Staff Grade, Associate Specialist, and Specialty Doctor (SAS) HANDBOOK

SECOND EDITION
Welcome to the second edition of the Association of Anaesthetists of Great Britain & Ireland’s SAS handbook. During the preparation of the first edition it was felt that it would be useful to have a single document containing all the relevant information related to SAS doctors to which SAS doctors, managers and clinical directors could refer.

Since the publication of the first edition there have been new developments in the NHS, including a new SAS contract. As much of that new information as possible has been included in this second edition but inevitably events will overtake it as soon as it is printed. Therefore this handbook will be updated on the website annually.

There is a new section on ‘good practice guidance for SAS doctors’ dealing with various aspects of terms and conditions of the SAS contract relevant to the specialty of anaesthetics. This section arose from comments expressed in the 2010 survey of SAS doctors working in anaesthetics that was conducted by the AAGBI SAS Committee and the Career Grade Committee of the Royal College of Anaesthetists (RCoA).

I would like to thank all the contributors who are experts in their respective fields and also the members of the AAGBI’s SAS Committee. My particular thanks go to Dr Iain Wilson, AAGBI President, AAGBI Council and members for their full support and guidance.

I would also like to thank Christine Tabano and the staff at 21 Portland Place for their help. I hope that this second edition will serve as a useful companion to all the SAS doctors working in anaesthetics.

Dr Ramana Alladi
AAGBI SAS Committee Chairman
July 2011
2. THE AAGBI SAS COMMITTEE

Dr Kate Bullen, the only SAS doctor to become an elected member of AAGBI Council, established the SAS Committee a decade ago. At that time SAS doctors were often treated as a pair of hands and were not considered part of the anaesthetists' hierarchy.

The SAS Committee has come a long way. This is obvious from the strength of the SAS Committee in the AAGBI now and its achievements during the last five years. It goes from strength to strength and increasing numbers of SAS doctors have joined the AAGBI.

The Committee comprises a Chair, all AAGBI Officers, three elected council members nominated by the President and six other SAS members including representatives from the RCoA, the British Medical Association (BMA), Scotland and four other members of good standing chosen by the Chairman and the Committee. The Chairman of the SAS Committee is a co-opted member of the AAGBI Council, and also represents the SAS grade on other AAGBI Committees.

The SAS Committee now meets twice a year. The Chair is a co-opted member of the Career Grade Committee of the RCoA. Both Committees meet once a year at a joint meeting to discuss issues of common interest. The terms of reference of the SAS Committee include: advising Council on matters relating to SAS doctors, representing their interests, responding to enquiries from the SAS members, encouraging medical and non-medical career development and ensuring collaboration with other professional bodies on issues of mutual interest, such as the RCoA, other colleges and the BMA.

Continuous Professional Development (CPD) activities

The Committee organises two seminars annually at 21 Portland Place dealing with academic and topical medico-political subjects. On alternate years the SAS Committee organised a session regularly at the AAGBI's Annual Congress. These sessions are well attended. In 2010 for the first time the SAS Committee organised a two-day current topics meeting that included a social evening on the first day and was very successful. From time to time the Committee organises seminars on management and job planning issues.

The SAS Committee has an SAS page in the AAGBI's magazine Anaesthesia News that includes contributions from the SAS members. This acts as a forum for those who wish to express their ideas on any topic related to SAS doctors. The AAGBI has awarded SAS doctors who have made significant contributions. Dr Anthea Moore was awarded the Pask Certificate in 2009 for her contribution to SAS doctors. Dr Ramana Alladi, chairman of the SAS Committee, has been awarded the prestigious 'Anniversary Medal' for his contributions to SAS doctors and anaesthesia in the UK and Ireland. Dr Sudheer Medakkar, Associate Specialist in anaesthetics in Torquay, was awarded the Evelyn Baker Medal at the Winter Scientific Meeting in 2011.

Publications

The AAGBI first published the SAS Handbook in 2007, and it proved to be extremely popular. The AAGBI also produced a guideline entitled Staff and Associate Grades in 2008 that contains guidance on both new and old contracts. It has also produced guidance on re-grading to Associate Specialist grade this year. Within the last two years, the SAS Committee instituted two major awards, a SAS Research and Audit Prize and a SAS Travel Grant to encourage doctors to contribute to academic anaesthesia. These are exclusive annual prizes for SAS doctors. It is important that more members apply to prove that SAS doctors are active in research and other activities outside their normal job plan. The Committee also runs the SAS pages on the AAGBI website.

There is still a lot to be done: the Committee owes its success to all the Presidents, members of AAGBI Council and members of the SAS Committee who have given immense support and continue to do so. None of the success would have been possible without this support. It has been a pleasure and privilege to be a part of the SAS Committee. It is important to continue to maintain the momentum and on to greater achievements in the future.

3. WHY JOIN THE AAGBI?

Benefits of joining include:

• Personal injury and life insurance cover of up to £1 million for patient transfer
• Subscription to Anaesthesia – renowned international monthly journal
• Free copies of the Association's guidelines
• Free monthly Anaesthesia News (newsletter) and e-newsletters
• Special rates for scientific meetings
• Priority booking and special rates for seminars at Portland Place
• Free advice and information
• Free information handbooks
• Exclusive Audit and Research Prize and Travel Grant for SAS doctors
• Representation at Westminster and Department of Health
• 20% discount on textbooks – from Oxford University Press and Blackwell Publishing
The RCoA and SAS anaesthetists

SAS anaesthetists have the same needs and concerns as consultants and trainees. At the same time, the RCoA also recognises and understands that there are other needs and concerns that are unique to us. We have our own Committee and there are two SAS members of RCoA Council who are there to represent all your views and concerns. They are not just SAS members, but full members of Council who take part in all the activities of the RCoA including meetings with the Department of Health (DoH), especially where matters pertaining to SAS doctors are discussed.

The RCoA is concerned with standards of anaesthesia. This means that the overall level of competence and education of all anaesthetists is under the remit of the RCoA. To this end, the RCoA looks at professional standards, continuing medical education, appraisal and revalidation (with the General Medical Council [GMC]).

4. The Royal College of Anaesthetists’ Career Grade Committee

The RCoA SAS Council Member

Dr Andy Lim

Professional standards, teaching

This is part of the wider role that we have available to us if we wish to take it on. The RCoA regards us as a vital part (approximately 20%) of the anaesthetic workforce in the NHS, not just in terms of our contribution to service provision but also because of the contribution we can make to training. This is not only in the workplace, but also through contributions to courses such as the ATS and ALS courses. College Tutors are encouraged to look for SAS doctors who wish to teach, encourage them to attend ‘teaching the teachers’ courses, and accredit them as teachers.

SAS anaesthetists as teachers

The GMC states that all doctors have a professional obligation to contribute to the education and training of other doctors. It further states that teaching skills can be learnt – just because you are an SAS doctor does not mean that you are excluded from the teaching process, both as a giver and as a receiver of teaching. The RCoA takes the view that the instruction (of trainees) can be undertaken by SAS doctors providing they have been identified by the local College Tutor and have been nominated to the local school of anaesthesia, specifying the areas in which they have appropriate expertise. The RCoA further states that attaining the Fellowship is not a prerequisite. However, if you do decide to undertake teaching, the onus is on you as a teacher to maintain your continuing medical education and professional development, as well as being familiar with the current RCoA recommendations on training and assessment and agree to understand, accept and carry out the necessary responsibilities.

Dr Andy Lim
RCoA SAS Council Member

5. Other Support Mechanisms and Organisations

Local Negotiating Committee (LNC)

The LNC represents medical and dental staff of all grades employed within an organisation in local negotiations and employment issues. The LNC is made up of local, elected representatives from different grades. Though it is supported by BMA and its Industrial Relations Officer (IRO), one does not necessarily need to be a member of BMA to get involved in the LNC. It is an ideal local platform for the SAS doctors to get management and committee experience. Further guidance on LNCs can be found on the BMA web site http://www.bma.org.uk/representation/local_representation/3_local_neg_committees/index.jsp

Medical Staff Committee (MSC)/Medical Advisory Committee (MAC)

This is another body that consists of all the career medical staff in a hospital including SAS doctors. The MSC/MAC meets regularly to discuss matters of mutual concern between colleagues and enable regular communication between senior medical staff and management. These Committees provide yet another platform for SAS doctors to get involved and develop their leadership skills.

SAS Tutor

Also known as an SAS Educational Advisor, this is an educational role usually filled by a senior SAS doctor who oversees educational placements, arranges tutorials, lectures, etc. SAS Tutors manage the local SAS development budget and can be approached for any help regarding education and career development.

Role of mentors

Many departments have dedicated SAS mentors (consultants or senior SAS doctors) whose role is to support and guide the SAS doctors in their professional practice, personal wellbeing and personal and professional development. The DoH, BMA, several deaneries and many independent organisations offer mentoring schemes and training. It has been proven in several studies that mentoring helps in improving confidence and reducing stress.

Deanery support

Most deaneries have dedicated Associate Deans for SAS doctors. They oversee the development of CPD opportunities, thereby enabling these doctors to have wider options for career development. They also ensure close working relationship between deaneries, local educational providers, the Royal Colleges and the faculties. Some deaneries have mentoring schemes which help and support doctors. Please visit the individual deanery’s website for further information.

Other

Many doctors directly come from overseas to take up SAS or other middle grade posts. There are many international medical graduate organisations which offer support and guidance for the doctors coming from outside the UK to take up posts in the NHS. The support includes mentoring schemes, induction programs, web forums, etc.

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The NHS employer should aim to provide a working environment that recognises both the diversity of the SAS doctors and the major contribution that they make to patient care. The NHS employer should realise that SAS doctors need both support and resources to develop personally and professionally. The NHS employer should be committed to ensuring that the role of the SAS doctor is fully acknowledged and respected by management, colleagues and patients. In order to deliver these aspirations, the following recommendations are suggested.

Each employer should work towards every SAS doctor having the following:

- An appropriate contract of employment incorporating national terms and conditions and ideally following the BMA recommended model contract format
- An appropriate agreed job plan. This may only be changed by mutual agreement between the SAS doctor and the Clinical Director (in accordance with the procedure for the agreement for the review of job plans), and from recommendations following appraisal
- An adequate daytime sessional allocation with separate and identifiable time allocated for administration, education, audit and teaching commitments, etc.
- Access to office accommodation and a computer in each directorate where SAS doctors are employed. This should include email and suitable storage facilities for confidential work, related papers, books, etc.
- Adequate support and time allocation to allow SAS doctors to fully participate in the employer’s appraisal process (including access to appraisal training) and the necessary CPD and study leave requirements, which are a natural consequence of appraisal
- Adequate and fully funded study leave
- Membership of the MSC/MAC/Hospital Medical Board including invitation to attend meetings
- SAS representation on the LNC
- Access to a fair and appropriate mechanism for the award of optional points for staff grades and discretionary points to associate specialists who remain on the pre-2008 contracts. A minimum number of discretionary points/optional points should be awarded in a similar fashion as for consultants
- Equal access to the benefits of the ‘Improving Working Lives Initiative’
- Full membership of the directorate including invitation to attend directorate meetings

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The minimum entry requirements are:

- Full registration with the GMC.
- Minimum of four years (or equivalent) of postgraduate training, of which two must be in a relevant specialty (although the RCoA expects Specialty Doctors in anaesthesia to have three years experience).

Salary grade

The grade has 11 pay points. There is annual progression up to point 5. In order to progress from point 4 to point 5, the doctor will need to have passed the threshold in clinical care, and evidence for this must be provided before the move can be made. Progression from point 5 to point 8 is at two-yearly intervals. To progress from point 7 to point 8, the doctor will need to provide evidence to enable passage through Threshold Two. Progression from point 8 to point 10 is at three-yearly intervals.

Contracting

The post holder will be required to undertake annual appraisal and annual job planning. It should be noted that these are separate processes and should be carried out as such. There is no requirement that they are done at the same meeting, or by the same person.

Working week

A full-time Specialty Doctor contract is for 10 Programmed Activities (PAs). In general each PA is a four hour unit of activity, which may be programmed as blocks of four hours, or in half units of two hours each. The only exception to this is work done out of hours (ooh), including all forms of direct Clinical Care (dCC), including all forms of emergency work, and other similar activities.

Additional Programmed Activities (APAs) may be allowed, subject to the Working Time Regulations of a 48 hour working week.

Programmed activities are separated into:

- Direct Clinical Care (DCC), including all administrative, management, and research activities that are part of regular day work, such as: telephone calls, letters, reviewing results, travel to peripheral sites to deliver clinical care, attendance at multidisciplinary team meetings about specific patients, etc.
- Supporting Professional Activities (SPA), including continuing medical education, professional development, teaching and training, audit, research, and other similar activities.
- Additional NHS responsibilities such as Rota Coordinator, or Lead Clinician.
- External duties such as trade union duties, work for Royal Colleges or Specialist Societies, or work for Her Majesty’s Government.

Job planning

Participation in job planning is an agreed requirement under the new national terms and conditions of service for Associate Specialist and Specialty Doctor, under Schedule 4 of the Terms and Conditions of Service. It is also applicable to the other closed SAS grades.

Purpose

A job plan is a prospective agreement that sets out a doctor’s duties, responsibilities and objectives for the coming year. It will build upon existing NHS activities in the main. The job plan meeting should be undertaken in a spirit of partnership, and ensure clarity of expectation for the doctor and also for the employer about the time and resources to meet the prospective objectives, which will be both individual (informed by the personal development plan generated in the appraisal process) and also any agreed service objectives.

Process

Current activities need to be reviewed and considered alongside future service needs. This should be supported by use of activity data and work diaries. The work diary should be kept for a minimum of one rota cycle, or for six weeks, but a longer period will ensure more accurate information. It should include all work undertaken from each of the four categories listed above. Some departments agree generic specialty team job plans, which can then be personalised and adapted as necessary during the individual job plan meeting.

There is no one model for a job plan, but it will contain:

- Main duties and responsibilities
- Schedule of commitments (timetable)
- Agreed personal objectives and service objectives

SAS contract background

In April 2008, a new SAS contract was introduced into the UK, called the ‘Specialty Doctor contract’. At the same time, the previous SAS grades (comprising Staff Grade, Associate Specialist (pro-2008), Clinical Assistant, Hospital Practitioner, senior Clinical Medical Officer and Clinical Medical Officer) were closed, so that no new appointments to these grades can be made in England.

