different to those you will be used to as a trainee. Satisfy your lifestyle as much as possible by the EWR model, which means you may find yourself on-call for 25/48/72+ hours and providing treatment much earlier than the first time in your career. This is a difficult adjustment and you will find yourself checking obsessively your phone battery/reception and unsure how to spend the time when you are not needed in the hospital. It takes a bit of getting used to, but if you find that you are in more than your colleagues because you are new then you are not alone. You will need to find your own way in this one. A sensitive department should ease you in gently and/or provide a designated colleague as back-up early on. Don’t be afraid to ask for this if you feel you would benefit – remember you have 20+ years to do this job so you will have ample opportunity to ‘pay back’ later on. You may find that you miss some of the benefits of working night shifts more than you anticipated, although this can be somewhat offset by a more predictable working week.

6. Supporting Professional Activities (SPA sessions)

You will have thought of an answer to the question of how you would spend these sessions for your consultant interview. Now is the time to put some of this into practice. However, a few words of caution: don’t take on too many responsibilities too soon in your on-call role. This should be the main focus of your first year and it is easier to underestimate how much effort this may take. There will always be people looking to offload some of their least favourite responsibilities, so unless it is a fantastic opportunity to do something you really enjoy you are allowed to say “no thanks” in your first year. Do clarify what is required in these sessions, especially whether or not you are expected to be present in the hospital. Remember to include any activities you undertake in your diary.

7. Continue your research and development

It pays to develop the research that you did for your consultant interview; subjects you have previously been able to ignore will become much more important. Read around and keep abreast of developments regarding important topics such as appraisal and revalidation, private practice and the Clinical Excellence Awards scheme so you are not either shown up or caught out. Helping your trainees to prepare for their future consultant interviews is an excellent way to top up your knowledge.

8. Ask for help and advice

Aside from the above, the greatest changes you will notice are those in the level of responsibility that you have and the freedom of choice that accompanies this. It runs contrary to the feeling that you have, even again one from the top to the bottom of the ranks. Although there is no official recognition of the term ‘junior consultant’, you will probably feel like one. It is ok (and probably quite common) to look over your shoulder for the boss and realise it is you! Remember: one is never too senior to ask for help or advice, and never be too proud to do so.

9. Some things remain unchanged

Some things remain unchanged from your halcyon days as a trainee. These include the need to maintain an up-to-date logbook and CV, the expectation that you will actively participate in clinical governance and teaching, and the further development of any special interests that you have. All of these will play a role in your appraisal process and you would be foolish to overlook them.

10. Work-life balance

Becoming a consultant is traditionally associated with a better work/life balance, almost as a rite of passage. This is now disputed with the development of novel consultant job plans in the current NHS, but there are opportunities for improvement and you do have a little more control over how you spend your time. Enjoy it!

I hope these tips, born from my own experience, help you to do so. Good Luck!
An academic interest became full-blown, card-carrying research active. Indeed, in order to get shortlisted for a senior registrar job, a CV with several published studies was almost essential. To appreciate where we are now with respect to trainees within the NHS and the real damage that this has caused; they are determined to reverse it. An example of their commitment is the creation and generous funding of the National Institute for Health Research (NIHR), funding that remains remarkably unscathed in the recent spending review. This is a good time to be involved with research; the future is more promising than it has been for some years.

Getting started may not be easy but it is definitely achievable if you are pro-active and committed. Here are some top tips:

* Find a mentor: This could be anyone who is involved with, or has experience of, research; ideally, an enthusiastic consultant.

* Have realistic ambitions: Don’t try to cure cancer in your first study. Make sure that your project is simple, well designed and achievable.

* Get involved with established teams: Are there any active research teams on your patch that need a pair of hands? This could be commercial or non-commercial research.

* Consider working in the laboratory: Are there any local opportunities here? Laboratory work is very easily than clinical research.

You must become the new generation of research active consultants who will safeguard the academic base of anaesthesia and its related specialties. So, grasp the nettle, get involved and get started.

**PROFESSOR DAVID J ROWOTHAM**

Professor of Anaesthesia and Pain Management, University of Leicester Research Council Chairman, National Institute for Academic Anaesthesia Dean, Faculty of Pain Medicine R&D Director, University Hospitals of Leicester Director, Leicestershire, Northamptonshire & Rutland NIHR Comprehensive Clinical Research Network
ACADEMIC CLINICAL FELLOW

STRUCTURE OF THE NATIONAL INTEGRATED ACADEMIC TRAINING PROGRAMME

This programme has established dedicated specialty training posts that incorporate academic training. These posts are available across the spectrum of specialties and across the UK (the Scottish programme differs slightly from what is described here). This programme came out of the Walport Report and is funded by the National Institute for Health Research, so academic-track trainees are sometimes referred to as Walport trainees or NIHR trainees.

The two posts available under this scheme are Academic Clinical Fellowships (ACFs) and Clinical Lecturerships (CLs). ACFs were designed to cover the first three years of specialty training and include 75% clinical time and 25% academic time, while CLs cover the final four years of specialty training with a 50/50 clinical/academic time split. ACFs are intended generally (but not exclusively) for trainees who do not yet have major research experience, for whom the primary aim of the ACF is to secure funding to support a PhD. ACFs are sometimes referred to as Walport trainees or NIHR trainees.

For further details see: www.ukcrc.org/workforcetraining/. This integrated training pathway in their

INTEGRATED ACADEMIC TRAINING AND ANAESTHESIA

The Royal College of Anaesthetists has strongly endorsed this integrated training pathway in their National Strategy for Academic Anaesthesia (the Pandit Report: www.RCoA.ac.uk/niaa/docs/Academic_full.pdf). Over the past few years there have been a number of ACFs in anaesthesia, mostly in London. Unlike many other specialties, in anaesthesia these posts have largely been awarded to trainees who are post-FRCA or have at least completed the FRCA Primary exam. However, this is not exclusively the case; for example, my ACF post commenced at ST1 (although at post-doctoral level and with some previous experience in anaesthetics and intensive care).

BENEFITS OF AN ACF POST

Over the years I have known registrars in various specialties who became disillusioned with research because they were compelled to undertake small projects of questionable significance with no time or resources, under supervisors with limited interest or experience. An ACF offers the complete opposite: protected, paid time in which to explore an area of research that you find interesting under the supervision of an experienced and enthusiastic academic. An ACF provides an excellent pathway towards a PhD, which is the ‘CCT in research’ required for an academic career.

OBTAINING AN ACF POST

There are obvious, although not necessarily easy, things you can do to help an application for an ACF, such as passing as many FRCA exams as possible, and demonstrating some prior interest and involvement in research. A less obvious possibility is to be proactive in the creation of the ACF post in the first place. Departments lay to be assigned ACF posts from a central pool, and they have to be fairly distributed across specialties and geographical areas. Potentially, academic anaesthetic departments that have not yet had an ACF might consider bidding for one if approached by a keen trainee who presents a good case. The ACF would of course still be appointed under open competition, but at least the post would exist.

AN ACADEMIC CAREER

Anaesthetists who are interested in research may identify with the following description of the clinical academic life, which comes from a senior professor in another specialty. Clinical work, he says, is often quite interesting and exciting day to day, but over time can become a little repetitive. Research, on the other hand, can often be quite a grind day to day, but over time, it’s possible to look back and take satisfaction from seeing real progress. Combining two is a privilege that is worth the challenges involved.

For those considering applying for an ACF, I would add the following observations:

■ Research and clinical medicine are complementary but very different, so training in research is in many ways like training in an entirely different specialty.

■ Developing skills in both clinical anaesthesia and research from scratch, while passing FRCA exams and setting up a PhD is a lot to fit into three years; you are probably more likely to be successful in obtaining and undertaking an ACF post if you have already mastered at least one of these components.

■ Although ‘eureka’ moments are rare (at least in my research), I highly recommend them.

THOMAS SMITH
Academic Clinical Fellow, Oxford

HOW TO …. "CONDUCT AN AUDIT"

WHAT IS AN AUDIT?

Audit is a well-established mechanism whereby an individual or a group of individuals review current practices and processes and strive to improve them if possible. Clinical audit relates to clinical practices and not only helps to improve the quality of care delivered to patients but is also invaluable in helping to maintain and monitor standards of care.

THE AUDIT CYCLE

Clinical audit is a cyclical process where standards are agreed and data collected. Analysis of this data shows whether the standards are being met. If not, changes are planned and implemented and data collected for a second time and analysed to see if any improvements have resulted from these changes (Figure 1). It is important to realise that data is collected and analysed on two occasions. A single data collection exercise does not constitute audit. The first data collection is to establish the current position and the second is to see if any improvements have been made.

Figure 1: The Audit Cycle
WHY SHOULD I DO AN AUDIT?

Best practice and best outcome should be the goal of every clinician. Voluntary critical self-appraisal of one's performance is a useful way of ensuring this. Clinical audit enables one to achieve these goals. All consultant contracts in the NHS have clinical audit as part of their job descriptions, hence it is a good idea to get into the habit early. There is now a clear expectation that trainees will complete yearly audit project during their training and this will undertake continuing audit during their NHS careers.

AUDIT OR RESEARCH?

There is a difference between audit and research. Research is a process that tries to find out what you should be doing to your patients. Audit is a process that looks at what needs to be audited. Research seeks new knowledge or refines existing knowledge and audit reviews current practice to stimulate change.

