THE SAS HANDBOOK
THIRD EDITION

An essential handbook for SAS anaesthetists

THE ASSOCIATION OF ANAESTHETISTS of Great Britain & Ireland
Welcome to the third edition of the Association of Anaesthetists of Great Britain & Ireland’s (AAGBI) SAS Handbook.

This Handbook aims to be a good reference source for SAS doctors, managers and clinical directors and will be supported by the SAS section of the AAGBI website where further updates will be added.

Much has changed since the last edition of this Handbook in 2011, particularly with regard to the revalidation system and that chapter has been updated to reflect this. The chapter on Addiction, Sickness and Returning to Work now has a list of useful resources and contacts so anyone requiring help can feel fully supported. Chapter 15 provides good practice guidance for SAS anaesthetists and the Career Progression and Development section contains several chapters to help you negotiate the numerous hurdles in our profession.

We live in dynamic, continuously changing times which bring new challenges to the way we work. The professional input of SAS doctors has now been recognised and valued, significantly improving the confidence of SAS doctors. We want to continue our advancement and deserved recognition so that it is kept in the spotlight and continues to be driven forward.

The future of SAS doctors is in our hands. We cannot predict the future and difficulties ahead but we can remain alert and prepared. Let us continue with good practice in providing compassionate care for our patients and excellent values that will deliver good spirit and ethics in our work and enable us to feel motivated and fulfilled in our roles.

I would like to thank Dr Ramana Alladi for his tireless work and contribution as the previous AAGBI SAS Committee Chair. I am grateful to Dr William Harrop-Griffiths, past AAGBI President, for the incredible support SAS doctors have received. I would also 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 to Dr Andrew Hartle, AAGBI Immediate Past President, and the AAGBI Council and Members for their full support and guidance. We welcome and embrace the new challenges that will come our way in the future.

I would also like to thank the staff at 21 Portland Place for their help. I hope you find the information in this Handbook helpful and informative and if you have any comments then please do contact the SAS Committee (email: sas@aagbi.org).

Dr Olivera Potparic
AAGBI SAS Committee Chair

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

This has been designed as an interactive document and accessible links are highlighted in blue. Weblinks were correct as of November 2016.

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THE SAS HANDBOOK THIRD EDITION
GENERAL
2. THE AAGBI SAS COMMITTEE

Dr Kate Bullen, the only SAS doctor to become an elected member of the 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 SAS Committee comprises the SAS Chair, all AAGBI Officers ex officio, elected AAGBI Board members, and co-opted SAS members including representatives from the RCoA, the British Medical Association (BMA), and others qualified to assist or advise the Committee for specific activities or projects, including representation from the devolved nations and Ireland. The Chair of the SAS Committee is a co-opted member of the AAGBI Council, and also represents the SAS grade on other AAGBI committees and working parties. The SAS Committee normally meets twice a year.

The Chair of the SAS Committee is also a co-opted member of the RCoA SAS Committee. Both Committees meet once a year at a joint meeting to discuss issues of common interest. The terms of reference of the AAGBI SAS Committee include advising the AAGBI Board on matters relating to SAS doctors, representing their interests, encouraging professional development, and developing educational and information resources for SAS doctors, which may include seminars, education, guidelines and handbooks, and website content. The Committee also ensures collaboration with other professional bodies on issues of mutual interest, such as the RCoA, other colleges and the BMA.

Continuous Professional Development activities

Each year, the SAS Committee organises two seminars at the AAGBI’s London headquarters which deal with academic and topical medico-political subjects. On alternate years, the AAGBI conducts an ‘SAS Joint Review Day’ in association with the RCoA’s SAS Committee, and the AAGBI’s SAS Committee regularly organises a session at the AAGBI’s Annual Congress. From time to time the Committee organises seminars on management and job planning issues.