Individuals currently in those grades may remain in these posts until they leave the post, but any new appointments have to be to the Specialty Doctor grade. Details of the terms and conditions of these closed grades can be found in the AAGBI guideline Staff and Associate Specialist Grades and also on the BMA and NHS employers websites. SAS grade doctors currently in the closed grade posts may transfer to the new contract at any time, by requesting to do so. It should be noted that the approval of an irreversible decision once implemented.

At the same time as the Specialty Doctor contract was introduced, a new Associate Specialist (2008) contract was introduced, with similar terms and conditions of service as the Specialty Doctor post.

Entry to this grade was only possible for those SAS grade doctors and dentists who successfully underwent personal re-grading following application within the ‘window of opportunity’ between 1 April 2008 and 31 March 2009. No further applications can be made for personal re-grading, and the grade is also now closed.

SAS contract and job planning

7. SAS CONTRACT AND JOB PLANNING

The SAS Handbook into the UK, called the ‘Specialty doctor contract’. In April 2008, a new SAS contract was introduced
8. REVALIDATION AND APPRAISAL

Revalidation

The GMC is, over the next few years, changing how doctors within the UK are regulated to practice medicine. This involves introducing a system of revalidation for all doctors, to provide assurance that doctors are fit to practise. Revalidation is the process by which licensed doctors will demonstrate to the GMC normally every five years, that they remain up to date and fit to practise. It is intended that this is a formative process that will provide a focus for professionals to plan continuing improvement on personal practice.

Relicensure

All doctors wishing to practice in the UK require a licence to practise, which is issued by the GMC, and is renewed every five years, using the revalidation process. All doctors who are registered with the GMC, with a licence to practise will have to participate in revalidation. Revalidation will be based on a local evaluation of the doctor’s performance against national standards approved by the GMC. A portfolio should be collected on an ongoing basis, containing information drawn from their practice to evidence that the required standards are being met.

To revalidate, the GMC needs to receive assurance that the doctor is meeting the required standards. In most cases, this recommendation will be made to the GMC by the Responsible Officer for the employing organisation. This recommendation will be made, normally every five years, based on the doctor’s appraisals over this period, together with information derived from local clinical governance systems. The Responsible Officer makes a recommendation to the GMC on revalidation. Accordingly, the appraisal process is being strengthened to ensure it becomes fit to support revalidation. This is explained in the document Assessing the Quality of Medical Appraisal for Revalidation from the Revalidation Support Team.

Revalidation will require a more structured and planned approach to CPD, which should be based on what one does, or should be capable for doing, as an anaesthetist. A CPD matrix has been developed by the RCoA to assist in planning CPD to ensure that over the five year cycle all necessary areas have been covered.

Strengthened appraisal

The generic principles of strengthened appraisal are that a portfolio of evidence will be required to demonstrate standards of practice as set down in the GMC Good Medical Practice guide.

Principles

These fall into four domains

- Knowledge, skills and performance
- Safety and quality
- Communication, partnership and teamwork
- Maintaining trust

The evidence required for these domains is the same as was previously collected when there were seven headings of Good Medical Practice.

Domains

Each domain has areas of attributes, with generic standards that map to these attributes. The RCoA is producing specialty specific guidance to match these generic standards.

Knowledge, skills and performance

- Maintain your professional performance
- Apply knowledge and experience to practice
- Keep clear, accurate and legible records

Safety and quality

- Put into effect systems to protect patients and improve care
- Respond to risks to safety
- Protect patients and colleagues from any risk posed by your health

Communication, partnership and teamwork

- Communicate effectively
- Work constructively with colleagues and delegate effectively
- Establish and maintain partnerships with patients

Maintaining trust

- Show respect for patients
- Treat patients and colleagues fairly and without discrimination
- Act with honesty and integrity

Portfolio

The portfolio of evidence that will be required to demonstrate compliance with the standards will include, among other things:

- Confirmation of participation in CPD
- Results of appropriately tailored multi source feedback (MSF), both peer and patient
- Outcomes-based assessment of performance

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AAGBI SAS Committee Member
• Robust audit data
• Peer review of departments (not individuals)
Some forms of evidence will cover more than one standard, such as MSF.
Examples of evidence required
• Confirmation of participation in CPD:
  • Log of CPD and training activity
  • Evidence from courses attended, including attendance certificates and reflections on how it may change practice
  • Log of any teaching or research activity, including any feedback
  • Any work for the wider NHS
• Link evidence to job plan
  • MSF:
  • Available material from patients surveys, and relevant colleague correspondence and feedback
  • Details of complaints with relevant explanations and resolution
• Letters of accolade or appreciation
• MSF:
• Available material from patients surveys, and relevant colleague correspondence and feedback
• Details of complaints with relevant explanations and resolution
Outcome-based assessment of performance:
• Review of previous personal development plan, and achievements
• Identification and recording of reasons for any areas that are incomplete in PDP
Clinical audit data:
• Collection of data relevant to you and your department
• Ensuring that data being collected on your behalf is valid, reflects your clinical responsibility, and are evidence-based

Departmental peer review, if available:
• Case discussions
• Audit meetings
• RCoA assessments

Process
The appraiser will evaluate all the evidence in the portfolio against the specialty standards and will record, for each domain, whether the evidence is sufficient to make any comment for an attribute this will be noted.

A Personal Development Plan (PDP) will be generated during the discussion, with personal objectives. These personal objectives feed into the job planning process.

The appraiser will complete a summary of the appraisal discussion, to which the appraiser may add comments.

This summary, together with the forms for each domain and the PDP, are sent to the Responsible Officer, and are used over a five year period to enable a recommendation on revalidation to be made to the GMC.

Dr Anthea Mowat
AAGBI SAS Committee Member

9. WORKING LESS THAN FULL-TIME (LTFT)

Anaesthesia is a specialty that lends itself easily to working less than full-time, and many SAS anaesthetists do exactly that. Let us first of all define clearly what we mean by part time or less than full-time. This depends upon what contract you are on. In essence, you are full-time if you work the same as, or more than, the number of hours needed to be paid the basic salary for your terms and conditions of service. For example:

• 2008 Specialty Doctor and Associate Specialist (AS) contract: full-time = 40 hours per week; pre-2008 Staff Grade contract: full-time = 40 hours per week

This means that if you are working for 38.5 hours per week on the old AS contract, you are deemed to be full-time; but if you work 38.5 hours per week on the new AS contract, doing the same work, you are technically part-time, even though this is still more hours than other NHS workers who are ‘full-time’ on Agenda for Change contracts.

Why work part-time?
Just as there are many reasons to be working in the SAS grades, there are also many reasons to seek LTFT work, with each person having their own individual story. Obviously, part-time work is particularly popular with mothers of young children, but other reasons include: working in another specialty or for a different employer for part of the week; undertaking further education or academic work; health issues or disability; caring for elderly or sick relatives; or even wanting to do a completely non-medical activity such as write a novel!

Contractual arrangements
When agreeing a part-time contract, it is important to read carefully the terms and conditions of service for your grade and ensure that you are given your rights under part-time workers regulations. Your contract should clearly state your hours, location of work and salary. The BMA offers a contract-checking service for members. You should, like your full-time colleagues, have an agreed job plan setting out your weekly timetable and on-call duties. You are entitled to have the same access to job planning and appraisal. You are also entitled to a minimum of one SPA session if you are on the new contract, although you need to provide evidence of what SPA work you do. You should also make sure that you have a sensible ratio of daytime sessions to out of hours work.

Problems and obstacles
Attitudes
It occasionally happens that full-time colleagues will believe that working part-time indicates a lack of commitment or enthusiasm, and as a result you could be ‘passed over’ when non-DCC work becomes available. This attitude is hopefully changing but it may still be the case that your Clinical Lead would find it easier to let a full-time doctor take on non-DCC work rather than a part-time colleague. The knock-on effect of this is that if you are part-time you will be less likely to be successful in applying for optional and discretionary points, and on the new contracts you may find it more difficult to pass through the thresholds. If you are in a large department there will already be many part-time anaesthetists so this should be less of a problem, but it is up to you to ensure that your commitment is never in doubt.

Additional Programmed Activities
The new 2008 contracts specify ‘full-time’ as 10 PAs or 40 hours. Any more than that requires a separate contract for ‘Additional Programmed Activities’. Part-time doctors may also be offered such additional duties too: for example, you may have a core job plan for 20 hours per week, but you can agree to APAs to undertake extra work on a temporary basis, with 3 month notice built in on either side.
**Leave arrangements**

You are entitled to a pro-rata share of annual leave and public/statutory days. The precise arrangements for this will vary from one department to another, but you should not be treated less favourably than your full-time colleagues. For example, you may be told that if you work half-time, you can only have three weeks annual leave instead of six; this is incorrect, and some examples later will illustrate this. National terms and conditions of service specify your leave as five weeks per year, or two, or three, depending on which part of the scale you are, on the anniversary of your incremental date. Passing to a higher threshold may be more problematic if you have not had the opportunity to meet the criteria, so it is more important than ever to ensure that this is raised at appraisal and at job planning well in advance of the expected threshold date. Your employer is obliged to make this possible for you and must not put barriers in the way of your progression. For example, if your full-time colleague has been given a session to undertake an audit, or research, or special project for the department, you should be given similar opportunity as well.

**Changing from one to the other**

It sometimes happens that a doctor who is working full-time wishes to change to part-time, and vice versa. Your employer has no obligation to allow this, but in practice, if you have a good reason to reduce your hours, a good employer would try to enable that. Increasing hours from part-time to full-time is also not a ‘right’, but if a vacancy arises in your department, they may find it a good solution to offer the vacant sessions to you instead of recruiting outside. If your full-time colleague has been given a session to cover an operation, your employer has no obligation to allow this, but in practice, they should consider the option of trying to achieve this contribution to the workforce.

**Appendix: Example job plans and leave calculations**

**Example 1**

Dr A works as a Specialty Anaesthetist. She has been full-time, but now wants to work for 20 hours per week and does not want to do any off hours; her Clinical Director is agreeable to that. She is not required to do prospective cover. They agree a job plan as follows:

- **Monday**: 08:00 to 13:00 theatre list
- **Tuesday**: 13:00 to 18:00 SPA (including attending the M&M meeting and taking care of the department library)
- **Wednesday**: 08:00 to 18:00 theatre list
- **Thursday**: off
- **Friday**: off
- **Saturday**: off
- **Sunday**: off
- **This is a job plan for 20 hours, or 5 PAs.**

**Example 2**

Dr B is an Associate Specialist on the new contract. He is resident in the labour ward one night per fortnight. He also does one Saturday morning trauma list every fortnight. He is not required to do prospective cover. His agreed job plan is:

- **Week one**: Monday, 08:00 to 18:00 theatre list
- **Tuesday**: 08:00 to 13:00 theatre list
- **Wednesday**: off
- **Thursday**: 08:00 to 18:00 SPA
- **Friday**: 13:00 to 18:00
- **Saturday**: off
- **Sunday**: off
- **This is a job plan for 20 hours, or 5 PAs.**

**Public holidays**

Dr A is entitled to 10 days per year, pro-rata, making 5 days in total. In the year in question, there were 5 days that fell on a Monday, 2 on a Tuesday, and 5 on a Friday. If Dr A took the time off as they happened to fall, then she would be absent on 5 Mondays. However, she normally only works in the mornings on a Monday, so to achieve her full entitlement of 5 days, she will need to take some time off on other days as well. Her Clinical Lead agrees that she should have 2 Thursdays off and 1 Wednesday.

**Conclusions**

Working less than full-time is an excellent way to continue to practise anaesthesia and have a satisfying career when full-time work is for some reason not possible. Part-time workers’ legislation has removed some of the problems that once existed with regard to annual, statutory and study leave, and good employers recognise and encourage this contribution to the workforce.
10. ADDICTION, SICKNESS AND RETURNING TO WORK

Addiction

Addiction is no respecter of age, race, creed, religion, colour or social class. Since the early 1990s it has been recognised as an actual disease [1], and is classified accordingly with other chronic illnesses. Unfortunately society’s attitude has not changed significantly and addiction is still a rather taboo subject. For the purpose of this article, the terms ‘addiction’ and ‘dependence’ are used interchangeably. Further and more detailed information on some aspects of addiction and its management can be found on the AAGBI website and in the Drugs and Alcohol Abuse amongst Anaesthetists – Guidance on Identification and Management (2011) guideline.

Out of each cohort at medical school approximately 10% will develop an addiction – so what allows the majority of individuals to ‘self detox’ after minor experimentation with drugs at university and never develop a serious problem, whereas a minority go on to develop full blown addictive states? There is evidence from DNA and biochemical testing that addiction is multifactorial, and can be regarded as having genetic, psychological, social and environmental components. There is often an alcoholic parent or history of child abuse which, just the right drug of choice, and whether it is nature or nurture which plays a predominant role, is debatable.

Definitions

Alcoholism is characterised by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial [1].

Substance abuse is characterised by the repeated, inappropriate use of a mood-altering substance which, in some way, interferes with health and/or quality of life. This diagnosis can be made if substance dependence diagnostic criteria are not met. Substance abuse may progress to dependence if unaddressed. In addition to the above, the hallmark of dependence is the presence of physical withdrawal symptoms and signs on ceasing to take the drug [2].

Impaired control describes the process whereby, despite for example promising to have just a couple of drinks, there is an irrational compulsion to continue, despite having an important meeting or case the next morning. Differences in GABA, 5hT & dopamine DA3 receptors have been demonstrated as part of this explanation for the latter. In active addiction, large amounts of time are spent trying to avoid being caught out, trying to sneak an extra one while no-one is watching, concocting excuses for being late or missing deadlines, leaving early, hiding bottles or ampoules, etc. Adverse consequences include mental problems, car accidents and drink-driving offences. Denial refers to a ‘protective mechanism’ that prevents the individual seeing objectively exactly how bad things have become, and the resulting reassurance this gives of not being seriously addicted. It can be quite prolonged, even with our medical knowledge. Similarly, ones colleagues may also be in denial of the situation, as it can be embarrassing, time consuming and a generally uncomfortable situation to deal with. Some signs of addiction at work [2]:

• Personality changes (most common)
• Loss of efficiency and reliability
• Increased sick time and other time away from work
• Patient and staff complaints about a doctor’s changing attitude/behaviour
• Indecision late for appointments
• Moodiness, anxiety, depression
• Increasing personal and professional isolation
• Physical changes – weight loss (and lack of makeup, etc. in women where previously very smart)
• Unexpected presence in hospital when off-duty (if obtains drugs from the workplace)
• Uncharacteristically poor handwriting (alcohol withdrawal tremor)
• Unexpected presence in hospital when off-duty (if obtains drugs from the workplace)
• Heavy ‘wastage’ of drugs
• Inappropriate prescription of large narcotic doses
• Insistence on personal administration of parenteral opioids to patients in pain despite high doses of opioids charted as given
• Long sleeves when inappropriate
• Frequent toilet breaks
• Alcohol on the breath
• Facial bruising (loss of consciousness at office desk particularly with propofol

Outside work

• Deterioration of marriage
• Financial difficulties
• Drink-driving conviction

Widely believed misconceptions are that to be diagnosed as alcoholic requires drinking every day, including first thing in the morning – no! Binge drinkers exhibit just as much loss of control as daily drinkers in that once they have one or two drinks, they are unable to stop, and will continue for a whole ‘session’. This happens usually on a daily basis until the end of the binge, which may last a few days or a few weeks. The same compulsion to continue despite negative consequences occurs, just that there may be a few weeks or more between binges.