ETHICAL COMMITTEE APPROVAL

Strictly speaking it is not necessary to seek ethical approval for audit projects. However at times there is a fine line between audit and research. Most trusts have a policy regarding approval for audit projects and you are advised to follow trust policy in this regard. In practice a submission to the trust's audit committee via the clinical audit lead is sufficient and for simple projects there may be an opportunity to join in an existing audit project. Alternatively start a new audit project from scratch. However at times there may be an opportunity to join in an existing audit project that is already in progress in the department in which you are working or are planning to join. You may consider taking over from a colleague who is moving on to another hospital and is perhaps unable to complete the project that he or she has started, or you may choose to re-audit a subject that has been looked at in the past. Your first port of call should be the clinical lead for audit within the department. This may not necessarily be a medical doctor but he or she will have the support of the department as a whole and will have been given responsibility to coordinate and monitor audit projects within the department. They may be able to suggest a possible subject that needs looking at, perhaps something that needs auditing or re-auditing that is of concern to the department. They will also ensure that, should you have a subject in mind, it is not already in the process of being audited nor already been audited by someone else recently. The other group of people to talk to are the permanent members of staff in the department who will be familiar with what has been done over the recent months or years and may have suggestions for what needs to be audited.

UNDERTAKING THE AUDIT

Audit should be done openly and transparently and should never be confrontational or threatening. Talk to as many people as you can about your plans and get others involved with the project. You have to carry your colleagues with you. This is especially important if the likely outcome is going to have an impact on their practice. Keep the project simple and stay focused. Do not be distracted by irrelevancies and minutiae. There is a tendency to collect far too much irrelevant data. This makes an audit unproductive, wasteful and slows everything down. Confine data collection to what is pertinent to the audit project. Select a topic that is relevant and exhibits potential benefit to the patients, to the department or the hospital. If the topic falls within your area of interest or expertise, success is much more likely. High risks, high harm or e.g. high cost practices are particularly good to audit as improving them can have a profound impact on the quality of care or the quality of service and can at times make a real difference. Do not tackle a topic where the likelihood of improvement is questionable or beyond control of yourself or the department. You should try and work within a given time frame. Innumerable audit projects are started which are never finished resulting in a waste of time, effort and resources. If you feel that a project cannot be finished by you e.g. because you have to move to a different hospital or as part of your rotation then you should recruit a colleague to take over so that the project can be completed.

PRESENTING YOUR WORK

Present your work at a departmental or a trust audit showcase meeting. This may be necessary if changes involve the whole department or other specialties. Invite as many participants as can. Don’t be inhibited to come back and present your findings to the host department if you have moved on to another hospital.

IMPLEMENTING CHANGE

If you have demonstrated that changes in your personal practice can enhance your clinical practice then implementing changes are not an issue. On the other hand, if changes are indicated across the whole department (or the whole hospital or trust) senior clinicians and senior managers will need to get involved and implementing change at such high level can take some time. It is crucial that the effect of any changes so implemented is re-evaluated after a given period of time.

CONCLUSION

Audit is part and parcel of modern clinical practice. It has tremendous potential benefits for the clinician, patients and the organisation(s) in which we work. High standards and good quality of service are desirable goals and clinical audit is an invaluable tool in achieving best practice in our modern clinical environment.

RANJIT VERMA
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Chairman, Society for Computing and Technology in Anaesthesia (SCATA)
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... DESIGN A STUDY

The strength of a study depends on its design. Rather than classify the different types of study and get bogged down in statistics, I’m going to approach it from a practical point of view.

THE IDEA

Some ideas arise from clinical cases (e.g. ‘is my anaesthetic technique better than yours?’). Others come from reading or discussing published papers, conferences, or just out of the blue. Sometimes a small-scale project like a local audit becomes much more interesting than expected, and can be expanded into a full paper. Many ideas fall by the wayside because of the practicalities (see below), and it’s always worth testing the idea to see whether it has a good chance of running, before investing too much time and energy. Sometimes an idea is generated by the challenge of only having a month to fall to the ‘PubMed hurdle’ – someone has done it before (not that this is a fatal flaw, most studies are worth repeating. In fact, an easy way to think of a project is to repeat someone else’s).

THE QUESTION

It may be surprisingly difficult to narrow down a general idea to a specific question or questions that might be answerable by a study. For example, ‘is my anaesthetic technique better than yours?’ could raise questions about individual operators (who? whose?), practical procedures and even individual anaesthetics. Even if one were to decide on ‘is drug A better than drug B?’, the matter of ‘what is better?’. Questions must also be defined (e.g. less pain, faster recovery, shorter hospital stay, lower cost, etc). For most outcomes there are also different measures of outcome from which to choose – e.g. ‘less pain’ might be measured as lower pain scores, less recovery time, requested less time before requests. Defining the question is vital since it determines the type of data collected and therefore sets the scene for the entire project.
... WRITE A PAPER

You've done the easy and interesting part and completed your study, but now you have to sit down, put fingers to keyboard and write the paper! Perhaps you are about to make a daunting task but it shouldn't be because you already written most of the paper. A well-written protocol should have the Introduction, Methodology and a lot of the Discussion ready for a bit of cutting, pasting and editing. Your literature search should contain most of the references you'll need and hopefully they have been entered into a reference management system ready to merge with your manuscript.

How to begin? Before sitting at your computer and launching Word, you should first give careful consideration as to which journal you intend to submit. Take advice from experienced colleagues on this question. Also, ask yourself who is the intended audience for your paper? Is it for a broad church of anaesthetists (think Anaesthesia, British Journal of Anaesthesia or European Journal of Anaesthesiology), or only of interest to a small sub-specialty group (either an anaesthetic sub-specialty journal or a relevant surgical journal)? Is it basic science or animal work (consider a basic science journal such as Nature)? Is it of interest to non-anaesthetists (perhaps suitable for the British Medical Journal or The Lancet)? Once you've chosen the journal, read it, get an idea of its style and layout and most important of all, carefully read the journal's guidance for authors. Then read the guidance for authors again and keep a copy handy to refer to when you've chosen the journal.

Simplify your study by answering these questions.

1. What is already known? This will drive you mad – this may be collecting the data, taking the samples, doing the follow-ups, etc. You have probably already written most of the paper. A well-written protocol should have the Introduction, Methodology and a lot of the Discussion ready for a bit of cutting, pasting and editing. Your literature search should contain most of the references you'll need and hopefully they have been entered into a reference management system ready to merge with your manuscript.

2. Where to begin? Before sitting at your computer and launching Word, you should first give careful consideration as to which journal you intend to submit. Take advice from experienced colleagues on this question. Also, ask yourself who is the intended audience for your paper? Is it for a broad church of anaesthetists (think Anaesthesia, British Journal of Anaesthesia or European Journal of Anaesthesiology), or only of interest to a small sub-specialty group (either an anaesthetic sub-specialty journal or a relevant surgical journal)? Is it basic science or animal work (consider a basic science journal such as Nature)? Is it of interest to non-anaesthetists (perhaps suitable for the British Medical Journal or The Lancet)?

3. You've done the easy and interesting part and completed your study, but now you have to sit down, put fingers to keyboard and write the paper! Perhaps you are about to make a daunting task but it shouldn't be because you already written most of the paper. A well-written protocol should have the Introduction, Methodology and a lot of the Discussion ready for a bit of cutting, pasting and editing. Your literature search should contain most of the references you'll need and hopefully they have been entered into a reference management system ready to merge with your manuscript.

4. How many things in life, size isn't everything! Keep your writing succinct, use plain English, avoid over use of the passive voice (e.g. we administered fentanyl to the patients'... is better than fentanyl was administered to the patients...), take care with punctuation and avoid excessive abbreviations; all of which will help to make it easier to read.

5. Now it's down to the writing. Start with the Introduction, which should have three clear messages: what is already known about the subject? What are the important questions needing answering and what does your study intend to answer? Keep it simple; three short paragraphs answering these questions.

The Method should already have been written and can be lifted directly from the protocol and edited, keeping it simple so that it contains enough detail for anyone else to repeat your study. If someone has described part of the methodology before, you do not need to repeat the description but clearly reference it. Include at the end a succinct but accurate description of the statistical methods you used for your analysis. Where relevant, you should include enough detail of your power analysis to allow the reader to confirm how you arrive at your sample size.

Clarity is essential in the Results section. Use clear group names (e.g. group morphine and group fentanyl rather than groups A and B or groups M and F). Make sure that you retain a consistent order of reporting, particularly when there are more than two groups. Avoid unnecessary duplication of results by perhaps using a table to provide details of numbers and simply give a brief summary of main or important findings in the text. It is important to ensure that tables are laid out as per the guidance for authors. If there are figures or photographs, make sure they are of sufficient resolution for printing (again refer to the guidance). Most journals reproduce images in black & white and it is important to check that the image remains clear with important detail retained when it is converted from colour.

Keep the Discussion simple, don't be tempted to draw it out for the sake of it, believing that a long discussion is
more impressive. You should consider what your results mean, how they fit in with existing knowledge, and why if rejected, don't feel that you have to use the editor's feedback, which should allow you to format the references correctly for any journal. To do this, you might have to take it as a personal rejection. It does not necessarily await the verdict. If it is not accepted, do not despair or take the process works.

There, it's all done and ready to be sent off to your journal. Your Summary is the gateway to your paper; it needs to be attractive to the reader, why they do not distract from the validity of your finding. Finish your discussion with a concluding paragraph, reinforcing the main findings and suggesting areas for future research.

Inserting references should be straightforward, especially if you've been entering the results of your literature search into Reference Manager or EndNote, which should allow you to format the references correctly for any journal at the click of a mouse. Don't feel that you have to use every reference in your search, keep to those that are directly relevant to your paper and discussion. Finally, think of a simple, accurate title (avoid newspaper headline style titles) and write the Summary using a structured or unstructured format as prescribed by the journal. Your Summary is the introduction to your paper; it may in fact be the only thing read by many but can also draw the reader into exploring further. It therefore needs to be attractive to the reader why they do not distract from the validity of your finding. Finish your discussion with a concluding paragraph, reinforcing the main findings and suggesting areas for future research.