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 – the renowned international monthly journal
- Access to Learn@AAGBI – videos and lectures from recent AAGBI meetings giving you online learning at your fingertips
- Free copies of the AAGBI’s guidelines (on request) and access to the AAGBI Guidelines app
- Free monthly Anaesthesia News magazine and @AAGBI e-newsletter
- Discounted rates for AAGBI meetings and conferences
- Guidance and information for SAS doctors
- Information handbooks
- Exclusive SAS Audit Prize and Professional Development Grant for SAS doctors
- Representation at Westminster and the Department of Health
- 20% discount on textbooks from Oxford University Press and Wiley
- 30% discount on books from Cambridge University Press
- Basic TTE Education - huge savings on distance learning online course, designed to provide a good understanding of Basic Transthoracic Echocardiography (TTE)

To find out more about any of the member benefits available visit www.aagbi.org/about-us/becoming-a-member/member-benefits

4. THE ROYAL COLLEGE OF ANAESTHETISTS SAS COMMITTEE

The Royal College of Anaesthetists (RCoA) SAS Committee advises the College on all matters relating to non-consultant non-trainee anaesthetists. Its chief aims are:

- To encourage and facilitate the professional development and academic knowledge of SAS doctors
- To encourage and facilitate the career development of SAS doctors

Publications and Prizes

The AAGBI first published the SAS Handbook in 2007 and it proved to be an extremely popular resource. Within the last two years, the SAS Committee has instituted two awards, the SAS Audit Poster Prize and the SAS Professional Development 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 provides content for 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 the 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 and it has been a pleasure and privilege to be a part of the SAS Committee. It is important to maintain the momentum and go on to greater achievements in the future.

Dr Ramana Alladi
Former AAGBI SAS Committee Chair
doctors, in areas such as involvement with the delivery of training, examinerships and involvement with local and national management roles

- To provide information relevant to SAS doctors

The SAS Committee advertises from time to time for new members. There are two SAS doctors on the RCoA Council and there are SAS representatives on the major RCoA committees.

The RCoA is primarily concerned with standards of clinical care. From an SAS perspective, the chief priorities are ensuring that adequate supervision is available when necessary, adequate time is available to SAS doctors for CPD and professional development, and to ensure that they are up to date and facilitating career development.

All doctors need to comply with the needs of revalidation and appraisal, and the requirements for SAS doctors are the same as consultants.

SAS doctors are also encouraged to become RCoA examiners and to become educational and clinical supervisors.

The RCoA and the AAGBI

The RCoA and the AAGBI both have SAS Committees and they work closely together. Some SAS doctors have considered the possibility of getting onto the GMC Specialist Register, which is essential in order to apply for a consultant post. To be able to do this, they need to demonstrate that their training has been equivalent to the training they would have received on a UK recognised training post. A separate RCoA committee deals with applications for equivalence. Full details of this process are available on the RCoA and GMC websites.

Dr Richard Marks
RCOA Vice President and former RCoA SAS Committee Chair

5. OTHER SUPPORT MECHANISMS AND ORGANISATIONS

Linkman

The AAGBI Linkman Scheme aims to maintain links and facilitate communication between members and the AAGBI. This is a two-way process and not only allows the expeditious dissemination of important information to the members but also allows us to hear your views. Your Linkman is your representative to the AAGBI. You can find the details of your Linkman by logging into your AAGBI online account.

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 the BMA and its Industrial Relations Officer, one does not necessarily need to be a member of the BMA to get involved in the LNC. It is an ideal local platform for SAS doctors to get management and committee experience. Further guidance on LNCs can be found on the BMA website.

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

This is another body that consists of all the career grade 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 Adviser, 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 SAS doctors in their professional practice, personal wellbeing, and personal and professional development. The Department of Health, the 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 a close working relationship between deaneries, local educational providers, Royal Colleges and faculties. Some deaneries have mentoring schemes that help and support doctors. Please visit your deanery’s website for further information.

SAS Charter

A new charter for SAS doctors, agreed by the BMA, NHS Employers, Health Education England and the Academy of Medical Royal Colleges, sets out the objectives and support mechanism that Health Education England promotes and provides through individual Local Education Training Boards and Local Education Providers. The English and Scottish Charters can be found here.