Anaesthetists and opioids

Our specialty is over represented in treatment centres and we have the highest incidence of intravenous opioid dependence. Fentanyl is most commonly used, and severe dependence can occur after only 6 months of use. It is most common in the under 40s age group, particularly in trainees. It is because of this rapid decline with opioid, that inpatient treatment is required. Dr B is working 29 hours in week 1, and 36 hours in week 2, average 32.5 hours per week. This job plan is rated at 8 PAs for week 1, 9.5 PAs for week 2, and should be rounded up to a job plan paid as 9 PAs.

Annual leave

Dr B is entitled to 6 weeks annual leave per year. If the department uses a weekly system: he can take 6 weeks off, 3 being week 1, and 3 week 2. If the department uses a daily system: he can be off for 6 Mondays, 3 Tuesday nights, 6 Thursdays, 6 Fridays, and 3 Saturday mornings.

Public holidays

Dr B is entitled to 10 days per year, pro-rata, making 9 days in total. In the year in question, there were 5 days that fell on a Monday, 2 on a Tuesday, and 3 on a Friday. If Dr B simply took them as they happened to fall, it turns out that he would be off for 1 Tuesday night and 3 Fridays. He needs to discuss with his Clinical Lead how to achieve his full entitlement ensuring an even spread of day and night shifts.

Prospective cover

SAS doctors, whether full or part-time, have no contractual obligation to provide prospective cover for colleagues’ leave. However, it is considered sound professional practice to do so, with the PA allowance being adjusted. Further information on how to calculate this can be found on the BMA website at: http://www.bma.org.uk/sc/employmentandcontracts/working_arrangements/work_patterns/oncallbas.pdf

Dr Christine Robison
AAGBI SAS Committee Member

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Access to potent opioids is often cited as a cause for this addiction – this is true, but it usually only occurs in those who are ‘destined’ to become an addict, and the availability of opioids decides the drug of choice. Management and monitoring have recently improved, and some opioid-addicted anaesthetists have returned to work.

Alcohol, however, usually takes many years for physical dependence to develop, and is more common in the over 40s age group. It can sometimes be managed without coming to the notice of regulatory bodies. It is becoming more common for questions to be asked about what to do if you suspect a colleague has a problem with substance abuse.

The new AAGBI Drug and Alcohol Abuse guideline describes this in detail, the major concern being patient safety. It should be discussed with the Clinical Director (CD) or equivalent, with dates and times and what you have noticed. An intervention will then be arranged with evidence to hand, attended by the doctor in question, with occupational health (OH) and psychiatrists, etc. It will have to be built into a return to work programme. It is becoming more common for questions to be asked about a history of substance abuse. These should be answered honestly, as failure to do so could result in a probe issue and GMC involvement. It is important however to appreciate that an addict is not a bad person as such, but a sick one who deserves treating as does any patient with a chronic illness.

Sources of information and support are listed in the Drug and Alcohol Abuse guideline.

References:

It is not very helpful to report the doctor to the police for this theft. This causes more stress and complicates the proceedings unnecessarily. These doctors are basically honest people who only take these drugs as a consequence of their addiction. Usually opioid addiction results in GMC Fitness to Practise hearings and a term of 18 months suspension. Return to work involves prescribing restrictions, regular psychiatric appointments and hair or urine testing.

The GMC is aware that some doctors may seek help before it becomes obvious at work, and take those drugs as a consequence of their addiction. Usually opioid addiction results in GMC Fitness to Practise hearings and a term of 18 months suspension. Return to work involves prescribing restrictions, regular psychiatric appointments and hair or urine testing.

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Sick leave and return to work
Sick leave can be for many reasons, - physical, mental, planned or unplanned. For the purpose of this document, sick leave of over three months is discussed.

Some dos & don’ts
• You must be registered with a General Practitioner
• Keep in touch on a regular basis with your CD or other managers try to make the appointment soon after rather than just before an OH visit, allowing time for ensuing correspondence to be sent to your GP
• Don’t self-medicate
• Keep a copy of your sick notes when submitted

You are entitled to leave your home city to visit relatives, friends, etc. but do ensure managers are notified if for more than few days, to avoid missed emails or appointments. Bereavement leave is usually one week, but most HR departments’ absence policies will allow a further period under the heading of carer or special leave. More than this can be taken as short notice annual leave sometimes. It is possible to obtain some degree of financial compensation from your employer, if an injury is sustained at work, or as a consequence of your daily work, e.g. back trouble. If you should end up on half pay consequent on such an injury, this Temporary Injury Allowance will make up to 80% of what you normally receive, rather than 50%.

If you are attending the hospital for a review with your CD or other managers try to make the appointment soon after rather than just before an OH visit, allowing time for ensuing correspondence to be sent to your GP.

Injury Allowance will make pay up to 80% of what you normally receive, rather than 50%.

Regular contact is vital and provides several things: 1. General progress reports – it is however necessary for everyone else in the department to know all the details. Do not rely solely on email as the method of contact – phone calls are important. Ask your CD when is a good time to ring, as productive conversations are not best conducted in the middle of a busy list 2. Regular review – correspondence from OH and any other specialists, e.g. surgeons, psychiatrists consulted during the absence can be integrated and discussed with the CD and any other line manager involved 3. A plan for return can be discussed – this frequently involves working alongside another senior anaesthetist for a week or so, and so a plan is needed at least two weeks in advance. Any interpersonal difficulties can be avoided by not being rostered to do lists with certain colleagues 4. A link with work, which helps avoid feeling estranged from work 5. Any GMC restrictions or conditions on employment can be accommodated and integrated into the return to work plan

6. Importantly, any possible changes in pattern of work on return can be planned well ahead 7. If the workplace and its stresses are a significant...
factor in your illness, this can be discussed in order to minimise recurrent illness

8. Continuing reviews after return should allow for any new difficulties to be discussed; feeling that another week is needed before returning to solo practice, or perhaps feeling more tired than expected are issues that should be raised at the time – it is difficult to take more time off, once back in the workplace.

Things to do before return:

1. Ask for your home email address to be included in departmental communications and practise getting up early for at least a week before

2. If you have a local simulation centre, investigate the possibility of attending a course as an observer, by way of an introduction to the theatre atmosphere again

3. Annual leave: a prolonged period away from work may result in accumulation of annual leave. Sick leave of more than six months will result in half pay, but taking annual leave after being signed off sick leave and before return to work is at full pay rates. This may be regarded in a negative way by some colleagues, but two weeks holiday and rest are very different to being on sick leave. Return to work

A date for return to work should be reached after discussion with occupational health, your CD and rota

A date for return to work should be reached after discussion with occupational health, your CD and rota

1. Get to bed early

2. Don’t be surprised that it is a bit of a culture shock – it is

3. Don’t worry if for a while, all you do is get up, go to work and get a good night’s sleep

4. Don’t feel obliged to organise or take on new ventures – it is easy to feel a bit guilty after a while away and tempting to make up for it by volunteering for new things. Your personal welfare must come first at this stage

5. Try to be positive and appropriately enthusiastic, but don’t do things because you feel you ought to

6. Discuss the possibility of doing certain lists to learn things you’ve wanted to learn before – you may not get another chance to be free to do it!

7. Make sure that any out-patient and other follow-up appointments are allowed for in your initial work plan

Following depressive illnesses, night time medication may cause some drowsiness and it is important that you are stable on these treatments, and it may require postponement commencement of on-call duties.

Dr Ruth Mayall
AAGBI Welfare Committee Member

11. CLINICAL GOVERNANCE

Clinical governance may be the two most over-used words in the NHS, either as an excuse not to do something, or a justification for change (usually spending money) but rarely with an understanding of its provenance. Once described as ‘corporate responsibility for clinical performance’, its incorporation into the fabric of daily work followed a number of incidents, exemplified by the public inquiry into paediatric cardiac surgery in Bristol. Clinical governance is the overarching framework that ensures that patients receive the highest possible quality of care. It covers how the healthcare professional treats patients; the level of information provided to patients; their involvement in decision making; the provision of up to date and well supervised services and the reporting, learning and thus prevention of errors and accidents.

It is a framework through which NHS organisations are systematically accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Every doctor working in the UK is required to comply with clinical governance, both as part of their contract of employment (in the NHS) and as part of their licence to practise from the GMC. It is there for the benefit of everyone: staff, patients and the organisation. It aims to deliver the highest quality of patient care that is possible by identifying and redressing failures in the system whatever their cause. Clinical governance may be broken down into separate, overlapping elements:

Clinical effectiveness

These include clinical guidelines for specific conditions and national service frameworks, published by NICE, QIS (Quality Improvement Scotland), Royal Colleges, or organisations such as the AAGBI.

Clinical audit

The NHS Executive defines clinical audit as ‘the systematic critical analysis of the quality of healthcare, including the procedures used in diagnosis, treatment and care, the use of resources and the resulting outcome and quality of life for patients. It embraces the work of all healthcare professionals’. Although complaints can identify failures, they are essentially a negative way of trying to improve matters. Clinical audit, on the other hand encourages individuals to look critically at one’s own practice and identify areas where improvements can be made. It is a cyclical process in which standards are agreed and data collected. Analysis of the data shows if the standards are not 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. This process can be repeated several times as necessary. Audit projects are now an essential part of appraisal for non-trainees, and the training requirements for trainees. All too often audits fail at the last hurdle – a recommendation for implementation of change, and a re-assessment of that change’s effectiveness.

Research

Research and audit are quite different, although they are frequently confused, particularly in submitted abstracts. Audit compares performance with an established standard (is what I’m doing as good as everyone else?), whilst research resolves an unanswered question (what should everyone be doing?).

The SAS Handbook
Research increases overall knowledge and seeks to discover best practice. Audit reviews current practice to achieve best practice. This is a process of ‘lifelong learning’ applicable to all individuals and teams aiming to meet the needs of patients and deliver the health outcomes and healthcare accessible to patients and their families and be fair to patients either through malice or incompetence of clinicians, and that systems exist to detect and limit any harm that may be occurring.

Professional regulation
These include pre-employment checks of registration details, qualifications, Criminal Records Bureau, as well as newer regulations related to children and vulnerable adults. Any registered medical practitioner is also responsible to the GMC for ongoing fitness to practise. These include pre-employment checks of registration details, qualifications, Criminal Records Bureau, as well as newer regulations related to children and vulnerable adults. Any registered medical practitioner is also responsible to the GMC for ongoing fitness to practise.

Risk management
This is a process that ensures that no harm comes to patients either through malice or incompetence of clinicians, and that systems exist to detect and limit any harm that may be occurring.

Incident reporting
Organisations and individuals learn from their own experiences and others’. Any healthcare organisation must have processes in place to learn from crucial incidents, where actual or potential harm has ensued. Local incident reporting systems vary in their effectiveness. Since 2009 there has been a national, specially created reporting system for anaesthesia in England and Wales (the SAPSA). At the time of writing this does not include Scotland, Northern Ireland or Eire. In Scotland, SASM (Scottish Audit of Surgical Mortality) collects data that included anaesthetic considerations.

Patient safety incident reporting is a crucial part of this process and incident reporting is an excellent way of learning about risks. Complaints procedures must be accessible to patients and their families and be fair to patients either through malice or incompetence of clinicians, and that systems exist to detect and limit any harm that may be occurring.

Legal background
In the UK, although the numbers are still very small, over the past few years increasing numbers of doctors have been charged with criminal charges including gross negligence or manslaughter as a consequence of fatal medical errors. The level of proof required to succeed with a criminal charge is ‘beyond reasonable doubt’ (~>95% likelihood).

Most litigation against doctors, however, involves civil as opposed to criminal charges, where the level is ‘on the balance of probabilities’ (~50% chance). The subsection of civil law most commonly invoked is the law of tort (civil wrongdoing) and specifically the claim of clinical negligence.

The legal criteria for clinical negligence are:

1. The existence of a duty of care. This is rarely documented but inferred from the doctor-patient relationship. If the patient consents to treatment the clinician owes that patient a duty of care
2. There must be a breach of that duty of care. In order to establish this, the standard of care expected must be defined. In legal terms the practitioner must act in accordance with the opinion of a reasonable body of medical practitioners (known as the Bolam test). More recently, the courts have demanded that the opinion must be ‘reasonable’, i.e. capable of withstanding logical analysis. The standard of care will also partly depend on the experience and qualifications of the practitioner. If an anaesthetist is a qualified ALS provider, then they will be expected to undertake adult advanced life support competently. Guidelines and protocols are useful indicators of currently accepted practice. As such, knowledge, particularly of local guidelines, is essential. Ignorance is not a legal defence. If the anaesthetist plans to deviate from such guidelines he/she must have and document a reason for this.

3. There must be foreseeable injury arising from the breach of duty of care. Most cases fall on the basis of caudation. Negligent practice may have occurred but frequently there is insufficient evidence to link the injury claimed to that negligence.

Common themes in litigation against anaesthetists
This has been recently comprehensively reviewed in an analysis of claims against the NHS in England taken from the NHS Litigation Authority databases. Anaesthesia as a specialty made up only 2.5% of claims of which nearly half involved regional anaesthesia and close to 1/3 in obstetric patients. Table 2 lists the specific events involved.

The preponderance of obstetric cases and those involving regional techniques reflect a growing area of litigation – that involving the issue of consent and specifically of informed consent. Even in expert hands, complications occur, and it is vital that the patient is made aware of these and if alternative techniques are available.

Until recently, the patient had to persuade the court that if they had known of the complication that occurred they would not have undergone the procedure. However, in a more recent ruling (Chester versus Afshar), the successful claimant admitted that she would have undergone the procedure, even if she had been informed of the complication that arose. The ‘injury’ that arose from the surgeon negligently failing to warn her of this was that she was denied her right to make an informed decision on the matter.