There are many ways of pleasing an editor but let's confine it here to submitting an article for publication. I won't go into the reasons why it's important to conduct and write up projects, or how to design studies; let's assume that you've completed your study and are now preparing it (and yourself) for the final challenge: convincing the reviewers/editors that it's worthy of inclusion in a reputable journal. First, a little about how the process works.

HOW TO SUBMIT A MANUSCRIPT AND WHAT HAPPENS WHEN YOU DO

Nowadays, submissions are almost all electronic, either by email plus attachment or a web-based system of filling in blank boxes and uploading files. Each has its own advantages and advantages – to both the journal and the author. Either way, you should receive a notification confirming receipt and giving you the number assigned to your manuscript. Take note you quote this number whenever you contact the editorial office. You may have to submit a declaration form at this stage, vouching for your work's originality and that it's not being considered by another journal – if the journal asks for one, make sure you send one.

Your manuscript will then be reviewed by a number of people, depending on the journal. For some journals, the editor-in-chief will screen all manuscripts and reject the hopeless, unethical and intelligible ones at this stage. For others, they'll be reviewed by two or more editors and/or external reviewers, with the final verdict made by the editor-in-chief, taking the others' opinions into account. This process can be lengthy if: the paper is complicated, there are only a few experts in the topic to ask for an opinion and they're all busy; the external reviewers are slow to provide an opinion; the reviewers disagree and it has to go for a further opinion(s); the editorial office is dealing with a large backlog or even a crisis (e.g. technical); or your email or the one to/from reviewers) gets lost in the ether. Most journals should be able to give you a verdict within one to two months at the most; in general, if you've not heard anything then a polite enquiring email to the editorial office won't offend anyone.

REJECTION

Rejection is never easy to take and one usually goes through the classic stages of shock, denial, anger, depression and acceptance (not by the journal, alas). There are two bits of advice I can offer at this stage: first, remember that reviewers and editors do miss the point sometimes, but they are very experienced at what they do and have seen hundreds of manuscripts. If they have missed the hidden value of your manuscript then it's probably because you haven't made it clear enough. Take the comments you receive, use them to improve your manuscript, and submit it somewhere else – or even to the same journal if you feel strongly enough.

Second, the good journals have a very low acceptance rate for Anaesthesia (~20-25%), so there may well be nothing actually wrong with your manuscript, but it's not perfect (it can't be quite as good as interesting as the others). So take the comments you receive, use them to improve etc.

ACCEPtance

If your manuscript is accepted, the work doesn't stop there. You'll get a list of requirements from the editor, e.g. removing this or explaining that – do exactly as the editor asks, and don't take too long. Despite the conviction of many authors that journals are slow, ponderous beasts (though admittedly, some are), you're probably looking at proofs, which will usually be sent to you a couple of months or so after the final version of your manuscript has been sent to the publishers. Make sure you turn them around quickly, or your editor will be displeased (see title).

Having rumbled on about the process, I'll now give you my guide to how to please the editor.

1. Follow the instructions
You'd have thought this was self-evident, wouldn't you? Amazingly, it's very common for authors to send manuscripts in the wrong units, with American spelling, and the graphs and tables in the wrong format. At best, this will irritate everyone at the journal, and could influence the verdict; at worst, it might even lead to an instant rejection. All journals have instructions/guidance on their websites; find them and read them. Then read them again. Then download or print them and read them at intervals whilst preparing your manuscript. Then read them once more before you submit. If there's a checklist to complete before submission, use it and make sure you've done everything required.

2. Construct your paper well
I won't go on here about what to say in each section of the manuscript, but take a look at Anaesthesia's Guidelines for Authors at http://onlinelibrary.wiley.com/journal/10.1111%28ISSN.291365-2044/homepage/ ForAuthors.html (or you could just Google it if you can't face typing that out). Or you could look at any...
other journal’s guidance; they all tend to say the same thing. We’ve tried to make our guidance helpful too, rather than just prescriptive. Remember, the aim of your writing is to explain clearly to the editor/reviewer/reader what you did and why it might be important; if it’s not clear then that in itself can be a reason for rejection, or at best it’ll lead to a request(s) to clarify various aspects of your work. The best papers are simple and easy to follow; they avoid complicated sentence structures and refer to the groups and outcomes in the same order throughout the text, so the reader doesn’t get confused.

3. Seek help

You simply must seek the advice of someone who has done it before. What else can I say?

4. Give yourself time but get on with it

Most people cannot churn out good, readable text in a day. If you’ve set out in the right way, you’d have written a decent protocol before you started the study and you can use that as a basis for constructing the final manuscript. But it takes time. My advice is always to start off by writing stuff down as it comes to you, and not to worry too much about structure etc to begin with – just get it down. You can shape it later, with an experienced person’s input. Often, it’s helpful to leave it alone for a couple of weeks, then take a fresh look. Having said that, you cannot leave it too long – first, because someone else may publish on the same topic before you, and second, because a study done several years ago will be of less relevance and therefore interest than your study but then disappear overseas without starting, taking all the data with them.

5. Be ethical

I’m referring to two areas that cause problems: first, research ethics: ensuring that your study has the appropriate ethical approval; and second, publication ethics: making sure that you haven’t copied any text from another source, haven’t left out authors who should be included, or included those who shouldn’t, and certainly haven’t made up or manipulated any data.

You can get into serious trouble for this kind of thing, as can your colleagues, so take care. Anaesthesia’s website has some guidance we hope will be useful.

6. Follow the instructions

7. Follow the instructions

8. Have fun

Yes, it is possible. And good luck.

STEVE YENTIS
Editor-in-Chief, Anaesthesia

TAKING CARE OF YOURSELF

KEEPING OUT OF TROUBLE

It is time for a confession – even I have been in trouble during my 29-year career in anaesthesia. There have of course been lots of minor episodes of trouble, like the time when I accidentally dissolved an antibiotic in a long-acting non-dopaminergic neuromuscular blocking drug (pancuronium) instead of water and gave the resulting mixture five minutes before the end of the operation. I was stuck in the recovery room ventilating the patient’s lungs for two hours afterwards and was the butt of not a small amount of ridicule from my peers, and subsequently the subject of a trip to the lead clinician’s office for a rap across the knuckles. There have also been more serious episodes, including one accusation of gross professional misconduct and one of attempted murder – I kid you not! Tempt me into a public house one day and ply me with a beer or several and I will reveal all. Suffice it to say in summary that I was innocent of both charges but learned a lot about life in the process of defending both cases. The truth in anaesthesia (and critical care and pain medicine and any other medical subspecialty) is that it is much better to keep out of trouble than it is to learn to be adept at getting out of trouble once you are in it. I have a few tips for keeping out of trouble that I will share with you.

LOOK AFTER YOUR PATIENT AND YOURSELF

Although a relatively recent novitiate into the motorcycling fraternity, I have already learnt some of its mantras. One of my favourites is: don’t ride drunk, don’t ride tired, don’t ride sick, and don’t ride upset. The principle is that riding a motorbike requires a great deal of concentration if you are going to stay on it and avoid an impromptu flying lesson that will undoubtedly end in pain and physical damage. You cannot concentrate on this important task if you are drunk, tired, sick or distressed. There are obvious parallels to treating patients, with one notable difference. With motorcycling, you risk your own life; when treating patients you risk their lives - but you also risk your career. If you find yourself required to work but feeling impaired for whatever reason, tell someone...
and see if you can find a way of not treating patients until you feel well enough to do so. As a trainee, there should always be a consultant to whom you can turn and there is an arrangement service to make sure that patients are protected and that you are given the chance to recover.

However, looking after yourself goes beyond just making sure that you are fit to work on a particular day. It extends to developing a lifestyle that means that you are as fit as you can be all the time. You need enough sleep, a reasonable amount of exercise for friends and family, a good diet, a passion outside of medicine and a lifestyle free from drugs, smoking and anything more than a modest amount of alcohol. These may seem like trite recommendations, but a visit to the General Medical Council’s website, and in particular the judgements of the Fitness to Practise panel, will show you that many of the doctors who go off the rails ignore these trite recommendations. Your health and sanity is very much conducive to the health of your patients. If you find yourself failing to live up to these recommendations, I would strongly advise you to seek some help of some sort, even if it is talking to a sympathetic friend who knows you well enough to support you and point you in the right direction.

DON’T GET OUT OF YOUR DEPTH
No anaesthetist can do everything and no anaesthetist can be expected to be able to do everything. This is true for all anaesthetists but is particularly true for those in the profession who do not know you but who have your best interests at heart. It is an entirely natural tendency to avoid contact with a patient whom you may have harmed or annoyed as a result of an error. Don’t do this. Patients and their relatives will understand this as you being evasive and defensive. Talk to a consultant about what happened and then go and see the patient and their relatives and explain the situation honestly. Sometimes, it may be appropriate for you to face the patient alone; sometimes you should have a consultant or other senior member of staff with you. At this meeting, you should apologise for what happened if this is appropriate. This does not mean you are admitting guilt; it means you are human and openeness will often satisfy the patient and persuade them not to take any further action.

NO ONE’S PERFECT
This follows on from the above point. No one is perfect; everyone makes mistakes. Making a mistake doesn’t usually mean you are a bad person or a bad doctor; it just means that you are human. By all means take every effort to avoid mistakes, but do not be too hard on yourself or do make a mistake under difficult circumstances. Similarly, be understanding of others who make honest mistakes.