Other

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

Useful websites

- British Association of Physicians of Indian Origin
- British International Doctors’ Association
- Medical Association of Nigerians Across Great Britain
- Association of Pakistani Physicians & Surgeons of the UK
- Egyptian Medical Society
- Sri Lankan Medical and Dental Association in the UK

Dr Achuthan Sajayan
Former AAGBI SAS Committee Member
Consultant Anaesthetist, Heart of England Foundation Trust
EMPLOYMENT ISSUES
6. MODEL CHARTER FOR SAS GRADES

NHS Employers, the Academy of Medical Royal Colleges, Health Education England and the BMA have jointly agreed a Charter for SAS grade staff in England to recognise both the diversity of SAS doctors and the major contribution they make to patient care. This is available for download. Similar guidance is being developed in the devolved nations.

NHS employers should be committed to ensuring the role of the SAS doctor is fully acknowledged and respected by management, colleagues and patients. The AAGBI has previously suggested the following recommendations and the points remain valid.

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
- All SAS doctors (permanent staff) should be members of the MSC/MAC/Hospital Medical Board and should be invited to attend meetings
- SAS representation on the Local Negotiating Committee
- 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’
- Membership of the directorate and be invited to attend directorate meetings

Dr Anthea Mowat
Chair BMA Representative Body

7. SAS CONTRACT AND JOB PLANNING

SAS contract background

In April 2008, a new SAS contract was introduced in the UK called the ‘Specialty Doctor contract’. At the same time, the previous SAS grades contracts (comprising Staff Grade, Associate Specialist (pre-2008), Clinical Assistant, Hospital Practitioner, senior Clinical Medical Officer and Clinical Medical Officer) were closed, so that no new appointments to these grades could 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 on the BMA and NHS Employer 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 this is an irreversible decision once implemented.

At the same time 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.

Specialty Doctor grade

It is expected that entrants to the grade will be competent doctors with experience, who will develop to be highly competent with a specialised area of expertise. The level of responsibility delegated to the Specialty Doctor will depend on experience and capability and will be agreed between the doctor and their Clinical Manager as part of the job planning process.

The minimum entry requirements are:

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

Salary scale

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 pass through Threshold One, 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.

Contractual requirements

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 4 hour unit of activity,
which may be programmed as blocks of 4 hours, or in half units of 2 hours each. The only exception to this is work done out of hours (OOH).

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 work associated with clinical care, such as: telephone calls, letters, reviewing results, travel to peripheral sites to deliver clinical care, attendance at multidisciplinary team meetings about specific patents, 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, Specialist Societies or for Government

For full-time doctors, most PAs will be devoted to DCC, with a minimum of one PA per week for SPA work. It should be noted, however, that the Academy of Royal Colleges has confirmed that it is likely that SAS grade doctors will require at least 1.5 SPAs in their work pattern in order to meet the requirements of revalidation, and employers are advised to consider this in the job planning process.

All work undertaken outside normal working hours (OOH), between the hours of 7pm and 7am, and all work at weekends and on public holidays, will be paid at an enhanced rate of pay of time and a third. In most cases, this will mean that a PA of work undertaken OOH will last for 3 hours instead of 4, but will be paid as 4 hours. Alternatively the OOH PAs could remain as 4 hour units of time, but will be paid at time and a third.

Where work is carried out as part of the basic 10 PA working week, this will be pensionable. PAs for any work over and above the basic 10 PA working week, such as APAs or OOH work, which are undertaken in excess of the basic 10 PA commitment, are not pensionable. All emergency work that takes place at regular and predictable times should be programmed into the working week, and counted towards the PAs.

For shift work, all time on-call will be counted as working time and will be paid as such. For those doctors who undertake on-call instead of shifts, only the time actually worked on a regular and predictable basis during the on-call period can be included in the PA total, but there will be an availability supplement, paid as a percentage of the basic salary, that is payable to recognise the frequency of the on-call. Shift work does not attract this supplement as all time on-call is already being recognised in the PA allocation. The implication of the Working Time Regulations is that there should not be resident on-call, as such work may be better suited to a shift pattern. Advice on resident on-call work is available for BMA members on the BMA website.