12. MEDICOLEGAL PITFALLS IN ANAESTHESIA AND HOW TO AVOID THEM

In practical terms anaesthetists may become embroiled with the law in a number of ways:

They may be subject to civil law or more rarely criminal law proceedings. They may be required to attend Coroner’s Courts, Fatal Accident Enquiries, or GMC hearings. Although the vast majority of cases either abandoned by the claimant or settled out of court, [see Table 1], the cost – financial, in terms of time and emotional – is such that it is far better to avoid such situations altogether.

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Not just common complications but rare but serious ones should be mentioned. For example the parturient professional can give rise to injury. Again obstetrics provides an example: the section for fetal compromise was not performed even though it was indicated. Proponents of claims. Meticulous checking of procedures undertaken should be self evident.

Poor communication with the patient and between professionals is a recurring theme. In cases where pain during surgery is claimed, the anaesthetist may have decided that the patient was experiencing anxiety instead. This is hard to defend especially if there are mandatory. Injuries to teeth and eyes, due to positioning or due to invasive procedures, are also common causes of claims. Meticulous attention to detail and ensuring competency in procedures undertaken should be self evident.

The use of faulty equipment and faulty use of equipment are common themes. Meticulous checking of equipment (using guidelines where they exist) and familiarising oneself with equipment one is unfamiliar with are mandatory. Injuries to teeth and eyes, due to positioning or due to invasive procedures, are also common causes of claims. Meticulous attention to detail and ensuring competency in procedures undertaken should be self evident.

Avoiding medicolegal outcomes

1. Practise within your limits of competence and expertise
2. Adhere to guidelines and protocols unless there are good clinical reasons not to (and preferably after consultation with a colleague)
3. Listen carefully to the patient and communicate clearly with other health care professionals
4. Be a team player (you are more likely to get support if things go wrong)
5. Ensure your knowledge and practice are up to date
6. Be meticulous checking equipment, drugs and the patient

It is unfortunately not enough to be a good, conscientious and caring clinician.

It is essential there is documentary evidence of this. In the medicolegal context it is not written down it did not happen. Time and again clinicians let themselves down through poor note keeping. This is particularly so with documentation of discussions and risks.

Patients remember very little of what they are told. Doctors to date are not very good at recording discussions with patients. In the words of an eminent legal expert ‘for some reason they (doctors) do not realise … that although their skills are for the patients, their notes are for themselves’. Although ‘defensive’ medicine is to be deplored, defensive documentation is just good sense.

Table 1: Outcome of clinical claims received by the NHSLa in the past 10 years (01/04/97 – 31/03/08)

<table>
<thead>
<tr>
<th>Category</th>
<th>Main clinical event</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Obstetric anaesthesia</td>
<td>Inadequate regional anaesthesia during caesarean section/inadequate general anaesthesia during caesarean section</td>
</tr>
<tr>
<td>Inadequate anaesthesia</td>
<td>Inadequate general anaesthesia/inadequate central neuroaxial block/breath paralysis due to drug order errors/obstetrics</td>
</tr>
<tr>
<td>Airway</td>
<td>Tracheal tube/soft tissue injury/aspiration/hypoxia</td>
</tr>
<tr>
<td>Other respirator</td>
<td>Hypoxia/pneumothorax/equipment problems</td>
</tr>
<tr>
<td>Central venous cannulation</td>
<td>Vascular injury/carotid puncture/wire</td>
</tr>
<tr>
<td>Drug related excluding allergy</td>
<td>Drug switches/overdose/muscle relaxant</td>
</tr>
<tr>
<td>Drug allergy related</td>
<td>Administration of known allergen</td>
</tr>
<tr>
<td>Positioning</td>
<td>Nerve injury while insensate during general and regional anaesthesia</td>
</tr>
</tbody>
</table>

Table 2: Common clinical events associated with medical negligence claims

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Reference:

Recommended reading:

Dr Felicity Plaat
AAGBI Council Member
Handling complaints

“He who avoids complaint invites happiness”
Abu Bakar

“He who avoids complaint obviously doesn’t work in the NHS”

William Harrop-Griffiths

The public expect a high standard of service from the NHS in general and from the doctors who work in the NHS in particular. Most of the time, patients are more than satisfied by the care they are given. However, patients and their relatives sometimes feel they have cause to complain. Complaints are not simply an expression of dissatisfaction; inherent in the act of complaining is a wish to receive a satisfactory response to the complaint. Complaints take many forms. They can be informal or formal; they can be verbal, written or – increasingly – submitted via a portion of a website devoted to complaints. Complaints can come directly from patients or their relatives or can be submitted via the hospital’s complaints system or organisations such as Patient Advice and Liaison Service (PALS) or Independent Complaints Advocacy Service (ICAS).

The NHS Constitution enshrines a patient’s right to complain. Specifically, it says that a patient has the right to:

• Have a complaint dealt with efficiently, and properly investigated
• Know the outcome of any investigation into the complaint
• Take the complaint to the independent Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied with the way the NHS has dealt with the complaint
• Make a claim for judicial review if they think they have been directly affected by an unlawful act or decision by an NHS body
• Receive compensation if they have been harmed

All hospitals should have a formal, written complaints policy accessible via its intranet or from the Chief Executive Officer’s (CEO) office. I would advise anyone involved in clinical care to know the contents of this particular policy in detail. Most policies demand that written complaints submitted to the CEO are acknowledged within 48 hours and referred to properly within 25 days. Even if you are not the direct subject of a complaint, you may therefore be involved in writing reports relative to complaints that will come with notes from hospital Complaints Officers (or people with similar titles) demanding an almost immediate response. Be nice to them, as they are there under pressure while grappling with hospital bureaucracy and trying to translate medical gobbledygook into something comprehensible to members of the lay public within a short timeframe.

So much for the formalities of the complaints process. The substantial majority of complaints are dealt with informally, and only a few get to the stage at which they become written complaints. Indeed, most complaints should be dealt with when they are at the stage of being both informal and verbal: you should be prepared to listen and respond to comments or questions that may become complaints if they are not answered promptly and honestly.

If a patient or their relative communicates a complaint to you, it is reasonable to ask them whether they would like the opportunity to talk through the complaint. If the patient’s complaint is of a serious nature or if you think it may become complaints if they are not answered properly and within a timely fashion, then you should refer the matter to your clinical manager or the hospital’s Complaints officer, and you should make clear to the patient that you are doing so, explaining to them that you are doing so to make sure that their complaints are responded to as quickly as possible afterwards and you should keep these notes in case they are needed at a later stage.

Occasionally, you will think that complaints are vexatious, unfair or simply made to earn the complainant some form of financial reward. I would advise you to strike these thoughts from your mind at the early stages of a complaint. Complaints can be seen as very real to the patient, and if you start to think that a complaint is vexatious, you may not give it the consideration it deserves.

The basic principles that apply to responding to a verbal complaint hold true when composing a written response. Make every effort to understand and define the nature of the complaint and respond as sympathetically as possible, be scrupulously honest about any failings or mistakes. Write your report clearly and succinctly and, if mistakes were made, try to identify what happened; they may well be angry or distressed. Remember, most patients who complain want simply to be acknowledged that their complaints are responded to appropriately.

Offer the complainant the opportunity to bring someone into the meeting with them. Handling complaints in this setting involves a lot more listening than talking. Let the complainant describe the problem and allow them to express their feelings about what happened; they may well be angry or distressed.

Your response should be open and understanding; any aggression on your part will escalate problems, so be patient and let them speak fairly. If you need more details about what happened, ask simple, open questions to ascertain the exact nature of the complaint. Once you think you understand the situation of the complainant, repeat it to them and ask if you have got it right. Although it will often be difficult, you must appear calm, unhurried and sympathetic. People often complain about a myriad of problems, but it is worthwhile asking them to focus on the most important of these. If you can resolve issues related to one or two items of complaint, the rest of the minor problems often resolve themselves.

It is difficult to say “sorry” but it is sometimes appropriate. Saying “sorry” is not always synonymous with taking the blame. You can easily say: “I am sorry that this happened and that you are upset as a result”. This expresses sympathy without accepting blame. However, it is sometimes perfectly reasonable to accept the blame if it is your fault. Apologise, explain what happened and why it happened, and tell them what you will do to stop it happening again. A friend recalls saying to a bitterly complaining patient: “I am really sorry. We have been complete rubbish this afternoon and you are quite entitled to be absolutely furious at the inconvenience to which we have put you”. This statement defused the whole issue and was met with both a laugh and the end of the complaint. I was no way suggesting that this is the way to treat every complaint, but I would strongly encourage an attitude of openness and honesty that this response typifies.

At the end of such a meeting, there are two main outcomes: either the separation will be accepted by the complainant and, if appropriate, apologies, this may be the end of the process. However, you should offer to talk to them again if they wish to. If the patient is not satisfied at the end of the meeting, you should refer the matter to your clinical manager or the hospital’s Complaints Officer, and you should make clear to the patient that you are doing so, explaining to them that you are doing so to make sure that their complaints are responded to as quickly as possible afterwards and you should keep these notes in case they are needed at a later stage.

First of all, let me start with an ‘Alcoholics Anonymous’ style confession. Hello, my name is William and I have been in trouble.

The story begins with a patient who was accused of gross professional misconduct. I was once responsible for the separation of four upper incisor teeth from their lawyer owner. I once made up some flaxlocloxicillin with 10 ml of pancuronium (rather than water) and gave it to a patient five minutes before the end of an operation. I was once handed up in front of the CEO of the hospital in which I was working and was accused of gross professional misconduct.
Although I am currently out of work, I am not careless, a bad doctor or anything out of the ordinary. Take anyone who has been giving anaesthetics for more than 25 years and ask them whether they have been there. They will tell you that they have been there. They will also readily tell you that if they had the time over again, they would rather not have done it. Nothing I can tell you will stop you making mistakes, but if you read the tips that follow, you may stand a better chance of avoiding trouble.

Look after your patient by looking after yourself

Although you relatively recent novice in the motorcycling fraternity, I have already learned some of its mantras. One of my favourite is: don’t ride drunk, don’t ride tired, don’t ride sick, and don’t ride upset. The principle is that riding a motorcycle 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, for whatever reason, 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.

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, time 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 GMC’s website and in particular the guidelines of the Fellowship to Practise, will show you that many of doctors who go off the rails ignore these trite recommendations. Your health and sanity are 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.

Don’t get out of your depth

No anaesthetist can do everything and no anaesthetist can be expected to be able to do everything. There will be times in the professional career of every anaesthetist, whether they are a consultant, a locum or a trainee, that their skills, knowledge and experience will not be sufficient to provide a patient with the best care available. When this happens to you, seek help from others. Practise within the boundaries of your abilities and when you think that you may be getting out of your depth, be honest about it. Both you and your patients will benefit as a result.

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 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 understandably see this as you being evasive and defensive. Go and see the patient and their relatives and explain the situation honestly. Then apologise for what happened if this is appropriate. This is not an admission of negligence, and your honesty and openness will often set 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 make every effort to avoid mistakes, but do not be too hard on yourself if you do make a mistake under difficult circumstances. Similarly, be understanding of others who make honest mistakes.

Don’t get goaded

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 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 doesn’t always have to be more experienced than you. I have often had difficulty persuaded by a line in and have asked a trainee to help me who watched the trainee put it in at their first attempt. This is good for the trainee and good for the patient and, after a while, it is likely to become 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 louzy practitioner, of course, then it can damage 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 for all eternity, better, than you were.

Communicate

Both from 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 alternatives are. This will 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 guideline Consent for Anaesthesia [2006]), but it is an important consideration. The best demonstration of what has been discussed: patients have notoriously terrible memories about what they’ve been told and, if a recognised complication occurs, you’ll want to be able to demonstrate that you warned them about it in advance. In the absence of a contemporaneous note from you, the courts will tend to believe the patient, and not you.

Follow guidelines

You may think you know best – and, to be fair, sometimes you do – but a lot of experts went to a lot of trouble to draw up those guidelines, and it’s their support that you want and need when things go wrong. They are more likely to smile favourably on you if you weren’t following some maverick path of your own at the time. Of course, you are a professional, and of course guidelines can’t deal with every situation, but if you are going to deviate, make sure that (a) it’s for a good reason and (b) you make a good note of why you did it.

Keep up to date

Doctors often fall foul of the GMC at two times in their career: when they are starting out and when they are not far from retirement. The latter group often fails to keep up to date with changes in medical practice. Anaesthetists are particularly prone to this problem, as the anaesthetic technique you perfect shortly after training seems to work well for all your patients thereafter. However, if you practise anaesthesia that is 20 years out of date, you may not be providing the best care for your patients. Go to meetings, watch others give anaesthetics, read the journals and keep up to date.

Be nice

No anaesthetist is an island. We can only work well if we work well with others. No one should be responsible for their patients alone; the team of anaesthetists, the Oxford anaesthetist is arguably best placed to act as the hub for sharing and disseminating information. It’s a noble and important role, and fill it with distinction.

Like

It is a fact of life that the nice doctor who makes an error is far more likely to come out of it smelling of roses than the nasty doctor. You are bound to need the help and
support of your colleagues at times, and they won’t rush to help you if you’ve alienated them. The same applies to patients, who seem to be far more forgiving if they like you.

I am sure that there is much more advice that you would give others if you were asked. However, I will leave you with one more line of advice that is worth heeding if you wish to stay out of trouble: treat others as you would want to be treated yourself – and this holds true for both your patients and those with whom you work. Dr William Harrop-Griffiths AAGBI Vice President

14. DIGNITY AND RESPECT IN THE WORKPLACE

A survey in 2001 indicated that 37% of doctors reported being bullied at least once in the previous year and that this was more likely to affect black and Asian doctors. Bullying emerges when one or several persons, persistently, over a period of time, perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the one at the receiving end has difficulties in defending himself against these actions.

Examples of bullying behaviour include derogatory remarks, insensitive jokes or pranks, insulting or aggressive behaviour, ignoring or excluding an individual, setting unrealistic deadlines, public criticism or constantly undervaluing effort.

Bullying and harassment at work are not acceptable legally, morally or ethically.

Employers should have mechanisms to help employees deal with complaints about this issue, which is being widely discussed. Previous beliefs that a career would be affected if concerns were raised are diminishing as the medical profession and society recognise that certain behaviours are no longer acceptable.

All employees should be able to work in a safe environment and there is legislation both UK (sex, gender, race and disability discrimination, protection from harassment, health and safety) and European (equal treatment directive, protection of dignity at work) which confer certain rights to all. It should also be remembered that if the bully is a doctor they are not complying with the requirements of Good Medical Practice and could be reported to the GMC.