DON’T GET PROUD
A wise man (my father-in-law) once told me: ‘Never, ever think you are the best anaesthetist in the world; just be very grateful indeed that you are not the worst – there will always be people better and worse than you are’. Even if you are very good indeed, there will be days when nothing goes right - when it feels like you are wearing boxing gloves and none of the lines will go in. Don’t get proud – get someone else to help you. The person you ask to help you don’t always have to be more experienced than you. I have often had difficulty putting a line in and have asked a trainee to help, only to watch the trainee put it in at their first attempt. This is good for the trainee and good for the patient and, after a while, your pride will get immune to the odd dent, which will do it a deal of good.

KEEP GOOD RECORDS
When you make clinical decisions, you are - I am sure - going through a problem-solving process and reaching logical conclusions that dictate your management. However, years down the line, if something goes wrong and you have to defend your practice, your memory will have failed. If you are a good practitioner, then good, contemporaneous record keeping is your best protection (if you are a lousy practitioner, of course; then it can damn you for all eternity, but you’re not, are you). Good records will also mean that the next doctor who sees your patient will know what’s going on and will be able to provide continuity - especially important in the new age of shift-working. A good rule of thumb is that an anaesthetist who does not know you but who has read your anaesthetic chart should be able to give an identical anaesthetic based on the information in the chart. A good, tidy and complete anaesthetic chart, in particular, is the mark of a good, tidy and complete anaesthetist.

TREAT CONSENT SERIOUSLY
From both the ethical and legal viewpoint, the process of consent is becoming increasingly important. You are responsible for explaining what you are going to do to your patient, telling them what you hope to achieve by it, what might go wrong, and what the alternative is. Be guided by this simple question: ‘If I were this patient, in their position and with their concerns, what would I want to know in order to make a decision about this treatment?’ The debate between written and verbal consent is too complex to consider here (read the AAGBI booklet on the subject), but the most important principle is that you should not discuss the case with patients; patients have notoriously terrible memories about what they’ve been told and, if a recognised complication occurs, you (the anaesthetist) will have to demonstrate that you warned them about it in advance.

FESS UP
This is an obvious one; if you mess up, ‘fess up. Take responsibility for your victories and your mistakes. It is an entirely normal tendency to avoid contact with a patient whom you may have harmed or annoyed as a result of an error. Don’t do this. Patients and their relatives will understand this as you being evasive and defensive. Talk to a consultant about what happened and then go and see the patient and their relatives and explain the situation honestly. Sometimes, it may be appropriate for you to face the patient alone; sometimes you should have a consultant or other senior member of staff with you. At this meeting, you should apologise for what happened if this is appropriate. This does not mean you are admitting guilt; it means you are human and openeness will often satisfy the patient and persuade them not to take any further action.

COMMUNICATE
No anaesthetist is an island. We can only work well if we work with others, so ensure that lines of communication between you, the surgeon, the theatre staff, the wards, the labs and the myriad of other essential members of the team do not break down. The anaesthetist is arguably best placed to act as the hub for sharing and disseminating information. It’s a noble and important role; fill it with distinction.

NEVER REFUSE A COFFEE BREAK
When I started anaesthesia, I was told that there were three golden rules to follow: order) | Never refuse a coffee break | Maintain a clear airway | Give oxygen |
I have often thought the order might not be entirely correct, but I have never knowingly refused a coffee. Come and you will function better if you have frequent breaks.

LISTEN TO THE GMC (REALLY)
The very first line of the GMC’s key document is, “Medical Practice says: ‘Make the care of your patient your first concern’.” This is the best advice available if you would wish to stay out of trouble: treat others as you would wish to be treated yourself – and this holds true for both your patients and those with whom you work.

THE PREGNANT ANAESTHETIST
Pregnancy is a very exciting time. Adjusting to your changing body and planning your future at the same time as working in a demanding job can be challenging. Negotiating your way through the seeming maze of paperwork surrounding rights and benefits on maternity leave and pay can be difficult to fit in between antenatal appointments, busy shifts and preparing for a new arrival. This article aims to clarify some of the main issues facing pregnant anaesthetists and provide guidance on your rights and responsibilities towards your employer.

MATERNITY LEAVE
✱ You must notify your employer in writing before the end of week 25 of your intention to take maternity leave and the date when you wish this to commence (this can be changed with 28 days notice). This should include the MATB1 form which you receive from your midwife or GP and which states your expected date of delivery.
✱ You have the right to a reasonable amount of paid time off to attend antenatal appointments. What is considered reasonable is not defined in law and here common sense and consideration to the working of your department should be applied.
✱ Doctors are entitled to paid and unpaid maternity leave up to 52 weeks where they intend to return to work afterwards. To be eligible for this you must have worked for 32 months continuous service within the NHS by week 29 of your pregnancy.
✱ Occupational maternity pay gives eight weeks full pay followed by 18 weeks half pay then 26 weeks unpaid leave. Statutory maternity pay is paid in addition for 39 weeks regardless of whether you are returning to work or not.
✱ SMP is claimed by your employer on your behalf. Your employer can only do this if you have completed 26 weeks continuous service within the same trust. If you have recently moved NHS trust as part of a rotation then you are entitled to Maternity Allowance (MA) not SMP. This is the same amount and you have to apply via your local Job Centre Plus.
✱ During maternity leave you retain all of your contractual rights and benefits. This includes annual pay increments, study budget and accrual of annual leave, it does not include pay. You can attend courses during your maternity leave and claim funds from your study budget. Your annual leave must be taken within the normal calendar year and excess leave cannot be carried over to the next year.
✱ If after maternity leave you do not wish to return to work your NHS employer is entitled to retrieve the maternity pay awarded. This is at the discretion of the employer. To avoid this you must return to work for at least three months within 15 months of the start of your maternity leave.

EMPLOYER’S RESPONSIBILITIES
✱ The laws that protect you at work only apply once your employer knows you are pregnant.
✱ Once your employer knows you are pregnant a risk assessment must be conducted. If any risks are identified they must be removed or alternative working arrangements agreed to protect the safety of you and your baby at work.
✱ If you are unable to undertake your on call duties, it is the trust’s responsibility to arrange locum cover.
✱ Once you have informed your employer in writing of your intention to take maternity leave they are obliged to confirm in writing within 28 days your paid and unpaid leave entitlements, paid leave owed and expected date of return to work.

OCCUPATIONAL HAZARDS
Anaesthetists work in many different areas of hospitals and thus face a variety of potential hazards:
✱ Manual handling: there is little evidence to support this.
✱ Shift working/on-call commitments: on-call commitments can be very demanding on a pregnant trainee anaesthetist. You are entitled to stop your on-call commitment as soon as you discover you are pregnant. In some cases this is not a choice but an essential move to ensure a healthy pregnancy. If you do give up your on-call commitment early in your pregnancy the following months may not count towards your CCT. However, the rest of your next block will come and you will function better if you have frequent breaks.

Find out more about the GMC’s guidance for pregnant anaesthetists here:
https://www.gmc-uk.org/guidance/pregnant-anaesthetists
Your CCT

The RCoA will need to be informed of your intention to start your maternity leave. Your CCT date will then be suspended until your actual return to work. This allows for unplanned extended maternity leave to be factored in. Upon returning to work you must notify the training department of the RCoA of your return date and whether you are returning on a LTBT basis. In this way, a new CCT date will be issued. If your maternity leave is post fellowship then you may be able to claim up to three months of your maternity leave as training. This can only be done for a total of three months per pregnancy. You will require a letter of support from your regional advisor stating that during your maternity leave you continued to undertake non-clinical commitments e.g. attended courses, wrote up research, completed audits etc. The RCoA will then allow up to three months to count towards your CCT. You must apply for this time to be paid by the NHS.

Paternity Leave

Finally, let’s not forget the fathers-to-be out there. Time off to attend antenatal appointments will be claimed retrospectively if you were unaware of this.

Paid Maternity Leave

You are entitled to 52 weeks of paid leave you must have been continuously employed for at least 26 continuous weeks. Your maternity leave is to be paid at basic daily rate for hours worked and you are required to pay your subscription fee as you are still undertaking non-clinical commitments. This may be claimed retrospectively if you were unaware of this.

Returning to Work

1. Recently ‘keeping in touch’ days have been introduced to allow a smooth return back to work. These are arranged by mutual agreement between employer and employee; neither party can insist on them. They will be paid at basic daily rate for hours worked and you are allowed a maximum of 10 days. SMP continues as long as 10 days are not exceeded.

2. You have the right to the same job on the same terms and conditions.

3. You are also entitled to time off, such as unpaid parental leave and family emergency leave.

Paternity Leave

Finally, let’s not forget the fathers-to-be out there. Paternity leave entitles fathers or the mother’s husband/partner who will be responsible for the baby to 10 days leave (not to be taken as odd days) after the arrival of the baby. Same sex partners will be included as will partners if a child is being adopted. To be eligible for paid leave you must have been continuously employed by the NHS for at least 26 continuous weeks. Your intention to take paternity leave must be given to your employer by the 15th week before the expected due date. You also have the right to a reasonable amount of paid time off to attend antenatal appointments.

References:


Susan Williams

Previous GAT Committee member
Split, Wales

Training with a Long-Term Illness

Being the patient will be a role you are unaccustomed to as a doctor. It brings with it a multitude of conflicting emotions and anxieties, and for many of us it will be the first time we confront these despite with patients everyday of our working lives. Your health, recovery and wellbeing should undoubtedly be your priority. Your responsibilities to your family, your friends, your colleagues and your employer will weigh heavily on you, but without your health you will not be able to sustain any of these.