**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 the employer about the use of 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 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
- Support and resources required to fulfil the agreed activities

Within the job planning meeting, consideration should be given to the balance of activities within the job plan, so that there is not an excess of OOH activity. The balance of activities should also include some elective work and not consist of only emergency cover. Consideration should be given to the health effects on older SAS grade post holders of undertaking such OOH activity. If a job plan cannot be agreed, local mechanisms should be used to try and reach resolution. Failing that, there is an appeal mechanism in the terms and conditions of service.

Job plans should be undertaken annually. Should the workload or service needs change in the meantime, either the individual or the employer may call for an interim job plan meeting to discuss these issues. Guidance on job planning is available on the NHS Employers' website.

Dr Anthea Mowat
Chair BMA Representative Body

8. REVALIDATION AND APPRAISAL

**Revalidation**

The GMC has introduced 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 work 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 is 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 provide 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 doctors appraisals over this period, together with information derived from local clinical governance systems. The Responsible Officer makes a recommendation to the GMC, but does not approve revalidation/relicensing. The final decision for this is taken by the GMC.

For the majority of doctors, the evidence to be gathered within a portfolio is very similar to the evidence that is already required for a robust appraisal, with a structured and planned approach to CPD, which should be based on what one does, or should be capable of 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.

**Appraisal**

The generic principles of 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:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and team work
4. Maintaining trust

**Domains**

Each domain has areas of attributes, with generic standards that map to these attributes. The RCoA has produced 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 should include, among other things:
- Confirmation of participation in, and reflection on, CPD
- Results of appropriately tailored multisource feedback, both peer and patient
- Outcomes-based assessment of performance
- Robust audit data
- Peer review of departments (not individuals)

Some forms of evidence will cover more than one standard, such as multisource feedback.

**Examples of evidence required**

**Confirmation of participation in annual 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

**Multisource feedback:**
- Available material from patients surveys, and relevant colleague correspondence and feedback
- Formal feedback is required prior to revalidation date, but not annually
- Details of complaints with relevant explanations and resolution
- Letters of accolade or appreciation

**Outcome-based assessment of performance:**
- Review previous personal development plan (PDP), and identify achievements over the year
- Identify and record reasons for any areas that are incomplete in the PDP

**Clinical governance:**
- Collect clinical audit data relevant to you and your department
- Ensure data being collected on your behalf is valid, reflects your clinical responsibility, and is evidence-based
- Evidence of annual participation in clinical governance systems

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

**Process**

SAS doctors can be trainers but they will require recognition by the GMC, this is usually covered in annual appraisal.

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 show that there are no serious concerns for patient safety or quality of care. If evidence shows no areas for concern but that further development is needed this will be highlighted. Also if the evidence is insufficient to make any comment for an attribute, this will be noted.

A PDP will be generated during the discussion, with personal objectives. These personal objectives are reviewed at future appraisals, but may also feed into the job planning process. The appraiser will complete a summary of the appraisal discussion, to which the appraiser may also add comments.

This appraisal 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**
*Chair BMA Representative Body*
Anaesthesia is a specialty that easily lends itself to working less than full-time (LFTT), and many SAS anaesthetists do exactly that. Let us first of all define clearly what we mean by part-time or LFTT. This depends on 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
- pre-2008 AS: full-time = 38.5 hours

This means 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.

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 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 Supporting Professional Activity (SPA) session if you are on the new contract, although you need to provide evidence of what Supporting Professional Activity work you do. You should also make sure you have a sensible ratio of daytime sessions to out of hours work.

Problems and obstacles

Attitudes

Sometimes 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-direct clinical care (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-timer drop a theatre list than someone who has only a few lists in the week. You can end up having a much higher ratio of DCC to other work than your full-time colleagues. The knock-on effect of this is that if you are still on the pre-2008 contract, you are 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 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 (APA). Part-time doctors may also be offered such additional duties, 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 months notice built in on either side.

Waiting list initiatives

The new contracts have no specific guidance on this, or on payment, but if your department is offering waiting list initiatives to full-timers, they should offer it to part-timers as well. You may come up against attempts to pay you only ‘plain rates’, a matter for robust negotiation with assistance from your Local Negotiating Committee or local SAS committee.