Employers should have a policy which defines how the issue of bullying is dealt with in your workplace and this will be available from the Human Resources (HR) department and website.

An important first step in dealing with this situation is to recognise that it is happening and to be willing to share your thoughts and feelings with another person, either a trusted colleague or your partner. The clinical tutor in the postgraduate centre is also a useful impartial listener.

Your line manager (the CD) should be informed whenever possible. The College Tutor is also an impartial source of help and support.

The HR department can provide advice if you are being bullied and can refer you to OH and counselling services. Some employers have established a confidential service to advise staff who feel bullied and harassed.

If there is no-one locally you feel able to talk to then the postgraduate deanery or the BMA will be able to help. Talking about what happened is never easy but is the first step in taking control of the situation.

It is advisable to write down what happened, where and when, who was present, what was said and how you felt. Try to get witnesses to incidents by avoiding situations where you are alone with the bully. If you feel bullied and harassed it has usually happened more than once, is there a pattern?

It may also be helpful to reflect on your own behaviour and feelings. Those who are feeling low and depressed or who are dealing with loss or personal stress will have more negative thoughts and feel less assertive. If you are seen as passive by others, the development of assertiveness skills can help you feel more comfortable when dealing with this situation and courses are widely available, as are self-help books and websites.

Most recipients just want the bullying to stop and do not wish to formalise their complaints or resort to the legal system. Informal resolution should be attempted whenever possible but the situation may be so serious that the employer has to take action.

Do not take action alone and seek support from your employer's HR department. Informal resolution is possible if you feel able to discuss your feelings with the other person and there is the possibility of resolving the problem. This will bring long term benefits for other potential victims and help you regain your self-respect; however, this may be a difficult decision to make. The person concerned may feel they are acting quite reasonably and be completely unaware of the effect of their behaviour and actions on you and others.

Those who do not feel able to confront the bully should discuss how they wish to proceed with an impartial supporter. It is always helpful to have an impartial supporter with you so that you feel in control of what happens next. You may wish to take a more formal route to resolving the situation and all employers will have a reporting system which you can use. If this seems like the correct way to resolve the situation you should use it.

There is good and structured advice available from numerous sources on how to deal with bullying and harassment and most employers will operate a zero tolerance policy. Whatever the outcome, it is important for those who feel bullied to realise that they are not powerless and have choices in dealing with the situation.

Dr Melanie Jones Past Chair of Anaesthetists in Management (AIM)

The survey suggests that the main problems concerning those who responded are:

1. OOH work
2. Aged doctors and residency on-call
3. Minimum elective or daytime work (anaesthetic sessions)
4. CPD activity [covered elsewhere in this handbook]
5. Career progression opportunities and criteria for pay thresholds
6. Clinical governance and supervision [covered elsewhere in this handbook]
7. Health and welfare [covered elsewhere in this handbook]

Dr William Harrop-Griffiths AAGBI Vice President

15. GOOD PRACTICE GUIDANCE FOR SAS ANAESTHETISTS

The SAS Committee of the AAGBI, in association with the RCoA Career Grade Committee, conducted a survey in 2010 of SAS doctors working as anaesthetists. Several of the doctors responding to the survey expressed concerns about aspects of their job plans and terms and conditions. The AAGBI formed a working group to discuss these concerns and to issue guidelines on some aspects of terms and conditions of work for SAS doctors. The main purpose of this group was to consider the minimum criteria and conditions that should apply to conform to the basic requirements of the contract based on good evidence, health considerations and the need for CPD. Although the group can offer its opinions and some advice, the details of any contract are for the employer and the employee to agree.

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Dr Melanie Jones Past Chair of Anaesthetists in Management (AIM)

SAS work

Working outside ‘normal’ hours is an accepted part of the role of doctors. In addition to providing the service required by the hospital, it offers doctors ongoing clinical exposure to emergency cases, thereby maintaining

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key anaesthetic skills. Several SAS doctors have been offered job plans that place more than 50% - and up to 75% - of their scheduled clinical work in what would be termed premium time in the 2003 consultant contract, i.e. OOH. Very often this work involves busy and clinically demanding duties such as covering ICUs, obstetric units and general on-call activity. This is more likely to be the case in smaller hospitals. The working group was concerned that such working patterns may cause problems in terms of fatigue and thereby clinical governance, might give anaesthetists less opportunity to observe the practice of colleagues, and are not conducive to a good work-life balance. The working group suggests that the balance between works scheduled in weekday hours and that scheduled OOH should be similar for SAS doctors and consultants in the same department, and that the proportion of OOH work for any SAS anaesthetist should not, as a rule, exceed 50%.

On-call
At some point during their careers, many anaesthetists seek to relinquish their on-call duties for a variety of reasons that include illness, increasing age, and family or other domestic and professional commitments, although if ‘on-call’ is part of the contract, there is no right to drop it. If an SAS doctor wishes to drop their on-call duties, they should discuss this with their clinical director. If the reason relates to stress or illness, assessment by the OH should be a minimum of three fixed sessions in the average full-time job plan.

Criteria for pay thresholds
There is such a variety of work and roles that anaesthetists play that it is difficult to determine criteria for thresholds. The basic principle is the ability to take independent decisions and cover for some of consultants’ work without supervision. The following webpage deals with this issue: http://www.rhmemployers.org/payandcontracts/medicalanddentalcontracts/StaffAndAssociateSpecialists/ContractDetails/Pages/ContractDetails.aspx

Progression through Threshold Two
The criteria for progressing through Threshold Two requires the higher level of skills, experience and responsibility of those doctors working at that level. Doctors will pass through Threshold Two if they have met the criteria at a) b) and c) as set out below:

a) Doctors should meet the Threshold One criteria set out in paragraph 6 above;

b) Doctors should be able to demonstrate an increasing ability to take decisions and carry responsibility without direct supervision; and

c) Doctors should also provide evidence to demonstrate their contributions to a wider role that a doctor could provide.

Progression through Threshold One
All doctors will pass through this threshold unless they have demonstrably failed to comply with any of the following criteria:

• participated in job planning
• made every reasonable effort to meet the time and service commitments in their job plan and participated in the annual job plan review
• met the personal objectives in the job plan, or where this is not achieved for reasons beyond the

doctors control, made every reasonable effort to do so and
• worked towards any changes identified in the last job plan review as being necessary to support achievement of joint objectives

• participated satisfactorily in the appraisal process in accordance with the GMC’s requirements set out in Good Medical Practice

• undertaken 360 degree appraisal/feedback (in the year preceding threshold one) and

• for those doctors undertaking private practice, taken up any offer to undertake Additional Programmed Activities in accordance with Schedule 7 of the Terms and Conditions of Service and met the standards governing the relationship between private practice and NHS commitments set out in Schedule 10 of the Terms and Conditions of Service.

Career progress and development

The SAS survey clearly indicated the SAS doctors felt that there are limited or no opportunities to obtain career progress. The RCoA recommends that all the departments employing SAS doctors contribute to consultant Educational Supervisor (ES) responsible for overseeing the career development. As it is recommended that such career development be based on attainment of competencies identified in the curriculum document, the ES should link with the College Tutor. There is a move towards appointing SAS Tutors in the hospitals and appointment of Associate Deans in the deaneries who will oversee the career development needs of the SAS doctors.

• Innovation

• Audit

This list referred to above is not exhaustive but is intended to give an indication of the types of evidence of contributing to a wider role that a doctor could provide.

In making a judgment about whether a doctor has met the requirements for Threshold Two, there will not be an expectation that the doctor has attempted to provide evidence in all wider areas of contribution listed in addition to those required for Threshold One. An overall picture will be considered.

Threshold One and Two – process
When a doctor has successfully demonstrated that they have complied with the criteria to pass through a threshold, this should be signed off by a Clinical Manager. The Clinical/medical/medical Director will have the responsibility of ensuring processes are in place to sign off the threshold assessment. It is expected that payments will be made automatically unless payroll are informed otherwise. [1]
An individual’s clinical skills and competencies will be expected to develop over time and this is essential to ensure a satisfying career. Several SAS doctors have very strong sub-specialty interests like obstetric anaesthesia, chronic pain and critical care, to mention a few. There are very limited opportunities to develop and nurture these skills.

Opportunities for top-up training must be available for SAS doctors to develop these specialty skills. Employers and post-graduate Deans will have to support such career development opportunities actively if they are to be realistic goals, the reason being a need to commit periods of time for top-up training, not service delivery. Employers should see this as an opportunity to develop the careers of some of their permanent ‘non-training’ staff to ensure long-term retention of its workforce. The AAGBI has a responsibility to support and advise its SAS members, but it is not a trade union. However, it is able to respond to most enquiries about terms and conditions of jobs and job plans. The AAGBI publication Staff and Associate Specialist Grades provides useful advice but is not a definitive document: it offers the opinion on some common contractual issues. SAS doctors who fail to reach agreement with their Clinical Managers on the details of contracts, job plans, working arrangements, terms and conditions should follow mediation and appeals processes within their hospitals and should consider seeking the support of their LNC. The AAGBI recommends that all the anaesthetists should be members of a trade union that can offer formal support in resolving disagreements about contractual matters.

The AAGBI recommends that SAS doctors only take up jobs that conform to national terms and conditions. This will make it easier to negotiate in case of any issues that may arise. Otherwise it will be entirely up to the individual doctor to resolve any issues concerning their contracts.

The overall principle is that of accountability and mutual respect for both parties. The profession accepted a time-sensitive contract, in which there is a simple and direct relationship between the time spent working and the payment for this work. All the allocations of time spent working should be discussed in the job-plan meetings.

Dr Ramana Alladi
AAGBI SAS Committee Chairman
Dr William Harrop-Griffiths
AAGBI Vice President
Dr Anthea Mowat
AAGBI SAS Committee Member
Dr Christine Robison
AAGBI SAS Committee Member
Dr Jonathan Alper
Associate Specialist in Anaesthetics, Musgrove Park Hospital

Reference:
16. CERTIFICATE OF ELIGIBILITY FOR SPECIALIST REGISTRATION

Introduction
To be a substantive consultant in the NHS in the UK, the individual must be on the GMC’s Specialist Register. This is the only legal requirement as defined in the respective devolved nation statutory instruments. This legislation does not stipulate how an individual enters the Specialist Registrar. For the majority, entry to the Specialist Registrar will be through the award of the Certificate of Completion of Training (CCT) in anaesthetics (including the former versions issued under the old UK training), the award of the Certificate of Eligibility of Specialist Registration (Combined Programmes) (CESR(CP)), the holder of a recognised European specialist qualification or the Certificate of Eligibility for Specialist Registration (CESR).

The CESR route is open to applicants who have not completed an anaesthetics training programme, completed a European programme which is not recognised by the European Union or have completed specialist training outside of the European Union. Those who apply under the CESR route must demonstrate equivalence to a newly graduated CCT holder. How is this done? Quite simply, by providing the GMC with evidence which demonstrates that the individual’s training and experience when considered together are the same as a newly graduated CCT holder. How is this done? Quite simply, by providing the GMC with evidence which demonstrates that the individual’s training and experience when considered together are the same as a newly graduated CCT holder. how is this done? Quite simply, by providing the GMC with evidence which demonstrates that the individual’s training and experience when considered together are the same as a newly graduated CCT holder.

Demonstrating equivalence
From the outset it needs to be highlighted that demonstrating equivalence is a paper exercise. The RCoA cannot visit you in the workplace and conduct a clinical assessment nor can your application be discussed with your colleagues. Good applications provide an abundance of good evidence for the assessors to review and usually amount to approximately 800 to 1000 pages. Good evidence can be characterised by its ability to provide a positive answer to the questions posed by the GMC when analogue the requirements of the CCT in anaesthetics 2010 curriculam. The GMC requires the application to be assessed against the four domains of Good Medical Practice (GMP). The four domains have sub-domains. These are:

GMP 1 Knowledge, skills and performance
A. Has the applicant demonstrated that they have the full range, depth and breadth of experience and skill to the level required?
B. Has the applicant demonstrated application of knowledge and experience to practise (e.g. recognising and working within the limits of their competence). In particular, keeping up to date with CPD, audit, clinical governance, applying the skills and attitudes of a competent teacher/trainer, and making appropriate referrals to colleagues and keeping clear and legible records?

GMP 2 Safety and quality
A. Has the applicant demonstrated putting into effect systems to protect patients and improve care, (e.g. taking part in and responding to the outcome of audit, appraisals, performance reviews, risk management and clinical governance procedures, and reporting adverse drug reactions or concerns about risks to patients)?
B. Has the applicant demonstrated that they monitor and respond to risks to safety and that they safeguard and promote the health and wellbeing of vulnerable people (e.g. responding to risks posed by patients and following infection control procedures)?
C. Has the applicant demonstrated that they protect patients and colleagues from any risk posed by their health?

GMP 3 Communication, partnership and teamwork
A. Has the applicant demonstrated that they communicate effectively with:-
   (i) Patients, (e.g. keeping them informed about progress of their care) and
   (ii) Colleagues, (e.g. physician colleagues, nursing staff, allied health professionals, GPs and other appropriate agencies) in both clinical and management situations within and outside the team (e.g. passing on information when patients transfer, encouraging colleagues to contribute to discussions)?
B. Has the applicant demonstrated that they work constructively with colleagues by supporting them, delegating effectively, acting as a positive role model and providing effective leadership?
C. Has the applicant demonstrated that they establish and maintain partnerships with patients and encourage them to take an interest in their health and obtain appropriate consent to treatment?

GMP 4 Maintaining trust
A. Has the applicant demonstrated that they show respect for patients (e.g. polite, considerate and honest with patients and implemented systems to protect patient confidentiality)?
B. Has the applicant demonstrated treating patients and colleagues fairly and without discrimination (e.g. being honest and objective when appraising or assessing the work of colleagues, giving constructive feedback, raising issues of colleagues performance and responding promptly to complaints)?
C. Has the applicant demonstrated acting with honesty and integrity (e.g. is honest and accurate in any financial dealings, practice reports, obtaining appropriate ethical approval for research projects, etc.)?

When compiling evidence for an application, the GMC recommends applicants apportion the evidence provided for the domains according to the pie chart below.