For those anaesthetists unfortunate enough to be in this situation I hope that the following might address some of the concerns you may have about your absence from work and getting back to work. Some of it is just common sense and what, with experience, helped me.

Contractual Obligations

You are able to self-certify a leave of absence due to illness of up to seven calendar days. This should be submitted after the absence extends beyond the third calendar day.

Beyond this, you are required to submit medical certificates, completed by a doctor other than yourself, for the duration of absence.

You should inform the line manager of your expected duration of absence as soon as possible. Timely communication will greatly facilitate the rearranging of rota commitments and other responsibilities.

You are not entitled to occupational health at the outset, although your line manager might suggest it. From experience, there is much to be gained from involving the occupational health physicians early. Details of your situation are strictly confidential. Only the impact of your illness on your ability to carry out your duties will be communicated, and this will be undertaken directly with your line manager.

Your line manager is entitled to refer you to occupational health, and is entitled to six months’ full pay (including supplements e.g. bandings) and six months’ half pay.

Sick Leave Entitlement

This is formally laid out in the terms and conditions of your contract, particularly with regards to your return to work.
Injury sustained on duty, accidents sustained due to sport (professional) or a case in which contributory negligence is proved are dealt with individually. Specific conditions apply to absence due to injury resulting from a violent crime.

Unpaid sick leave may be negotiated.

Due to the relatively short period during which you are entitled to full pay on sick leave, it is important to consider an income protection policy that will serve to top up your salary when your organisational benefit expires. Long term illness is usually unexpected, so please consider this seriously, particularly if you have dependants.

PSYCHO-SOCIAL CONSIDERATIONS

Serious illness is very isolating. The world, or the world you were part of, carries on without you—apparently seamlessly. This happens at a time when you were part of the world you were part of, carries on without you-

The impact of your illness may precipitate strain for a multitude of reasons in your closest relationships, rendering your usual support systems unavailable.

Do not underestimate the knock-on effects of all this on you. Be open to the idea of talking to someone neutral about how you’re feeling. It might be your training scheme mentor, it might be a senior anaesthetic colleague or it might be the BMA’s Doctors for Doctors advisory service.

OCCUPATIONAL HEALTH

Health is essential. They do know what they’re teaching you do not have to resume working in an identical role. Again Occupational Health can assist and advise you. Less Than Full Time training or specific exclusions to your duties might be appropriate.

You are not going to be operating at your usual peak performance immediately. Don’t place yourself under undue pressure by committing to new projects or taking on new responsibilities. For a period of time just adjust to working again, and coping with it physically. In my experience, it took longer than I thought.

RESOURCES:

BMA Junior Doctors’ Handbook

www.bma.org.uk/doctorsanddoctors

Doctors for Doctor: telephone 0845 920 0169 (not a 24h service as yet)

www.aagbi.org/sites/default/files/welfareresource_

pack_2008_0.pdf

KATE O’CONNOR

GAT Committee member

SRK, Severn

MEMBERS’ WELFARE

Anaesthesia may attract a certain type of personality, as described by Gaba, that seeks excitement, fast paced work with danger lurking just below the surface as attractive attributes of the job. However, excitement is inevitably accompanied by stress, which is part of our working and personal lives. There is a common perception that anaesthetists are exposed to increased stress due to the responsibility of having the patient’s life in their hands, and having to cope with acute critical situations which are sometimes beyond their control.

Kain et al reported that many anaesthetists exhibit symptoms of chronic stress. Some stress is beneficial but too much causes problems. Female anaesthetists reported higher stress levels due to the added responsibilities of work and domestic commitments.

Trainees seem to be more vulnerable to stress and high emotional exhaustion (burnout) with the compounding pressures of inexperience, training, examinations and increased competition for jobs. The recent GAT welfare survey identified two important stressors: examinations and undertaking work about which the trainee may feel less than confident. With the break-up of team structures and departments getting larger, our current working environment may make these normal life stressors more difficult to cope with. For trainees, the new shift systems have weakened traditional networks of support. Post-fellowship trainees have the added pressure of trying to get good jobs in an increasingly competitive market, in the face of recession and consequent staffing restrictions. The feelings of uncertainty and perceived lack of control that this engenders contribute enormously to stress.

Individuals respond to pressure in various ways: some use constructive coping strategies, while others resort to more destructive means, for example alcohol or drug misuse and aggression, or display other behavioural changes such as social withdrawal and altered mood.

There is evidence to indicate that trainees are more susceptible to drug and alcohol abuse. The art of achieving optimal wellness can, at times, be devilishly hard to achieve. Doctors do not behave like other patients when accessing healthcare and it is well known that we are reluctant to seek help or admit that something is amiss. There is evidence that medical personnel including anaesthetists are less likely to admit to the effects of uncontrolled stress and fatigue on performance when compared to other professional groups such as those from the aviation industry.

This has implications on patient care and safety.

The AAGBI recognises that a proportion of members will at some point in their career, experience difficulties, either personal or professional, of sufficient severity to require external help. The AAGBI Welfare Committee replaced the AAGBI Sick Doctors Scheme and was convened in June 2006 to provide support and help to anaesthetists in difficulty. Their aim is to provide a framework in which members feel able to access appropriate support and guidance, and to provide, oversee and monitor a system to support anaesthetists with difficulties.

The AAGBI Welfare Resource Pack published in 2008 is designed to provide members with a wide range of information. In 2011 the Drugs and Alcohol Abuse amongst Anaesthetists glossy was updated, and gives good guidance on how to recognize, seek help and obtain treatment for addiction, which is increasingly prevalent in society. Anaesthetists are perhaps more vulnerable, with easy access to drugs in their working environment. It is very difficult for an anaesthetist abusing narcotics to continue a career in anaesthesia.

Other areas of continuing work for the Welfare Committee include: improving the Members’ Wellbeing webpages; where they have set up a forum and added links to shared material with other welfare organisations, both nationally and internationally; establishing a voluntary database of anaesthetists with disabilities (a resource to help anaesthetists who have experienced a disability during their career); establishing formal links with the Royal Medical Benevolent Fund to help anaesthetists who have experienced financial difficulties during their career or who are seeking practical help and advice in other areas.

Life-skills which can help you and your colleagues to cope include communication skills, assertiveness,
conflict management, time management and constant reflection on your work life balance. A national survey of members reported that local support for anaesthetists in difficulty was found extremely helpful. A few departments have successful monitoring systems in place and the committee is exploring ways to set up a viable and effective monitoring or ‘buddy’ system, which can be replicated nationwide in departments of anaesthesia. If you need to speak to someone outside your hospital, call the BMA Counselling and/or the Doctors for Doctors advisory service on 08459 200 169 where you will be given advice and a sympathetic ear. Three members of the Welfare Committee work as voluntary advisors for BMA Doctors for Doctors, which is available to AAGBI members, and contact details are published every month in Anaesthesia News as well as on the back of the AAGBI membership card. There will be times in your busy and stressful life when we all need a sympathetic ear and good counsel, so seek help to get over a rough patch or low point. If you can, seek local help initially or alternatively, contact the AAGBI Secretariat at wellbeing@aagbi.org who will contact a member of the Welfare Committee for advice. Further details can be obtained from the Members’ Wellbeing webpages: http://www.aagbi.org/professionals/welfare.

Some practical advice: get a life outside of work. Have a ‘buddy’ or better ‘buddies’ who you can talk to regularly, do not have to be from your own trust but can give you a frank reality check when you need it. It is important to judge success in your career by your own standards and not those of others. If you are enjoying your work, you keep up to date, give safe anaesthetics and enjoy domestic and social-life, you are having a successful career and life. But there will be times when we all need a sympathetic ear and good counsel. So do not be afraid to seek help. You are not alone.

**TRANSPORT OF THE CRITICALLY ILL**

Despite over nine years’ experience in performing consultant delivered retrievals of critically ill children, this is not a ‘how to do it’ account. There is sufficient evidence that dedicated and trained paediatric intensive care retrieval teams produce significantly fewer critical incidents compared with informal ad-hoc arrangements. The most important issue on which to focus for anaesthetic staff in hospitals admitting acutely ill children without access to paediatric anaesthetists and intensivists, is the prompt recognition, resuscitation and stabilisation of an acutely deteriorating child. This includes early involvement and communication between senior anaesthetic and paediatric staff.

The consultation document from the Department of Health, ‘The acutely or critically sick or injured child in a District General Hospital: A team response’, is a useful guiding document. It particularly stresses the importance of inter-disciplinary teamwork. For most anaesthetists this translates as everybody not disappearing once the tube is in.

The document also reiterates the position of the RCoA that it is the duty of the individual anaesthetist to do the best they can despite not having current paediatric practice. It makes the important point that it is the responsibility of the employing hospital to support staff working outside their normal remit if things go wrong. The guidance given in the AAGBI safety guideline ‘Interhospital Transfer (2009)’ is a useful basis for all transfers. Hospitals that transfer ventilated critically ill patients should have contingency plans for staff and equipment. The equipment should be stored in a known place, be complete and regularly checked. The days of sending the most junior trainee with a hastily assembled box of equipment and an assistant of unknown talents should be a thing of the past. The aim is to deliver the appropriate patient to an expertly staffed team in the right area of the correct hospital without incurring avoidable events that will impinge on a good outcome.

Currently, due to limitations on working time and clinical quality issues, there is ongoing centralisation of acute services and sub-specialties. This will increase the number of transported vulnerable patients between hospitals. There is a need for a more structured approach to training in patient transport and greater use of audit and critical incident reporting as quality assurance tools.