Rotas

If you are on an on-call rota, or have resident out of hours or weekend work, one thing you need is a calculator. The precise arrangements for your working week are in your job plan. It is particularly important to have agreement on whether or not you will be providing prospective cover for absent colleagues in order to calculate your PA allowance and salary correctly.

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, going up to six after you have completed two years’ service, and your contract should do the same, but many departments calculate leave in days rather than weeks. Some places are calculating leave in sessions, and where micromanagement is the norm it could even be in hours.

Continuing Professional Development and Study Leave

The RCoA currently recommends that anaesthetists complete 50 hours of CPD on average per year and does not reduce this for part-time anaesthetists. A minimum of 20 hours each should be allotted to internal and external activities. The College website provides detailed advice about how to use the CPD Matrix and keep a logbook of your CPD activity. Some of this will require you to apply for study leave; this is paid leave, so you should either claim additional salary if you go on study leave on a day when you are not normally at work or get time off in lieu. Study leave is not pro-rata. It is advisable to plan ahead with your appraiser, consultant supervisor, or SAS educational lead, what your CPD needs are for the forthcoming year. You should also include this in your annual job-planning meetings: as a generality, ‘external’ CPD is achieved by taking study leave; whereas ‘internal’ CPD could be included in your SPA time, although this varies.

Tax, insurance, pensions

You are advised to seek expert advice on what effect working part-time is likely to have on tax, national insurance and pensions. For example, it is often not realised that NHS pension contributions are based on your full-time equivalent salary and therefore takes a higher proportion from it.

Increments and thresholds

It is incorrect that part-time doctors cannot progress through annual pay increments or thresholds on their incremental date alongside their full-time colleagues. Your basic salary on the new contract should progress each 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, research, or special project for the department, you should be given a similar opportunity.

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. For example: this author worked full-time as a junior doctor for nine years; then was unemployed for three years while her children were little; returned to work as an SAS anaesthetist part-time for 18 years; became full-time for seven years; then back to part-time in the lead up to retirement. Such flexibility is an important means of managing your personal and family life according to circumstances. 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 incurring recruitment costs. In either case, you will need an amended contract and a new job plan.

Working LTFT is an excellent way to continue to practise anaesthesia and have a satisfying career when full-time work is 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.

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 out of hours; her Clinical Director is agreeable to that. She is not required to do prospective cover. They agree a job plan as follows:

<table>
<thead>
<tr>
<th>Monday</th>
<th>08:00 to 13:00 theatre list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday</td>
<td>Off</td>
</tr>
<tr>
<td>Wednesday</td>
<td>13:00 to 18:00 SPA (including attending the M&amp;M meeting and taking care of the department library)</td>
</tr>
<tr>
<td>Thursday</td>
<td>08:00 to 18:00 theatre list</td>
</tr>
<tr>
<td>Friday</td>
<td>Off</td>
</tr>
<tr>
<td>Saturday</td>
<td>Off</td>
</tr>
<tr>
<td>Sunday</td>
<td>Off</td>
</tr>
</tbody>
</table>

This is a job plan for 20 hours, or 5 PAs.

Leave arrangements

Dr A has a leave entitlement of 6 weeks per year. If the department uses a weekly system: she can take 6 full weeks off. If the department uses a daily system: she can take 6 Mondays, 6 Wednesdays, and 6 Thursdays off each year (but she shouldn’t take 12 Mondays plus 6 Thursdays).

If the department calculates leave in sessions, then she can take 5 x 6 = 30 sessions off per year, but, they should be evenly balanced and include the SPA sessions as well as the DCC sessions.

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 3 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.

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:

<table>
<thead>
<tr>
<th>Week 1</th>
</tr>
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<tbody>
<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
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<tr>
<td>Wednesday</td>
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<td>Thursday</td>
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<td>Friday</td>
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<tr>
<td>SPA</td>
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<tr>
<td>Saturday</td>
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<tr>
<td>Sunday</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
</tr>
<tr>
<td>Tuesday</td>
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<tr>
<td>Wednesday</td>
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<tr>
<td>Thursday</td>
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<tr>
<td>Friday</td>
</tr>
<tr>
<td>SPA</td>
</tr>
<tr>
<td>Saturday</td>
</tr>
<tr>
<td>Sunday</td>
</tr>
</tbody>
</table>

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 duty.