Types of evidence
The GMC defines evidence as either primary or secondary. The important thing to consider with primary evidence is that it must stand on its own. An example of primary evidence is a logbook, case diary, logbook summary, appraisals, qualification certificates (e.g. a degree, curriculum validated by the Institution) and CPD certificates. In all cases, they must be validated, preferably by the institution where the evidence originated from. Secondary evidence covers the structured references, notas, notes for teaching, thank you cards, testimonials and other validated evidence.
When collating your evidence, you should aim to have more than one piece of evidence demonstrating equivalence for each domain. The evidence is triangulated to decide whether the applicant has passed or failed each sub-domain. For example, if the applicant did their specialist training in India, the applicant should provide a copy of the logbook, a copy of the training programme they undertook, evidence from the institution where they completed the training programme and, if available, copies of assessments.

Logbooks

In order to demonstrate a breadth and depth of clinical experience it is important that logbook evidence supports exposure to subspecialties in the curriculum. The logbook should be validated by the institution at which the experience was gained and include a number of important pieces of information, e.g. patient age, ASA grade, operation, complexity, level of supervision and involvement in the cases. Also important are the dates when this experience was observed. The age of the patient is crucial when looking for evidence of paediatric training and experience.

A logbook summary should be available and should populate the evidence template for all subspecialties indicating large numbers of cases limited to a few indicating in the curriculum. An extensive logbook supports exposure to subspecialties in the curriculum through workplace based assessments or practice defined by the UK CCT in anaesthetics 2010 curriculum through workplace based assessments or practice defined by the UK CCT in anaesthetics 2010. Logbooks or theatre records do not always provide evidence of caseload in intensive care and pain medicine. Case study evidence in these subspecialties should be specifically addressed by applicants.

Letters of support/testimonials

Letters of support from anaesthetists practising within that specialist field strengthens an applicant. The letters of support should indicate the level of competencies attained i.e. core, intermediate, higher and advanced. Applicants should seek advice from the RCoA and the institution at which the training is to be undertaken in order to determine the level of competencies, which are deliverable within the proposed time scale.

More information on types of evidence is available on the RCoA www.rcoa.ac.uk and GMC websites www.gmc-uk.org.

Triangulation of evidence

The triangulation of evidence is important in the assessment of equivalence. Evidence should indicate the breadth and depth of experience shown in each module of the curriculum. Each piece of evidence submitted is strengthened by cross-reference to other evidence, which supports that curricular requirement. As an example, if one was looking for higher competences in paediatric anaesthesia then evidence should include:

a. Evidence of a post or rotation within that sub-specialty indicating duration of training and experience, and the level of training reached
b. Testimonial letters from supervising consultants indicating the level of competencies reached and in this example relating to the higher competencies in the sub-specialty of paediatrics
c. Logbook/electronic record and summaries of the cases undertaken indicating the age spectrum, surgical procedure, complexity and level of supervision

Test of knowledge

All applicants have to demonstrate that they have passed an acceptable test of knowledge. The test of knowledge should cover the same areas to the same level as the RCoA’s final Fellowship examination. There is a list of examinations on the RCoA website in the equivalence section which have already been assessed as acceptable tests of knowledge for a CESR application. If your test of knowledge is not on the list, you must provide a validated copy of the curriculum used for the examination from the institution, the method of standard setting, the structure of the examination, the pass rate and the method of quality assurance.

The RCoA process

When the GMC considers sufficient evidence for an assessment has been provided by the applicant, the GMC will send the application pack to the RCoA for formal assessment. The RCoA has an Equivalence Committee which meets once a month to consider applications. Each application is reviewed independently by at least three medical members of the Committee prior to the meeting and then each application is discussed at the Committee meeting. The Committee reviews the evidence for each GMP domain and agrees an outcome. A draft assessment is written by the Committee Secretary and it is reviewed by the RCoA Training Manager and the Chairman before submission to the GMC.

The logistics of the process is available on the RCoA website.

Not recommended for specialist registration

Recommendations not to be added to the Specialist Register are usually the result of a lack of and/or poor evidence. Remember, this is a paper exercise and a lack of evidence makes it difficult to demonstrate equivalence. In such cases, the assessors will err on the side of patient safety.

When an applicant is not recommended for specialist registration, the applicant will be advised where they failed and what they need to do to demonstrate equivalence. For example, if the applicant has failed to demonstrate higher level cardiothoracics, the RCoA will advise the applicant to provide more evidence demonstrating they have the training and/or experience or suggest a period of clinical attachment where the applicant can demonstrate the required level of clinical practice defined by the UK CCT in anaesthetics 2010 curriculum through workplace based assessments or equivalent. The RCoA equivalence administrator is available to provide advice if needed.

Key tasks before deciding to apply for CESR

1. Read the CCT in anaesthetics 2010 curriculum carefully to ascertain what you need to demonstrate equivalence in and to what level
2. Read the guidance on the types of evidence you should provide
3. If you cannot demonstrate equivalence with the evidence that is available, discuss the possibility of obtaining top-up training with the College Tutor/Training Programme Director/Regional Adviser
4. Arrange the top-up training and ensure that you are assessed to the correct level using the approved workplace based assessment tools
5. Contact the RCoA if you have any questions
6. Choose your structured referees carefully. The CD and/or Departmental Head should be selected if possible. Structured references from medically qualified individuals from the last five years have a higher evidential weighting as they can comment on current practice and cover the other GMP domains

Dr Hywel M Jones
Former Chair of the RCoA Equivalence Committee
Mr Craig Williamson
RCoA Training Manager
The RCoA Fellowship Examination

The Career Grade Committee at the RCoA has ensured that SAS anaesthetists are able to sit the FRCA examinations. Indeed the RCoA wishes to encourage anaesthetists who have not already gained a Fellowship to sit the appropriate examination.

To be eligible to enter the primary or final FRCA examinations candidates must meet the following criteria:

- left approved training more than five years ago
- are currently practising anaesthesia in the UK
- are a member of the RCoA and
- have the written support of the local Regional Advisor

SAS doctors who have left approved training within the last five years are eligible to apply as former trainees.

The FRCA is a comprehensive, well recognised exam that requires significant preparation and studying in order to succeed.

Reasons for obtaining the fellowship diploma might include:

- Personal satisfaction
- Status
- Enhanced ability to teach and train others
- Facilitate re-entry into training
- Application for CeSR and hence facilitate entry onto the Specialist Register
- Ability to apply to be an FRCA examiner

A recognised test of knowledge is an essential component when applying for a CeSR and possession of the FRCA fully meets this criterion. Entry onto the Specialist Register is an essential criterion when considering an application for a consultant post.

Any SAS doctor who has passed the FRCA exam is eligible to apply to become an examiner too. You will of course need to meet all the criteria in the same way as our consultant colleagues but is a very rewarding activity.

The FRCA continues to be a two part examination; however there have been many changes to the regulations over the past few years. The most recent regulations (currently 2010) are available on the RCoA website.

Both the primary and final parts of the Fellowship are divided into components and it is no longer essential to pass all the components at the same sitting.

Primary FRCA

The primary FRCA examination is divided into three sections taken on two separate days:

- a multiple choice question (MCQ) paper
- an objective structured clinical examination (OSCE)
- a structured oral examination (SOE)

Candidates must pass the MCQ paper before they can apply to sit the OSCE and SOE.

A pass in the MCQ paper will be valid for two years, after which time if the whole examination has not been passed the MCQ must be re-taken.

At the first attempt, the OSCE and SOE sections must be taken together.

A pass in the MCQ paper will be valid for two years, after which time if the whole examination has not been passed the relevant section(s) must be re-taken.

Candidates will be allowed five attempts at the MCQ and four attempts at the OSCE and SOE.

Checklist for CESR application

GMP 1 – Knowledge, skill and performance
- Logbooks
- Logbook summary
- Curriculum, assessment method, standard setting
- Letter from institution confirming above
- Structured referees
- Testimonials
- Letters of support
- Rotas/theatre lists
- Job description/job plan
- Training certificates/assessments
- Case diaries for ICM and/or pain medicine
- Record of procedures learnt
- Difficult airway courses – certificates
- CPD certificates
- Train the trainer course
- Feedback from trainees
- Teaching and training rotas
- Educational qualifications

GMP 2 – Safety and quality
- Audit activity (defining, conducting, presenting)
- Testimonials
- Appraisal (includes 360 degree)
- Structured referees
- Research project (planning, conducting, presenting)
- Letters of support
- Management qualifications
- Management courses – certificates

GMP 3 – Communication, partnership and team work
- Structured referees
- Appraisal (includes 360 degree)
- Testimonials
- Letters of support
- Feedback from trainees
- Equality and diversity training certificate

GMP 4 – Maintaining trust
- Appraisal (includes 360 degree)
- Structured referees
- Letters of support
- Thank you letters from patients
- Equality and diversity training certificate

17. THE RCOA FELLOWSHIP EXAMINATION

The primary FRCA examination is divided into three sections taken on two separate days:

- a multiple choice question (MCQ) paper
- an objective structured clinical examination (OSCE) and
- a structured oral examination (SOE)

Candidates must pass the MCQ paper before they can apply to sit the OSCE and SOE.

A pass in the MCQ paper will be valid for two years, after which time if the whole examination has not been passed the MCQ must be re-taken.

At the first attempt, the OSCE and SOE sections must be taken together.

If one section is failed, only that section must be retaken, whilst if both sections are failed, they must be retaken at the same sitting.

A pass in the OSCE or SOE will be valid for two years, after which time if the whole examination has not been passed, the relevant section(s) must be re-taken.

Candidates will be allowed five attempts at the MCQ and four attempts at the OSCE and SOE.
## 18. PERSONAL DEVELOPMENT PLANNING FOR SAS ANAESTHETISTS

Deering’s definition of Personal Development Planning (1997) describes how anaesthetists can use this process to monitor, build and reflect upon their personal development. It is an essential component of revalidation for all anaesthetists, including career grade anaesthetists. A doctor’s Personal Development Plan (PDP) is a series of personal statements linked to individual objectives that help to improve the quality of care each doctor provides to patients.

### The RCoA's Contribution

The RCoA has recently published two documents that set out the place of Personal Development (PD) Planning in CPD and revalidation; it applies to all substantive work activities. These documents are: Revalidation: interim guidance for anaesthetists (1997) describes how anaesthetists can use this process to develop their careers effectively so that each anaesthetist can efficiently identify and achieve their professional goals, one of which is the requirement to revalidate. All anaesthetists should maintain a Personal Portfolio (PP) containing their evidence in support of their CPD and their revalidation. Whenever possible, a PP should be maintained electronically with a safe backup procedure, but if this is not possible, it must be maintained in a paper-based format and kept safe. The PP will be subject to external scrutiny as part of revalidation, both as part of a career grade anaesthetist’s directorate annual appraisal and performance review and as part of their five yearly GMC revalidation process. To support this, the RCoA is producing an online system for all anaesthetists that will allow the recording of CPD activity and updating of their PDP. This will be part of the services provided to all those who maintain an annual membership subscription to the RCoA.

### The RCoA CPD Guidelines

The RCoA CPD guidelines should be at hand when developing your PDP. A CPD matrix describing three levels of CPD activity, Level 1, Level 2 and Level 3, accompanies them and it must be consulted when creating your PDP. Level 1 CPD topics cover the core knowledge areas expected of all who have trained as anaesthetists; each Level 1 topic must be completed during each five-year revalidation cycle. Level 2 CPD topics completed during each five-year revalidation cycle must reflect the whole of the individual’s clinical practice including on-call responsibilities in non-specialist centres. Level 3 CPD covers the knowledge and skills that must be completed in each five-year revalidation cycle by those whose clinical practice includes one or more ‘specialist interest’ areas. So, an anaesthetist with orthopaedic lists in their job plan would be required to have evidence of maintaining the following: all of Level 1 CPD and their Level 2 CPD would include regional anaesthesia for local, regional and neuraxial techniques (identified in the matrix as Level 2G01, 2G02, 2G03 and 2G04).

If one of this doctor’s orthopaedic lists included anaesthesia for spinal surgery, the maintenance through CPD of the necessary skills and knowledge contained within Level 3A08 would also have to be planned for and completed over each five-year period for revalidation to be successful for this particular anaesthetist. PD Planning is the process used to develop ones career effectively so that each anaesthetist can efficiently identify and achieve their professional goals, one of which is the requirement to revalidate.

All anaesthetists should maintain a Personal Portfolio (PP) containing their evidence in support of their CPD and their revalidation. Whenever possible, a PP should be maintained electronically with a safe backup procedure, but if this is not possible, it must be maintained in a paper-based format and kept safe. The PP will be subject to external scrutiny as part of revalidation, both as part of a career grade anaesthetist’s directorate annual appraisal and performance review and as part of their five yearly GMC revalidation process. To support this, the RCoA is producing an online system for all anaesthetists that will allow the recording of CPD activity and updating of their PDP. This will be part of the services provided to all those who maintain an annual membership subscription to the RCoA. Career grade anaesthetists who are not Members or Fellows should use a paper-based system and the NHS appraisal documentation contains a suitable form for maintaining an annual PDP. An example of a PDP is shown in Figure 1 in which one item, the plan to complete an educational supervisor’s course in 2011, is fully set out. As an exercise, the reader might try completing the table for the second item, ‘Obstetric Update’. The basis for the components of a PDP, including those in Figure 1, will form the remainder of this section in the handbook on PD Planning.

### Figure 1.

<table>
<thead>
<tr>
<th>PDP Aim</th>
<th>Purpose</th>
<th>Resources required</th>
<th>Evidence of successful completion</th>
<th>To be completed by</th>
<th>Reasons for not completing on time and new completion date</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Supervisors Course</td>
<td>To meet Deanery standard for my role as an Ed Sup.</td>
<td>1 day study Leave, July 2011.</td>
<td>Certificate of completion</td>
<td>July 2011</td>
<td>Course cancelled, December 2011</td>
<td>December 2011</td>
</tr>
<tr>
<td>Obstetric Update</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Dr Roger Laihead

RCoA SAS Council Member
PD Planning by team members should help clinical teams to:
- Provide individuals with targeted support for their personal development
- Work with individuals more effectively
- Provide improved clinical care for patients

The steps required in the PD Planning annual cycle are set out below and illustrated in Figure 2. The period of reflection in the cycle should be supported by discussion with peers or perhaps a mentor and also with the designated and agreed appraiser. The outcome of this process is the PDP itself, which is recorded in the PP.

The content of the PDP should be Specific, Measurable, Achievable, Relevant, Timely (SMART) and it should be documented. An assessment should be made of the period of the PDP and an effort should be made to identify a timescale for each. The PDP can then blend with your organisation’s priorities and business plan rather than grate against it.

The annual cycle of PD Planning is completed by an appraisal and assessment process called the Annual Review in Figure 2. This will constitute the annual element of the five yearly revalidation process; the process then repeats itself annually.