**MARK PRICE**

Consultant in Paediatric Intensive Care and Anaesthesia, University Hospital of Wales

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**REFERENCES**


**SOME USEFUL RESOURCES**

- The BMA Doctors for Doctors advisory service www.bma.org.uk/doctorsfordoctors Tel: 0845 920 0169
- The Sick Doctors Trust. www.sick-doctors-trust.co.uk Tel: 0870 4445163
- The British Doctors and Dentists Group Tel: (North of England) 07976 717 211; (South of England) 07711 197 850, or via the Sick Doctors Trust helpline: 0870 444 5163
- Health Professionals Support Group Tel: 01327 262 823
- Alcoholics Anonymous www.alcoholics-anonymous.org.uk Tel: 0845 769 7555
- Narcotics Anonymous www.ukna.org

**MICHAEL WEE**

Past Chair, AAGBI Welfare Committee Advisor, BMA Doctors for Doctors

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*THE GAT HANDBOOK 2011–2012*
Medical protection organisations

Why do I need to belong to a medical protection organisation?

Medicine is a risky business. No matter how skilled, experienced or conscientious you may be, unfortunately, things will occasionally go wrong. When an adverse incident occurs, you will need specialist advice and support. The processes that may be initiated following an adverse event will probably be alien to you, which is why it is reassuring to be able to turn to an organisation with the necessary knowledge and experience to support you. The general perception is that professional indemnity is all about protection against the legal costs and damages for clinical negligence claims. In fact, this is the external aspect of professional indemnity, which covers doctors working in NHS hospitals for claims of clinical negligence arising from their NHS work. There are, however, many other medico-legal consequences of clinical practice that can threaten a doctor's professional reputation, which is why it is important to augment NHS indemnity with your own, personal, indemnity.

Membership of a medical defence organisation will give you access to invaluable independent advice and assistance with non-NHS indemnifiable problems, which arise from your professional work, such as a GMC inquiry, disciplinary or police investigation.

Medico-legal and ethical advice

The practice of medicine can generate a spectrum of medico-legal and ethical issues within everyday work, some of which are far from clear cut, especially when one ethical principle seems to conflict with another. Your duty of confidentiality, for example, may be put to the test when staying silent might end in harm or injury to your patient or another person. Life can be made much simpler with the benefit of advice on the legal and ethical framework to which you should adhere, as well as the opportunity to talk through a thorny situation with a fellow professional. It is important to remember that a medical protection organisation is not just there to pick up the pieces after things have gone wrong, but is also ready with advice to help members avoid problems or criticism in the future. You might, for example, be approached by the police for information about a patient who has just died on ITU.

Any uncertainty you may have about your duties and responsibilities in this situation can be easily clarified by a quick call to your medical protection organisation. Proactivity rather than just reactivity is the key. We are most commonly asked for advice on topics such as confidentiality, consent, data protection issues and professional responsibilities.

Complaints

You only have to open a newspaper or turn on the television to learn that complaints about care in the NHS are on the increase. They may be directed at the trust in general, or at specific healthcare professionals. Because the subject of a complaint can be a personally devastating experience and the last thing you would want is for it to become a protracted issue, the way in which a complaint is handled at the outset can have a dramatic effect on the likelihood that the matter will be resolved swiftly. Your medical defence organisation can advise you on the NHS complaints procedure and help you draft an appropriate response. It is often helpful to have the views of a fellow professional, with your interests at heart, who is also able to take a step back from the emotional impact of the complaint.

GMC

In addition to the rise in NHS complaints, over recent years there has been a marked increase in the number of complaints forwarded to the GMC, whether by an organisation or members of the public. Receiving a letter from the GMC is not something to be undertaken without the support and advice of an appropriately qualified solicitor. Before participating in any police interview under caution, it is important to request that a solicitor be present and this can be arranged through your medical defence organisation.

Writing reports

Writing reports has become an increasingly common part of everyday working life for medics, whether the request is to assist the trust with an internal risk management review or to provide a statement for the police or coroner. Medical defence organisations can provide advice and assistance with such matters.

Criminal investigations arising from your professional work

Although thankfully less common, doctors are sometimes requested to assist the police with their enquiries or arrested as a result of an event in their professional practice. An interview by police under caution can, and should be, a daunting prospect. It is not something to be undertaken without the support and advice of an appropriately qualified solicitor. Before participating in any police interview under caution, it is important to request that a solicitor be present and this can be arranged through your medical defence organisation.

Disciplinary matters

Your medical defence organisation can ensure that the correct procedures are followed and that you are treated fairly by your employer, in matters which arise from your professional work. Medical defence organisation membership does not usually include matters which relate to your personal conduct, not advice on contracts or criticism in the future. You might, for example, be approached by the police for information about a patient who has just died on ITU. You only have to open a newspaper or turn on the television to learn that complaints about care in the NHS are on the increase. They may be directed at the trust in general, or at specific healthcare professionals. Because the subject of a complaint can be a personally devastating experience and the last thing you would want is for it to become a protracted issue, the way in which a complaint is handled at the outset can have a dramatic effect on the likelihood that the matter will be resolved swiftly. Your medical defence organisation can advise you on the NHS complaints procedure and help you draft an appropriate response. It is often helpful to have the views of a fellow professional, with your interests at heart, who is also able to take a step back from the emotional impact of the complaint.

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Types of indemnity

Assistance is provided on an occurrence-based discretionary basis. What does that mean? Well, it means that you need to have been a member of a
medical protection organisation at the time the incident gave rise to a claim took place. The reason this is important – both for you and your patients – is that you can still request assistance even if your situation has since changed. For example, if you treated a patient in May 2000, and were in membership at the time, but a query does not arise in relation to the case until October 2007, by which time you have changed careers or moved to another office, you are still able to request advice and assistance with the matter. In fact, this extends even after your death. The alternative type of cover, offered by most insurance companies, is known as claims-made indemnity. With these policies you need to continue to pay a premium to keep the policy active or pay a lump sum when you cancel the policy, in order to be eligible to request assistance at a later date.

We all hope not to need legal assistance during our careers but it is inevitable that, as a doctor in the modern healthcare service, you will wish to ask for help at some point during your career. In reality, the circumstance and situations that arise may well be out of your control.

### ANGELIQUE MASTHUI
Medico-Legal Adviser
The Medical Protection Society

#### CONSENT AND UK LEGISLATION

#### CONSENT AND UK LEGISLATION

Consider a patient called X, who is admitted to hospital, confused and in multi-organ failure due to faecal peritonitis. What basis do we have for treating this patient? It may seem a facetious question, but we need to determine what shall be done with his own body; a human being of adult years and sound mind has a right to continue to pay a premium to keep the policy active or pay a lump sum when you cancel the policy, in order to be eligible to request assistance at a later date.

We all hope not to need legal assistance during our careers but it is inevitable that, as a doctor in the modern healthcare service, you will wish to ask for help at some point during your career. In reality, the circumstance and situations that arise may well be out of your control.

• Our patient is confused and cannot give or refuse consent.
• How then do we proceed? Following the revocation of the Sign Manual in 1960, the courts did not have the power to consent or refuse consent on behalf of an adult patient. Prior to this revocation, the Sign Manual gave the courts the power of ‘parens patriae’, literally translated as the ‘parent of the country’. This jurisdiction, which dates back to the thirteenth century, enabled the crown to take care of its vassals, where they were unable to take care of themselves; over time this power was delegated to the High Court. Despite the revocation, the Courts have still been approached on numerous occasions for declarations that treatment of patients who lack capacity was not unlawful. Although this is not the same as granting permission, it is sufficient that the courts were permitted. Prior to the passing of the Mental Capacity Act 2005, the common law had developed in a number of areas.

• Capacity: the test for capacity arose from the case of In re C [1997] a paranoid schizophrenic sentenced to life imprisonment for stabbing his girlfriend. C had a gangrenous right foot, which was life-threatening. He refused amputation, accepting the possibility of death as a consequence, but co-operated in other treatments. C had significant hallucinations and delusions, however Mr Justice Thorpe held: ‘I am satisfied that he has understood and retained the relevant treatment information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice’.

• Consenting for others: further it was clarified that individuals held no more power than the courts and were not able to grant or withhold consent on behalf of another. ‘... the next of kin has no legal right either to consent or to refuse consent’. This has been overturned recently by the Court of Appeal.

• Refusal of consent: it is also clear that individuals have the absolute right to refuse treatment. Lord Donaldson stated that ‘If [the decision] exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or non-existent’. This argument built on that of Lord Templeman, in Sidaway: ‘... the patient is entitled to reject that advice for reasons which are rational or irrational or for no reason’, and further confirmed by Butcher v Mapplebeck. ‘A competent woman who has the capacity to decide may, for religious reasons ... choose not to have medical intervention ...’. There may be other reasons for the perceived irrationality of a decision though, as Kennedy and Coubre argue, ‘Arguably a distinction must be drawn between a decision based on beliefs or values not commonly held or accepted (e.g. a Jehovah’s Witness’s refusal of a blood transfusion) and a decision based upon a misperception of reality (e.g. that blood is poison because it is red)’. The latter though could instead be said to be a symptom of the loss of capacity in that if the individual has such a misperception of reality, then they are unlikely to assimilate and comprehend information provided to them and thus fail the test proposed for capacity by Thorpe J in In re C mentioned above.

#### MENTAL CAPACITY ACT 2005

However, the situation has changed with Government accepting that this situation was untenable in the long term. Therefore, the Adults with Incapacity Act 2000 (Scotland) (AIA) and the Mental Capacity Act 2005 (MCA) were enacted to permit treatment of adults across the UK. These Acts change the legal landscape, although I will comment on the MCA.