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.

Dr Christine Robison
Associate Specialist, Anaesthetics
Deputy Chair Lothian LNC
Former member of Scottish SAS Committee
Former AAGBI SAS Committee Member

Former AAGBI SAS Committee Member
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 chapter, 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 Drug and Alcohol Abuse amongst Anaesthetists.

Out of each cohort at medical school, approximately 10% will develop an addiction – so what allows the majority of individuals to ‘settle down’ after minor experimenting 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 for instance, but whether addiction becomes an active problem, or is just ‘waiting in the wings’ for a trigger such as finding just the right drug of choice, and whether it is nature or nurture that 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 that, 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. The hallmarks of dependence include craving and compulsion to use a substance. Withdrawal also usually occurs, but can also be seen in chronic pain patients who are prescribed opioids; the latter, however, do not exhibit the craving and overwhelming compulsion seen in addiction proper.

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 and dopamine DA3 receptors have been demonstrated as, in part, an explanation for these traits. In active addiction, large amounts of time are spent trying to avoid being caught out, trying to sneak a ‘top up’ while no-one is watching, concocting excuses for being late or missing deadlines, leaving early, hiding bottles or ampoules, etc. Adverse consequences include marital 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 profound, even with our medical knowledge. Similarly, one’s 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:

• Personality changes (most common)
• Loss of efficiency and reliability
• Increased sick time and other time away from work
• Poorly prepared presentations, failure to fulfil departmental responsibilities
• Patient and staff complaints about a doctor’s changing attitude/behaviour
• Late for appointments etc. with increasingly elaborate excuses
• Moodiness, anxiety, depression
• Memory loss, indecision
• Increasing personal and professional isolation
• Physical changes – weight loss, less effort made with clothing and general appearance
• Inappropriate prescription of large narcotic doses
• Heavy ‘wastage’ of drugs
• Dropping/breaking an already empty ampoule to get a full replacement
• Insistence on personal administration of parenteral opioids to patients in pain despite high doses of opioids charted as given
• Preference for working alone
• Long sleeves when inappropriate
• Frequent toilet breaks
• Nasal rubbing/itching or drowsiness after ‘top-up’ breaks
• Nasal discharge, yawning, tears, pallor, sweating, piloerection and feeling cold if withdrawing
• Alcohol on the breath
• Poor anaesthetic charts – particularly altered or (deliberately) illegible entries. Similarly, uncharacteristically poor handwriting (alcohol withdrawal tremor)
• Using techniques without narcotics, falsifying charts and diverting drugs for own use
• Offering to prepare drugs for day lists before going home after a night shift
• Difficulty finding the person when on-call
• Frequent appearances in the hospital when not on-call or on leave (if drug abused is obtained from workplace)
• Frequent vague, unexplained or complex illnesses
• Frequent minor accidents and car crashes (if a case of propofol abuse)
• Messy CV – many locums or those working below qualification level will leave and change jobs when questions are asked

Outside work:

• Deterioration of marriage/relationships
• Decreased involvement in family activities and commitments
• Children developing problems
• Frequent arguments – life revolves around the partner’s addiction; family walk round ‘on eggshells’ due to unpredictable moods.
• Social isolation and loss of friends
• Cessation of hobbies and interests
• Financial difficulties
• Drink-driving convictions

Widely believed misconceptions are that to be diagnosed as alcoholic requires drinking every day and starting first thing in the morning. This is not the case. Also, binge drinkers may 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 usually happens 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 but there may be a few weeks or more between bouts.

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 a few weeks of use. Usage occurs most often in the under 40s age group, therefore more common in trainees. It is because of the rapid decline that occurs with opioid abuse
that in-patient treatment is required. Access to potent opioids is often cited as a cause for this addiction – this is true, but it usually only occurs in those who were ‘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.