The process of PD Planning, whilst owned by the career grade anaesthetists, will be most effective when undertaken with the support of their employer, specifically their appraiser. All substantive anaesthetists, including career grade anaesthetists, should be introduced to PD Planning, its purposes, obligations and anticipated benefits at their induction. An anaesthetic appraiser should ensure that every doctor has appropriate and regular access to an appraiser who will support (and challenge) them through the PD Planning process. It is vital for career grade anaesthetists that their appraiser ensures careers advice is integrated into the PD Planning process.

The activities required for successful PD Planning are many and varied because they reflect the wide variety of career grade anaesthetists’ job plans. Of particular note is the requirement in revalidation for the regular collection of 360 feedback from patients and peers.

What is the outcome of the PD Planning process?
PD Planning results in two main outcomes. The first is an enhanced self-awareness of strengths and weaknesses and of directions for change. Crucially, it relates to the development of the individual as a whole person. The second outcome is the PDP which has already been described. This record of learning experiences and achievement, personal reflections and plans for self-improvement provides a unique resource for each individual and constitute the basis for revalidation.

Who is responsible for the PD Planning process?
The individual owns the information in the PP. Its maintenance, authenticity and use are also the responsibility of the individual doctor. The CEO is responsible for the implementation, support and quality assurance of employer processes involved in revalidation, including PD Planning and this is usually devolved to the Clinical Director. This includes induction into the process, protected time to undertake the process and a commitment to respect the content of an individual’s PDP.

The GMC, the DoH and the RCoA have already provided explicit guidelines describing the place of confidentiality in assessment, appraisal and revalidation of the individual doctor. This includes detailed instructions as to who has access to the various elements of the PP and the DoH appraisal documentation. It can be anticipated that the same standard will continue to apply. The exception to this is when information about a doctor relating to behaviour harmful to patients or that is illegal becomes known. In this situation, the guidance provided by the GMC should be followed.

Commencing the PD Planning process
This section of the handbook finishes where it began by describing how to start the cycle of PD Planning. The job plan is the starting point for the annual cycle of PD Planning. It is then necessary to establish a personal framework for reflection. A good starting point for beginning what is often a daunting process is for each anaesthetist to ask themselves a few simple questions as follows whilst at the same time making a few notes. Having finished answering them, it is usually possible to fill in the first column of the PDP (Figure 1):
- What have I achieved over the last 12 months?
- What do I wish to achieve over the next few years?
- What training or resources would this require?
- What have my strengths during the last twelve months?
- What have I achieved over the last twelve months?
- What could these be remedied?
- Do I need guidance or help? If so, how would I obtain this?

To conclude, an added level of sophistication can be added in subsequent years of the PD Planning cycle by separating a PDP into the following sections: clinical issues, ‘training and educational issues’ and ‘organisational issues’.

Remember, if your situation needs to change, it can be changed safely.

Dr Charlie Cooper
Associate Postgraduate Dean, East Midlands Deanery

19. SUCCESSFUL CLINICAL AUDIT – TIPS

Clinical audit is an indispensable part of every healthcare professional’s career. Everyone (trainee, SAS or a consultant) gets asked about it at interviews, assessments (Review of In Training Assessment – RITA/ Annual Review of Clinical Progress – ARCP) and appraisal. When you search this phrase on the internet, several different definitions come up. Some describe the so-called seven pillars of clinical governance. This topic is confusing for everyone, juniors and seniors alike.

This is an attempt to clear the mist around ‘clinical audit’ and to provide a practical and useful version of how to do a successful audit. However, we have avoided giving specific examples, which are best left to your own circumstances and preferences.

Almost everything we do in our daily practice (procedure, pathway, drug administration, etc.) has certain set standards. These are described by the Royal Colleges, DoH or in peer reviewed literature. Occasionally, there may not be set standards but there are certain expectations or guidelines.

In its most simplified form, clinical audit is comparing current practice against certain standards.
The components of clinical audit or audit cycle

- Identifying standards
- Measuring current practice (data collection)
- Comparing results with standards (analysis)
- There are two likely outcomes at this stage
  - if the work load is very high, then the standards set are not met. Recommend changes
  - if the practice falls short of standards, then deficiencies have to be identified and changes have to be introduced

- Re-auditing to make sure practice has improved
- Continue re-audit to ensure that the standards are continually met

- This process is also known as completing the audit loop/cycle

- Preparation at local/regional/national meetings
- Depending on the strength of the project, you can hope to get a poster or even a paper out of it.

The following are the possible steps of an audit project.

1. Decide a topic/project. A good audit is one which starts with a clear and achievable goal. A supervisor (sometimes more than one) should be involved from the outset. This is even more relevant if you are doing a multicentre or multi-speciality audit.

2. Identify the team. The lead author must be agreed at this stage. Should the project lead to a poster or a paper, there can be confusion or even (sometimes major) arguments about who should be the first author/co-author. People often want to join a project which is moving towards success to get on as a co-author!

3. Decide the topic/project. A good audit is one which
   - has a clearly defined purpose
   - has a clear and achievable goal
   - has a clear and achievable goal
   - has a clear and achievable goal

4. Define standards of practice against which your results will be compared. Make sure some form of reference is available.

5. You must register the project at this stage with the relevant clinical governance unit. Usually, the forms are available on the organisation’s intranet. It is also a good practice to send a copy of the same to the consultant anaesthetist who is the Departmental Audit Lead.

6. Data collection: Prepare a data collection form. This can be in the format where a form is completed and then for each data set, the findings are transferred to a spreadsheet. Is your audit going to be retrospective or prospective? In reality, this does not matter much to the eventual outcome.

- Alternatively, data can be directly entered in a spreadsheet that can be on a handheld device, (e.g. a smartphone) or a laptop. Sometimes a web-based spreadsheet is very convenient.
- Always keep a backup copy of the data.
- Make sure that there is no patient identifiable information on your devices and that you are strictly complying with the local data protection regulations.

Surveys

Increasing number of audits are questionnaire based surveys. This is not necessarily a bad idea as long as you are aiming to compare specific outcomes against set standards. Occasionally, you may do a novel survey and may come out with revised or even new standards.

Surveys can be local, regional or national. Once again, these can be in paper format. Try and limit it to about 10-12 questions and on one side of A4 paper. Remember, people hate completing surveys. You can hand over the questionnaire personally and get it completed. In some cases, you will be expected to keep anonymity of the replies. You may need to post it, if it is a regional or national survey. Here, you will have to include a covering letter explaining the project and possibly a self-addressed stamped envelope. This means two-way postage. Costs. There is increasing awareness to set up online surveys by using websites like surveymonkey.com. You may prepare a simple email and request the recipients to click reply, enter answers and send it back to you. In any case, be prepared for poor response rates. A 30–40% response rate for a national survey should be considered as good!

Final steps

- You may need a statistician’s help if data are complex and he/she give you an idea about how many cases are required to make the project statistically robust. Often this is the stumbling block. The organisation generally has a statistician in the research department. If you anticipate the need for such help, talk to one at an early stage. He/ she may expect to be included as an author on the poster/paper.
- At this stage, do not forget the very basis audit concept: compare your results with the agreed standards.
- Start preparing a presentation. Talk to the audit lead to book a slot for presentation at the next meeting.
- Consider what else can be done at this stage. Possibilities include:
  - Introduce change and re-audit
  - Presenting at another forum
  - Can you get a poster out of this?
  - Can this be submitted for AAGBI SAS Audit and Research Prize?
  - Can you make a paper out of this for a peer-reviewed journal?
  - Can you make a paper out of this for a peer-reviewed journal?
  - Can you do the same exercise at another institute to make this a multicentre project?

Summary

Not every audit is complex. Topic selection is crucial. If you think you have got it wrong for some reason, do not hesitate to drop the project. You would still save time, effort and embarrassment. We think that a good audit is the one that can be completed and presented. As a rough guide, do not aim for more than one or two projects per year but this will vary depending on the complexity of the topic, the level of your involvement and most importantly, your ability in terms of time commitment.

Good luck!

Dr Smita Osvald
AAGBI SAS Committee Member

With contributions from Dilip Osvald, Consultant Radiologist, Mid Yorkshire NHS Trust, past member of the Audit Committee of the Royal College of Radiologists, 2008-2010.)
20. HOW TO 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 design

By ‘design’ I mean what is actually done during the study. For example, is any intervention happening, (e.g. giving a drug) or is it simply observational, with measurements being recorded but nothing ‘done’ to the participants? Is data collection prospective (or reverse prospective)? The latter is weaker since the data were collected without the study in mind, so one can be less certain about their accuracy or completeness. An important consideration is the choice of appropriate controls, for example drug A versus drug B, where drug B is the standard treatment (thus control) and drug A the newer (experimental) one. But even here, unless there is good evidence that drug B is effective, a finding that drugs A and B have similar effects could mean either that they’re equally effective or that they are equally ineffective.

The practicalities

The practicality of a study has to be abandoned because the study is just impractical in that setting. For example, anything involving extensive data collection, e.g. questionnaires to ward nurses, is likely to fail because such people are busy and furthermore have no interest (in the ‘ownership’ sense) in the study. Studies of rare outcomes require huge sample sizes and are probably not worth the effort on a local level. Some measurements are just too difficult to obtain. I always tell students embarking on a project that there are three golden rules of research: (i) you’re expecting to see in your control group; and (ii) what difference is worth looking for in the experimental group. This, and subsequent expectations like how to present or compare the data, really do require the input of someone who has done it before – and not necessarily a statistician. So time spent discussing the statistics is not only useful – it’s vital. Sometimes the complexity of the statistics or the sample size required is such that a study has to be abandoned at this stage because the practicalities don’t stack up.

The regulations

These are increasingly seen (by investigators) as barriers put in the way of honest folk whose only wish is to improve the world, but history is littered with dreadful abuses of research and publication ethics, as well as plenty of bad science. The most useful advice, as before, is to seek useful advice from someone who has done it before. In general, studies require ethical approval, hospital R&D approval, departmental approval, and possibly MRHA approval, depending on the type of study. Funding requirements add another layer of paperwork.

Dr Steve Yentis
Editor-in-Chief of Anaesthesia

21. HOW TO 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 see this as a daunting task but it shouldn’t be because you’ve actually 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.

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 more experienced colleagues on your 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 is it only of interest to a small sub-specialty group (either an anesthetic 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 out of the blue).

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 …repeat the process! The British Medical Journal or the passive voice, (e.g. “we administered fentanyl to the patients”)?

A common misconception of budding authors is that a long paper is more impressive than a short one. Like 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.

Now it’s down to the writing. Start with the Introduction, which should have three clear messages: which is already known about the subject, what is not yet known, i.e. the questions needing answering and what does your study intend to answer? Keep it simple: three short paragraphs answering these questions.

The design, in order to answer it you need to decide: (i) what you’re expecting to see in your control group; and (ii) what difference is worth looking for in the experimental group. This, and subsequent expectations like how to present or compare the data, really do require the input of someone who has done it before – and not necessarily a statistician. So time spent discussing the statistics is not only useful – it’s vital. Sometimes the complexity of the statistics or the sample size required is such that a study has to be abandoned at this stage because the practicalities don’t stack up.

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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 …repeat the process! The British Medical Journal or 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.

Now it’s down to the writing. Start with the Introduction, which should have three clear messages: which is already known about the subject, what is not yet known, i.e. the questions needing answering and what does your study intend to answer? Keep it simple: three short paragraphs answering these questions.
The Methods section 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. If someone has described part of the methodology before, you do not need to repeat the description but clearly reference it. Include the end 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 (eg 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: perhaps use 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 guidance for authors. If there are figures or photographs, make sure they are of sufficient resolution for printing (again refer to the guidance). Texts or 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 they don’t fit. It is important to be up-front and point out the flaws in your study as no study is perfect and it is important to consider and acknowledge these flaws and try to convince the reader why they do not distract from the validity of your finding. Finish your discussion with a concluding paragraph, summarising 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 inserting references should be straightforward, especially if someone has described part of the methodology before, you do not need to repeat the description but clearly reference it. Include the end 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.

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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 and be careful 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 gateway 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 summarise why you did the study, your methods, main results and conclusions, keeping the order of groups as described in the paper and ensuring that the results are the same – it’s surprising how often there are discrepancies because of transcription errors.

There, it’s all done and ready to be sent off to your chosen journal. No..., not yet; re read your paper, get all co-authors to read and edit in turn, and lastly, get a lay person to read it (partner or friend); they may not be able to understand the technical aspect of the paper but they will be able to tell you whether it is clearly written.

After submission, you can brace a big sigh of relief and await the verdict. If it is not accepted, do not despair or take it as a personal rejection. It does not necessarily mean that it is worthless; there are many reasons for rejection. Despite your careful selection, it may be felt inappropriate for that particular journal, or you may have just been unlucky with the choice of reviewers; the difference between acceptance and rejection is sometimes a fine line and quite subjective. Hopefully, the Editor has given you constructive comments and an explanation of why it was rejected. If not, it is worth writing back and politely requesting feedback on these comments to revise your paper and prepare for submission elsewhere, but only if you are very carefully read the new journal’s guidance for authors!

Dr Paul Clyburn
AAGBI Honorary Treasurer Elect and Editor of Anaesthesia

22. PENSIONS AND FINANCIAL PLANNING

In this article, I will 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 FAQ 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 future prosperity and security.

Financial advice – the good, the bad and the downright ugly

I will begin with a brief examination of the various types of financial advice currently available. There are two types of financial advisor; those providing financial organisation (such as acting on behalf of their company/ bank), and an independent financial advisor, able to draw on the entire market (thus acting on behalf of the client). The distinction between the two and benefits of the latter is set to increase even further as part of regulation changes imposed by the Financial Services Authority to take effect from 2013.

In my experience, doctors tend to favour an independent advisor who works on a fee basis rather than those advisers being remunerated by commission. The fee basis ensures that you are paying to receive independent, professional and impartial advice, not the sales pitch of an independently chosen financial product. After all, which patient would willingly consult a doctor paid by the pharmaceutical companies on the basis of the number and value of prescriptions written? Only a truly professional independent financial adviser that is able to create bespoke financial planning solutions that are right for your individual circumstances.

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 still 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 retirement, £5000 per annum full service, a starting pension of £50,000 per annum and a lump sum of £150,000. The pension itself then increases in line with inflation and any additional benefits negotiated with employer/civil partner 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 between 6.5% and 8.5% per annum depending on the level of your pay. In return, the scheme has been made more flexible, including the ability to take a larger tax free lump sum at retirement (though if taken this would reduce your pension) and the extension of pension death benefits to unmarried partners. Note: The Hutton Report recommended a reduction in this from 3% average across all public sector pensions. This has been accepted by the Treasury and further details are expected in the Autumn of 2011.