#### PERSONAL AUTONOMY

The Act makes clear in relation to patients aged 16 or over:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether for the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

The Act requires the test for capacity to be conducted in all patients who lack capacity. The stages (based on In re C) are as follows:

1. Understand information about the decision to be made.
2. Retain that information in their mind.
3. Use or weigh that information as part of the decision-making process.
4. Communicate their decision (by talking, using sign language or any other means).

The information must be presented in a manner that the patient could understand. Therefore, for example it is not acceptable to state that a patient lacks capacity if the patient does not speak English and that is the only way
the information is communicated. Alternatives must be tried, including (but not limited to): translators, sign
language, etc.

CONSENT FOR OTHERS

Further, the Act allows patients to appoint an individual as an attorney to consent or refuse consent on their behalf:

“A lasting power of attorney is a power of attorney under which the donor (P) confers authority to make decisions about all or any of the following, … giving or refusing consent to the carrying on or continuation of a treatment by a person providing health care for P”.[1]

This grant of ‘power of attorney’ must be made in advance of the current illness, but must be in writing and must explicitly grant the power to make healthcare decisions.

POWER OF THE COURTS

The Act goes further allowing the courts to make declarations regarding consent about an adult who lacks capacity. It also permits the courts to appoint deputies with similar powers.[2]  

FAMILY AND INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA)

Finally, the Act requires in regard to ‘serious treatment’ that, “Before the treatment is provided, the NHS body must instruct an independent mental capacity advocate to represent P”.[3] The IMCA service applies to individuals, who lack capacity to consent and also lack friends and family. If the latter exist, then treatment options should be discussed with them to find out what the patient would wish if they were competent. This is critical, as the friends/family are there to provide information; only if they hold a lasting power of attorney can they consent or refuse consent.

This provision of consultation with friends/family and the IMCA service may be waived temporarily, if the treatment needs to be provided as a matter of urgency, such as an ICU admission. Most IMCA teams only work Monday to Friday and are not staffed for out-of-hours consultations; this means that with elective, non-life threatening surgery, we are required to discuss treatment with the IMCA service if the patient lacks capacity.

CONCLUSION

Thus, in regard to our patient, X, the lack of capacity to consent ceases to be the potential burden it once was. If our patient has appointed an attorney, then we may look to them for guidance. In cases of dispute, the courts are present to back or refine decisions made by either doctors or attorneys. The converse is that, it is important for clinicians to realise that treatment decisions will be scrutinised by non-medically qualified individuals. We have become used to making decisions about non-competent adults and instituting our judgment even if that judgment goes against the wishes of our patient’s family. This will have to change. Whereas, the current position has been established by the development of case law, the new situation will be created by statute. The importance is that clinicians will be required to cooperate and respect the decisions made by these proxies. In effect, this is the development of a substituted judgement standard, such as the one that exists in the USA. If we do not respect these decisions, then we break the law. We are entering a new phase in the practice of medicine in this country and we should look to our colleagues in other countries to see where the pitfalls are and how to avoid them.

FURTHER READING

Law and Ethics in Intensive Care Edited by Christopher Danbury, Christopher Newdick, Carl Waldmann, and Andrew Lawson

REFERENCES:

2. Schloendorff v Society of New York Hospital 211 NY 123 (1914)
4. Re C. (Refusal of Medical Treatment). [1994] 1 All ER 819
5. Ibid
7. R (on the application of Oliver Leslie Burke) v General Medical Council. [2005] EWHC 1003
8. Sidaway v Birkett Royal Hospital Governors and others. 1985 All ER 643
9. Re MB (Medical Treatment). 1997 2 FLR 426
12. Ibid, 50
13. Mental Capacity Act 2005 section and section 9(1) and section 11(7)(c)
14. Ibid, Sections 15 to 21
15. Ibid, Section 37(3)

CHRIS DANBURY
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WHAT DO CONSULTANTS REALLY EARN, AND HOW DO THEY DO IT?

Few medical students chose their career on the basis of what they’re going to earn, but most are probably quietly confident that they won’t be poor. As you approach your CCT you need to start thinking about what sort of job you want; teaching or general hospital, sub-specialty, location? What’s generally not well known amongst trainees is the silent ‘M’ – Money!

NHS consultants are well paid; even on appointment at around £75,000 basic a year this is in the top 5% of earnings. The top of the scale extends to about £100k – well above the 97th centile. So you’ll be comfortable.

But how can you earn more than the basic scale? There are four main ways of doing this; private practice, clinical excellence awards, additional NHS work and medicolegal practice. Whichever, if any, you chose take sound financial advice, don’t live beyond your means, and remember that all good things can come to end (a bad fall on the ski trip could stop you earning for months!).

PRIVATE PRACTICE

Approximately 60% of consultants who are members of AAGBI undertake some independent practice. How much will depend on where you are which surgeons you work with, and whether you want to do it. It’s not the land of milk and honey though and can be unpredictable. There may be a syndicate or partnership in your hospital or it may be each anaesthetist does their own thing. You’ll need to pay additional professional indemnity insurance, depending on your income; keep good figures and get an accountant (definitely advised). You must be certain to ensure no conflict with your commitments (SPA time is not time for private patients!), ensure your availability to your patients post-operatively or arrange cross-cover. If private practice is something you’re considering, make sure to ask (discretely) while investigating any possible jobs. Probably best not to do it during the interview!

CLINICAL EXCELLENCE AWARDS

These recognise significant contributions over and above contracted work. Different systems operate within the four NHS organisations, but in general terms they are divided into employer-based and national awards. Application is by self-nomination on a standard form (the CVQ) and awards are competitive between all specialties. Contributions to the NHS are assessed in the area of care delivery, development, management, research and education. Local awards (Levels 1 to 9) are worth between just under £1000 to about £35,000 per year. National awards (Levels 9 to 12) are worth between £13k and £75k a year; all are currently pensionable. Approximately 40% of consultants have no award, 40% have 1-4 points and just fewer than 9% have 5-8 points. At the higher awards the numbers fall away quickly; ~8% have level 9, ~4% have levels 10/11, and less than 1% have level 12/13. Competition for these awards is fierce, and they are not given out lightly. They are not bonuses, but additional payment for significant and sustained contributions to the NHS. There is as much skill needed in completing the form as there is in delivering the work. At the time of writing the whole Clinical Excellence Award scheme is under review.

ADDITIONAL NHS WORK

Often known as ‘waiting list initiatives’, this work is for the NHS on NHS patients, although not necessarily done on NHS premises. It should all be covered by the NHS Litigation Authority, so should not affect your indemnity payments. There is Department of Health policy, supported strongly by the AAGBI, that payments for additional NHS work should be on the basis of parity (equal pay, for equal work), but there are often attempts to introduce pay differentials between surgeons and anaesthetists. Further advice can be obtained from the AASA. Additional NHS work is unpredictable, and may be one the first things to be cut in times of economic pressure.

TOOLS OF THE TRADE

And whatever you chose to do, or not to do, be nice against the other may be subject to significant change in the near future. Never assume any additional income will last forever, keep good records and get an accountant. And whatever you chose to do, or not to do, be nice about it; there are two things that cause disharmony in departments and they’re both money!

FINANCE

MEDICO-LEGAL WORK

This may include work related to civil claims, or the coronal system. It is not to be entered into lightly. The role of the expert is to provide advice to the court, and anyone considering this should prepare themselves carefully as to their duties and obligations. Familiarity with the legal process and the rules of evidence is essential, as is the ability to write accurate and logical reports, and to give evidence. Professional training courses are available, and for those with an interest it can be a fascinating experience. You are as professionally liable for medicolegal work as you are for your clinical practice, and the witness box can be a lonely place if you’re unprepared.

CONCLUSIONS

Despite what you may hear in the coffee room, there are no poor consultants, although some may not be as well off as they’d like. There are a number of ways of augmenting the consultant salary, all with their advantages and disadvantages. The benefits of one against the other may be subject to significant change in the near future. Never assume any additional income will last forever, keep good records and get an accountant. And whatever you chose to do, or not to do, be nice about it; there are two things that cause disharmony in departments and they’re both money!

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In this article, I would like to cover a number of topics, which, in my experience of advising hundreds of doctors over the last 20 years, seem to be at the top of the EQA list. These topics are the foundation to any successful financial planning strategy and, if managed correctly, will stand you in good stead for you and your family’s financial planning strategy and, if managed correctly.

In my experience, doctors tend rightly to favour the two, and benefits of the latter, is set to increase even further as part of regulatory changes imposed by the regulatory body.

Firstly, I should begin with a brief examination of the pension schemes which doctors are likely to come across.

PENSIONS – YOUR EXIT STRATEGY

The NHS pension scheme has changed and there are now two parallel schemes in operation: the existing scheme (1995 scheme), which continues relatively unchanged, and a new scheme for entrants post April 2008 (2008 scheme).

The NHS pension scheme remains an enormously valuable asset. It is a final salary scheme, which is to say that the pension you receive is based on years of service and salary, not stock market performance, charges or other variables.

The existing (1995) scheme is based on an accrual rate of 1/80th per annum, so that if you work for 40 years you will receive 40/80ths of your final salary as a pension. In addition, you will be entitled to a tax-free lump sum that accrues at 3/80th per annum.

Therefore, a doctor with a final salary of £100,000 would receive, in 2008, 40/80ths of your final salary, or £50,000, and a lump sum of £150,000. The pension itself then increases in line with prices and offers additional benefits for spouses and dependents in the event of your death.

This scheme remains available to existing members only. The only major change in (April 2008) is that your personal contributions have increased from 6% to 8.5% of your annual pension in order to receive it. It is important that you take advice before making any decisions about which scheme might be best for you.