However, with alcohol it usually takes many years for physical dependence to develop, and so problems are more common in the over 40s age group. Dependence can sometimes be managed without coming to the notice of regulatory bodies.

**What to do if you suspect a colleague has a problem with substance abuse**

The AAGBI guideline on drug and alcohol abuse 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, the CD, College Tutor (in the case of a trainee) and often a psychiatrist. It is not something that you should confront the doctor with on a one-to-one basis, and should never be a ‘corridor consultation’. If there is a perceived risk either to patients or the doctor him/herself, then the GMC may be contacted. If what the GMC would normally stipulate as ‘conditions’ are already being done at local level, there are occasions when it will not take on the case. These include referring to a treatment centre and peer support groups, plus Alcoholics Anonymous (AA), or Narcotics Anonymous (NA).

The GMC is aware that some doctors may seek help before the abuse becomes obvious at work, and go into treatment and return to work without it ever becoming known to them. Obviously the CD will have to be made aware, as time to attend peer support groups and appointments with occupational health (OH) and psychiatrists, etc. will have to be built into a return to work programme.

It is becoming more common for questions to be asked at job interviews about a history of substance abuse. These should be answered honestly, as failure to do so could result in a probity issue and possible GMC involvement. However, it is important to appreciate that an addict is not a bad person as such, but a sick one who deserves to get well and be treated as any patient of their own with a chronic illness would be treated. Sources of information and support are listed in the drug and alcohol abuse guidelines.

GMC hearings can be very stressful. The BMA Doctors for Doctors Unit now offers a confidential service to provide support at hearings, and throughout the course of a doctor’s GMC involvement. This has been favourably reviewed and can be contacted on doctorsupportservice@bma.org.uk or 020 7383 6707.

If the GMC has been involved in your case, it is very helpful, prior to any hearings, to gather evidence of attendance at peer-support groups, online learning modules and other CPD activities you may have pursued while on sick leave. This is evidence of you being keen to keep up to date and strengthens your case for wanting to get back to work.

**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 and don’ts:

- **DO** ensure you are registered with a GP
- **DO** keep in touch on a regular basis with your CD or equivalent. Many OH departments will only accept referrals from the CD and not self-referrals. Make sure you know how yours operates. If the CD is a personal friend, this may become a little awkward, and necessitate primary referral to another manager. OH require your consent, usually renewed at each appointment, for details of the consultation to be sent to your GP
- **DO** keep a copy of your sick notes when submitted
- **DO** ensure managers are notified if you are going to be away from home or uncontactable for more than a few days, to avoid missed emails or appointments
- **DON’T** self-medicate

Bereavement leave is usually one week, but most human resources departments’ absence policies will allow a further period under the heading of ‘carer’ or ‘special leave’; more than this can sometimes be taken as short notice annual leave.

If an injury is sustained at work, or as a consequence of your daily work, e.g. back trouble, it is possible to obtain some degree of financial compensation from your employer. If you should end up on half pay as a consequence of such an injury, this Temporary Injury Allowance will make pay up to 80% of what you normally receive rather than 50%.

If you are attending 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 seen. Most OH reports do not go into clinical details, but are restricted to fitness to work and a time frame where possible. You are not under obligation to discuss details of your illness with all your colleagues.

Regular contact is vital and provides several things:

- **General progress reports** – it is not 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 a good time to ring is, as such conversations should not be conducted in the middle of a busy list
- **Regular review** – correspondence from OH and any other specialists, e.g. surgeons and psychiatrists, consulted during the absence can be integrated and discussed with the CD and any other line manager involved
- **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**
- **A link with colleagues and the workplace, which helps avoid the feeling of isolation and being totally estranged from work**
- **Any GMC restrictions or conditions on employment can be accommodated and integrated into the return to work plan**
- **Importantly, any possible changes in pattern of work on return can be planned well ahead**
- **If the workplace and its stresses are a significant factor in your illness, this can be discussed in order to minimise recurrent illness**
- **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:

- Ask for your home email address to be included in departmental communications and practice getting up early for at least a week before.
- 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.
- 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.
- Each employer will have rules about carrying over annual leave not taken in the previous year, frequently five days. This should be confirmed by agreement with the appropriate manager and documented. More than this can sometimes be negotiated.
- It is important that your CD and the rota master know of any conditions or voluntary undertakings from the GMC, as these should be built into and considered in the return plan, e.g. any supervision, no on-call etc.
- Following depressive illnesses, night-time medication may initially cause some morning drowsiness and it is important you are stable on these treatments. It may, for instance, require postponing commencement of on-call duties. Similarly if you can’t drive following a drink-driving offence, allowances may have to be made.