Normal retirement age has been protected as 60 as well as the definition of final salary as ‘the best of your last three years’ pensionable income.

From July 2009 existing members will have the choice to move (on a no-return basis) to a new scheme designed for new entrants. This is part of the much publicised ‘Pension Choice’ exercise and which deserves careful consideration and a professional assessment before making the choice as there are a multitude of factors involved in the decision.

The new scheme has a retirement age of 65 rather than 60 and has a different basis for calculating final salary – ‘the average of the three best out of the last ten years.’

The new scheme has a retirement age of 65 rather than 60 and has a different basis for calculating final salary – ‘the average of the three best out of the last ten years.’
Financial protection – what do I need?
Thankfully the NHS offers some good in-house benefits. If you die whilst an 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 over 50 and are unwell and 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 ability 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 uplifting 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. Now increased to £1.8 million, the rules state that benefits in excess of this LTA amount can be taxed up to 55%, which is a punitive rate. For many doctors this will not represent a threat until later in their career, but whatever your circumstances the definitions (of listed conditions) varies quite widely among the definitions) of 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 your income you return to work or reach your normal retirement age. 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.

While Income Protection pays an ongoing income based on your income, Critical Illness Cover pays a once-off tax-free lump sum on the diagnosis of one or more 'critical illnesses'. The range (and sometimes the definitions) of listed conditions varies quite widely from provider to provider, and so careful selection is again required. If you die you will be paid for up to six months on full pay and then 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 over 50 and are unwell and 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 ability 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 uplifting your pension benefits but you should be aware that the Government introduced a pension ‘ceiling’ in 2006 called the ‘Lifetime Allowance’ (LTA).

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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.

Dr Mark Martin
Independent Financial Planner, Cavendish Medical Ltd

Information management
In this electronic age we are bombarded with information as never before. Email and text messages make dissemination of information all too easy. Many of these communications are not relevant to one’s own practice and simply clog up the inbox. Do not waste time opening these. Flag for follow up, or file, those that are of interest, delete all others. When disseminating information, consider who needs to receive it, avoid sending every message to all on your department’s email list.

Time management
Doctors have busy lives and must balance their work commitments with home life and hobbies. Those with a formal management role, e.g. Clinical Directors and Clinical Leads, invariably find that insufficient time is allocated within their job plan to undertake all their varied responsibilities. Learning to work ‘smarter’ rather than ‘harder’ may be achieved by considering what is important and urgent and dealing with these matters immediately; important but non-urgent tasks (job planning, appraisal) should be scheduled; and tasks which are neither urgent nor important can be shelved. Delegating appropriate tasks to colleagues is an effective way of completing a piece of work with a tight deadline and has the added bonus of developing the management skills other team members. Time management skills are easily understood – but perhaps less easy to put into practice.

Managing oneself
Self awareness
If one is to become an effective manager one must start with oneself. What are one’s strengths and weaknesses? What aspects of one’s personality are likely to be helpful and what not so helpful? How does one’s personality impact on those with whom one must work? There are a number of suitable personality tests available but the one which is most often used, and is well researched, is the Myers-Briggs Type Indicator (MBTI) assessment, a psychometric questionnaire designed to measure psychological preferences in how people perceive the world and make decisions.

23. LEADERSHIP AND MANAGEMENT

Doctors are ideally placed to lead clinical teams and have a duty to work with others, including managers, to ensure that the services within which they work are safe, effective, and efficient. Consultants, staff grade doctors, AS doctors and trainees, can all benefit from acquiring ‘management skills’. These may be considered under three main headings – managing oneself, managing other people and managing one’s environment.

Managing oneself

Managing other people

Managing one’s environment
Managing others
Communication and team working

Just as it helps to understand one’s personality when seeking to maximise one’s own influence, a knowledge of how others behave in a group setting will assist you in making your team more effective. It is as important to have a range of behaviours within the team as it is to have a range of appropriate knowledge and skills. For example, one needs people who will develop new ideas and push things through barriers just as much as those who will support and encourage others in the work of the team and those who ensure that the minutiae are not forgotten.

Working in committees

Good preparation is key to being effective on committees. Take time to read the minutes of previous meetings and consider the agenda carefully. Solicit the views of your colleagues on matters of direct relevance to them so that you can accurately reflect their opinion. Discussions at meetings are itemised on the agenda so that other committee members have time to reflect upon them prior to the meeting. Training in negotiating skills will assist you to become and effective negotiator, both during formal conflict resolution (for example following failure of the facilitation phase of job planning) but also in day-to-day negotiations with colleagues over leave, rotas, lists etc. Building the arguments to support your position, knowing what you are prepared to trade and what you might expect to receive in return, knowing what you and your ‘opponents’ need to achieve understanding and prioritisation. This is difficult to access a negotiating skills course; it is useful to talk to the members of the organisation’s LNC who will have had training in this area.

Dealing with difficult colleagues

This is where interpersonal and negotiating skills are truly put to the test. Of course there are many reasons why colleagues become ‘difficult’ and it is important to explore the underlying causes and act appropriately.

Mental health, alcohol and drug related problems may present as ‘difficult behaviour’ as may stresses caused by life events outside the work environment. Other difficulties arise from failure to keep abreast of best practice. The remedy must address the underlying problem and assist the colleague to rehabilitate through counselling, therapy or retraining. The advice of senior medical managers should be sought.

Managing the environment

Understanding the environment

Managers often describe the environment as being internal (within the organisation) or external (that part of the world that impacts the organisation). Whilst it is not necessary to understand the macro and micro economics of the health service in any detail, it is useful to know how money flows within the service both to the organisation and to the various departments within it. This will differ in each devolved healthcare system so it is worthwhile asking the Clinical Director or approach the directorate’s Finance officer for advice.

Financial management

Whilst it is not necessary to understand the macro and micro economics of the health service in any detail, it is useful to know how money flows within the service both to the organisation and to the various departments within it. This will differ in each devolved healthcare system so it is worthwhile asking the Clinical Director or approach the directorate’s Finance Officer for advice.
24. SAS DOCTORS AND DEANERIES

Executive summary

Associate Deans are instrumental to the training and development of SAS doctors and, where appointed, oversee the allocation of development funding at a Strategic Health Authority (SHA) level. As the SAS representative in deaneries, Associate Deans should work with local SAS doctors to identify and recommend priorities for SAS development and lead on their delivery.

Development funding

£32 million recurrent funding has been made available by the DoH under Modernising Medical Careers and in line with Choice and Opportunity Recommendations 5 and 6 to support the development of SAS doctors working in England; this is separate and in addition to any existing study leave fund and contract funding implementation.

This funding, commonly referred to as development funding, is allocated to SHAs and passed on to Trusts on a per capita basis, (i.e. the same amount is allocated for part-timers as full-timers). The BMA Staff and Associate Specialist Committee (SASC) has urged that Trusts involve deaneries in the process as much as possible and would strongly suggest that deaneries lead on distribution. Ideally funding should be given to any SAS doctor who needs it (including Clinical Assistants, SAS doctors have SAS specific representation in deaneries, Associate deans should oversee the allocation of development funding at a local level and usually have a separate development budget and usually have

Deaneries and Associate Deans, SAS Tutors and Clinical Leads

Deaneries are responsible for the management and delivery of postgraduate medical education and for the continuing professional development of all doctors and dentists. There are fourteen deaneries in England, one in Northern Ireland, one in Wales and four in Scotland. Further information about the UK deaneries can be found at http://www.bma.org.uk/careers/training_/Tutors/findyourdeanery.jsp

SAS doctors have specific representation in deaneries through the appointment of Associate Deans. They are responsible for the development and training of SAS grade doctors in their area. The majority of regions have already appointed Associate Deans (some of whom are from the SAS grades). The BMA SASC hopes that this approach will be adopted throughout the UK.

To support the Associate Dean and to liaise with local SAS doctors many areas have appointed other roles with a variety of terminology. The BMA SASC has attempted to simplify the variety of other roles as follows:

1. SAS Representative (otherwise known as SAS Lead): Every organisation that employs SAS doctors should have an SAS Representative. This is a trade union role, which would normally be held by the Chair of the local SAS Committee. This representative is elected by the body of SAS doctors and dentists to represent them on the LNC/local SASC/ etc. This representative should be ideally be a member in order to draw on the local BMA support and for accreditation purposes. This role should be funded by the Trust employer (through SPAs and time off for trade union duties) rather than from SAS development funding monies.

2. SAS Tutor (otherwise known as an SAS Educational Advisor): This is an educational role for a SAS doctor who oversees educational placements, arranges tutorials, lectures etc. They can also be known as an SAS Lead for Professional Development or Professional Development Manager for SAS, etc. This person would independently manage the local SAS development budget and usually have

an educational background with line management through the DME or Post-Graduate Director. The SAS Educational Advisor should liaise closely with the SAS Representative and Associate Dean (where appropriate) but where possible should not be the same person. The SAS Educational Advisor should be funded typically, one PA/week (by the employer in job plan or additional contract), or through the SAS development funds where local employers are unwilling to fund the role. This must be an appointed role through open competition (and interview).

3. Postgraduate Director of Medical Education (DME): is responsible for maintaining and developing high quality medical education and training within his/her NHS workplace. They are tasked with developing a local strategy for medical education and training and will be responsible for its provision, quality control and improvement.

Some smaller organisations may of course need to make different arrangements (for example, an SAS Tutor may have some of the duties of an SAS Educational Advisor) but the above is an indication of what the BMA would suggest for the majority of situations.

Person specification for a SAS Tutor (Educational Advisor)

To aid employers in the appointment of SAS Tutors (Educational Advisor), the BMA SASC has devised a person specification for a SAS Tutor. The specification, which can be found at http://www.bma.org.uk/careers/medical_education/professional_development/sasdututor.jsp#page=1 is not prescriptive but is intended as a useful guide for employers.

Best practice guidance

The BMA SASC has developed a number of guidance and policy documents to promote good practice and appropriate usage of the development funding monies which can be found at

http://www.bma.org.uk/careers/medical_education/professional_development/sasdututor.jsp#page=2

One key recommendation is that the funds be used to support the establishment of Associate Deans for SAS within the postgraduate deaneries, and Clinical Tutors for SAS at local level.

In addition, the BMA SASC has created the following list of suggested usage based on the 2008 BMA SASC survey of SAS doctors’ professional development and training needs and career aspirations which identified local need for:

• Secondment and time limited posts
• Courses and top-up training
• Diplomas and certificates
• E-learning and e-Portfolios
• Conferences and events

Further detail about these suggestions and the BMA SASC Statement of Principles for the Allocation of the Additional Funding for the Training and Professional Development of SAS Doctors can be found on the BMA website at: http://www.bma.org.uk/images/SASC/Funding_policyStatement1008_tcm41-179405.pdf

Facilitating access to training for SAS doctors

SAS grade doctors need improved access to training in order to develop further their specialist knowledge and skills to enable them to offer their full potential to their employer and the wider NHS, and to develop their careers. Many believe that it is only through formal systems for recognition of the competencies of this diverse group of doctors that this grade can be promoted as a positive career choice.

Training numbers are limited but it is a common belief that there is scope within the NHS, to allow SAS doctors short term secondments to training posts (perhaps to complete the knowledge gained on maternity/fellowship or career breaks). Over the last year there has been a great expansion in associate dean posts with a remit to assist SAS doctors in their development. A key part of this function should be in spotting gaps and offering
training to SAS doctors who could fill these gaps. The BMA has already secured funding in England to assist with back-fill of posts for those that require top-up training (either as recommended by the GMC after a CESR application or for more general development of skills). The BMA SASC will be working with Medical Education England and its counterparts in the devolved administrations to consider how SAS doctors can be further supported as part of the forthcoming review of the future shape of postgraduate medical training in order to open channels for those SAS doctors who desire to get back into training to further their career.

Dr Rajneesh Nirula
Associate Dean SAS Doctors, Wales

25. DEVELOPING A SPECIALIST INTEREST AS AN SAS ANAESTHETIST

Some hospital doctors elect to become SAS doctors only because they cannot get into higher professional training. Some of these doctors have vast experience and skills in the specialty and could be fit to practise as specialists. Many of them possess post-graduate qualifications. However, they are not free to practise their skills independently as they can only do so under the supervision of a consultant. It is difficult to acquire a new skill or experience in a branch of the specialty whilst working full time in the job. The study leave period allowed may not be sufficient. It may prove difficult to learn, obtain adequate experience and knowledge of a sub-specialty to have enough confidence to practise.

However, I believe that it is still possible to develop a special interest as an SAS doctor. The nature of working conditions in the specialty of anaesthetics actually affords excellent opportunities to develop specialist experience. It is advisable to consider a sub-specialty that figures prominently and has scope in the department already.

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AAGBI SAS Committee Chairman

The AAGBI's main aims as an organisation are to advance and improve patient care and safety and to promote and support education and research in the field of anaesthesia. We also represent, protect, support and advance the interests of our members. The AAGBI understands that the Specialist Societies also have these common goals and recognises the important contribution they make to advance the profession and ultimately improve services to their members.

The AAGBI has formed close working relationships with the various societies over many years, and realises that many societies rely on their executive officers to run their administrative function. Recognising that the AAGBI could offer support in this area the Specialist Society department was formed in 2003.

The goal of the Specialist Societies department is to provide an efficient and comprehensive administrative, finance and event service for those Specialist Societies that choose to use its services. Today the department supports 16 societies and has run over 40 Specialist Society events. The Specialist Society department goes from strength to strength and delivers a professional service across all aspects of administration. The department is entirely flexible, providing as much or as little support as each Specialist Society needs. The cost of services provided is based on cost incurred; AAGBI makes no profit from this part of its activities. Affiliated Specialist Societies also benefit from discounted advertising rates in Anaesthesia News.

The department continues to grow and aims to use the knowledge and experience of staff to develop and improve services to the societies and their members. Each year, the AAGBI holds a dedicated meeting for Specialist Societies, whether affiliated or not, which enables common interests to be discussed. This is in addition to individual meetings with each affiliated Specialist Society to ensure that the service provided meets their requirements.

Mrs Busola Adesanya-Yusuf
AAGBI Specialist Societies Manager
ARE YOU A STAFF GRADE, ASSOCIATE SPECIALIST OR A SPECIALTY DOCTOR?

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WHAT ARE YOU WAITING FOR?

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- FREE information handbooks for trainees & SAS grade doctors
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