‘Added years’, the traditional facility used to make up a shortfall in service, have been removed and replaced by a new facility called additional pension. Additional pension is self-explanatory in that it allows the individual to purchase an additional amount of pension at retirement between £250 and £5,000 per annum.

Those who wish to make contributions over and above the NHS pension have typically invested additional funds into personal pensions, benefiting from tax relief and building a larger fund at the same time. This remains a highly efficient way of splitting your pension benefits but you should be aware that the Government introduced a pension ‘ceiling’ in 2006 called the ‘Lifetime Allowance’ (LTA).

The LTA is the amount that an individual may have in tax allowable pension savings in his or her lifetime. New increased to £1.8 million, the rules state that benefits in excess of this LTA amount can be taxed at 55%, which is a punitive rate.

For many doctors this will not represent a threat until later in their career, but whatever your circumstances you should take professional advice in respect to your retirement pension planning as using the correct strategy in the beginning makes a big difference in the end.

FINANCIAL PROTECTION – WHAT DO I NEED?

Thankfully, the NHS offers some good in-house benefits. If you die whilst your employee your nominated beneficiary will receive a death-in-service lump sum equal to twice your pensionable salary as well as a dependant’s pension. If you are not well enough to work you will be paid for up to six months on full pay and then up to a further six months on half pay, depending on length of service.

If you are well enough to return to work but unlikely to be able to return to work, you may be eligible for early retirement on the grounds of ill health, which might include an enhanced pension.

However, many doctors find that whilst these are valuable benefits, they are insufficient for their own personal and family circumstances. Therefore, you can choose to make private arrangements over and above these benefits to ensure that neither you nor your family is financially prejudiced should the unforeseen happen.

The first choice is often income protection, tailored around the needs of your NHS practice. If you were still too unwell to work once the NHS sick pay runs out, you would receive an ongoing income until your annual sick pay runs out. This means you can still retain the same standard of living.

There are many permutations of this benefit available which can be tailored to your circumstances, but one aspect is uniform; it is paid tax-free.

Whilst income protection pays an ongoing income based on your inability to perform your normal duties due to ill health, critical illness cover pays a once-off tax-free lump sum on the diagnosis of one or more ‘critical illnesses’. However, the range, and sometimes the definitions, of

REFERENCES
www.dbh.gov.uk/ab/ACCEA/index.htm
Clinical Excellence Awards www.dbh.gov.uk/ab/ACCEA/index.htm

ANDREW HARTLE
AAGBI Honorary Secretary
Consultant in Anaesthesia & Intensive Care,
Imperial College Healthcare NHS Trust (St Mary’s Hospital)

PERSONAL FINANCES AND PENSIONS

In this article, I would like to cover a number of topics, which, in my experience of advising hundreds of doctors over the last 20 years, seem to be at the top of the EQA list. These topics are the foundation to any successful financial planning strategy and, if managed correctly, will stand you in good stead for you and your family’s financial planning strategy and, if managed correctly.

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listed conditions varies quite widely from provider to provider, and so careful selection is again required.

If you have debts and/or mortgage liabilities greater than the death-in-service lump sum mentioned above, you should take out life cover to ensure these are repaid if you die. You will need more still if you have a family, and there are a number of specialist types of life cover that are suitable for this function.

Lastly, make a will, especially if you have a family. Whilst you might think that on death your spouse or partner would automatically inherit everything, the laws of intestacy are not quite so generously disposed. Take even more care if you are in an unmarried, or non civil partnership, relationship, and/or if one of you is not domiciled in the UK. You should consult a solicitor for advice regarding the content and construction of your will. We at Cavendish Medical have professional relationships with a select number of law firms, for the benefit of our clients in this area of their financial planning, and so an introduction can be arranged.

When trying to find someone to have a sensible discussion about your personal financial situation and planning options there are a few things you should remember. An independent financial planner with experience of the medical profession and who charges for their advice will provide better value than 99% of the other sources of opinion.

* Mark Martin BMDA
  Independent Financial Planner
  Cavendish Medical Ltd
  www.cavendishmedical.com

The AAGBI publishes guidelines on a wide variety of topics. Many of these are concerned with the safe practice of anaesthesia and include topics such as standards of monitoring, checking equipment and fatigue in anaesthetists. A full list of these and full pdf versions are available on the website: http://www.aagbi.org/publications/publications-guidelines. GAT produces its own publications including ‘Organising a Year Abroad’, ‘Core Survival Guide’ and ‘Who is The Anaesthetist? which can be found at: http://www.aagbi.org/professionals/trainees/gat/publications. Look out for announcements of new glossies which are made via our website, e-newsletter and Anaesthesia News.

AAGBI GRANTS, PRIZES AND RESEARCH

There are a variety of grants, prizes and awards that you can apply for as a member of the AAGBI. AAGBI research funding (departmental project grants, research fellowships and small research grants) is now
allocated by the Research Council of the National Institute for Academic Anaesthesia (NIAA). The establishment of the National Institute for Academic Anaesthesia was announced in March 2008. Its vision, with respect to anaesthesia and related specialties, is to:

* Develop and maximise its academic profile within the healthcare profession, NHS, universities and major research bodies
* Facilitate high profile, influential research
* Facilitate and support training and continuing professional education in academia
* Improve patient care by promoting the translation of research findings into clinical practice.

The research agenda is governed by the Institute's Foundation. A summary of the grants and awards a national Institute for Academic Anaesthesia and Anaesthesia: Full details of the research funding the NIA offers, and how to apply, can be found at www.niaa.org.uk.

Grants, prizes and awards for SAS grade anaesthetists, trainees and undergraduates, plus travel grants and IRC funding, remain independently funded by the AAGBI Foundation. A summary of the grants and awards we offer is listed below and is correct at the time of publication.

TRAVEL GRANTS AND IRC FUNDING

The International Relations Committee (IRC) considers applications from AAGBI members who are seeking funding for projects usually, but not exclusively, in the developing world. There is no closing date for this grant; applications are welcomed year-round.

For further information and an application form, please visit: http://www.aagbi.org/international/irc-funding/travel-grants

EVELYN BAKER MEDAL

The Evelyn Baker Medal was instituted in 1998 for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgment and wisdom, and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse junior colleagues is seen as an integral part of communication skill, extending beyond formal teaching or academic presentation. The award is open to all practising anaesthetists (and those who have retired in the last two years) who are members of the AAGBI.

For further information, please visit: http://www.aagbi.org/about-us/awards/evelyn-baker-medal

GAT ORAL AND POSTER PRIZES

Trainee anaesthetists are invited to submit an abstract for oral or poster presentations at the GAT Annual Scientific Meeting. The authors of the six highest-scoring abstracts in the preliminary review will be invited to present their work orally and will be eligible for the Drager Oral Presentation Prize. A cash prize and AAGBI medal will be awarded to the winner.

The remaining successful authors will be invited to present a poster. Entries will be allocated into one of the following three categories depending on the grade of the presenting author: Foundation Year Doctors; ACCS/CT1/CT2 Doctors; ST3+ Doctors. A cash prize and a certificate will be awarded to the winner in each category.

All audits, whether shortlisted for oral or poster presentation, will also be eligible for the Dräger Audit Prize. Audits should demonstrate good understanding of the principles of clinical governance and evidence of completion of the audit cycle.

THE ANAESTHESIA HISTORY PRIZE

The prize is awarded by the AAGBI and the History of Anaesthesia Society for an original essay of 4000 - 6000 words on topics related to the history of either anaesthesia, intensive care or pain management. The £1,000 prize and an engraved medal will be awarded for the best entry, and the winner will be invited to present the paper at the GAT ASM.

For further information on grants and awards for trainees please visit: http://www.aagbi.org/research/awards/trainee-awards

WYLIE MEDAL UNDERGRADUATE PRIZE

The Wylie Medal is awarded to the most meritorious essay on the topic of ‘anaesthesia and patient safety’ written by an undergraduate medical student at a university in Great Britain or Ireland. Prizes of £500, £250 and £150 are awarded to the best three submissions. The overall winner will receive the Wylie Medal in memory of Dr W Derek Wylie, President of the Association of Anaesthetists 1980-82.

UNDERGRADUATE ELECTIVE FUNDING

All medical students in the UK who have successfully completed two years of clinical medical training are eligible to apply to the AAGBI for funding towards a medical student elective period. Preference will be given to those applicants who can show that their intended elective has an anaesthetic, intensive care or pain relief interest. Up to £500 may be awarded.

For further information on grants and awards for medical students please visit: http://www.aagbi.org/research/awards/undergraduate-awards

SAS AUDIT & RESEARCH PRIZE

The AAGBI also awards prizes for career grade doctors - the SAS Audit and Research Prize. This is exclusively for SAS doctors to encourage them to undertake research and audit. Entries are judged by the Research & Grants Committee of the AAGBI. All SAS doctors who are members of the AAGBI are eligible to apply for the prize.

SAS TRAVEL GRANT

The AAGBI invites applications for the SAS Travel Grant. This is a new grant (up to a maximum of £2000) exclusively given for SAS doctors to visit a place of excellence of their choice for two weeks. Please note that this is not meant for attending a meeting or a conference. Entries are judged by the SAS Committee of the AAGBI. All SAS doctors who are members of the AAGBI are eligible to apply for this grant.

For further information on grants and awards for SAS doctors please visit: http://www.aagbi.org/research/awards/sas-grade-anaesthetists
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<td>EACTA</td>
<td>European Association of Cardiothoracic Anaesthetists</td>
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<td>ECWL</td>
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<td>EDIC</td>
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<td>Euda CT</td>
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<td>FCA</td>
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<td>FY</td>
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