Return to work

A date for return to work should be reached after discussion with OH, your CD and rota master. A sick note specifying light duties, for instance, with a commencement date is needed, i.e. a ‘fit note’. Don’t rush back or try to bring the return date forward – the specialists looking after you know what time frames are reasonable far more than we ourselves may perceive. Nothing is to be gained from doing what you think would go down well with the department – you may be quite emotionally vulnerable for a while. Often there is a feeling of being ‘tested’ and under criticism from colleagues sharing their list with you. It is important to bring up any problems during your phased return and maybe accept that your previous sessions require some alterations.

Those first few weeks back at work:

- Go to bed early
- Don’t be surprised if it is a bit of a culture shock – it is!
- Don’t worry if, for a while, all you do is get up, go to work and get a good night’s sleep
- 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.
- Try to be positive and appropriately enthusiastic, but don’t do things because you feel you ought to.
- 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.
- Make sure any out-patient and other follow-up appointments are allowed for in your initial work plan.

Dr Ruth Mayall
AAGBI Wellbeing and Support Committee Member

Reference


General articles on addiction well worth reading


Some useful contacts for addiction problems

Practitioner Health Programme (PHP) – 0203 049 4505, http://php.nhs.uk
This is an NHS funded but entirely confidential service open to doctors and dentists (living or working in the London area only). Care is multidisciplinary in nature and provides appropriate specialist care and support for any doctor with addiction, mental or physical health concerns. Where in-patient therapy is thought necessary, this will be organised and funded by the PHP/NHS. Follow-up, monitoring and help with returning to work are also part of the services offered. Unfortunately this is currently only available to London-based doctors, but there are hopes that plans for expansion to cover other areas of the country will eventuate. Advice has been most useful and in some areas outside London can be obtained by phone. Further details on PHP services outside London can be found here.

Sick Doctors Trust (SDT) – 0370 444 5163, http://www.sick-doctors-trust.co.uk
The SDT is an independent charity established over 18 years ago, which provides a 24 hour helpline manned exclusively by experienced doctors who are in recovery from addiction themselves, and one trained counsellor. It provides help and support to doctors who think they may have a problem with their use of alcohol or other drugs, whether prescribed or not. Calls are treated with strict confidentiality, and callers may remain anonymous if they wish. Help offered includes assessment, advice, referral for treatment when appropriate and introduction to long-term befriending and support services. The helpline also accepts calls from family members or friends, concerned colleagues, PCT officers and others.

The British Doctors and Dentists Group (BDDG) – the National Secretary: 07825 107970 or via the Sick Doctors Trust helpline: 0370 444 5163, http://www.bddg.org
This is a countrywide network of doctors and dentists at various stages in their recovery from addiction, who are well again and who meet on a monthly basis at one of 18 groups covering the UK. Following initial contact, callers may be put in touch with another doctor (in some cases from the same specialty) nearer to their home who may then introduce a new doctor to the group at the local meetings.

Problems can be discussed at these meetings, which it may not be appropriate to discuss at meetings of AA or NA, for example, GMC proceedings and issues surrounding return to work etc. Doctors under the GMC for substance abuse problems will be required to attend these meetings as conditions on their practice, or as part of their stipulated undertakings. Certificates and proof of attendance can be obtained from the group secretary and given to the GMC.
There is also an associated families group, where direct relatives of addicted doctors and dentists can obtain help and support. Many of the BDDG meetings have a families group.

**Ireland**

Support in Ireland has unfortunately been rather sparse, but is improving. A Practitioner Health Programme has recently been set up and is in the early stages of operation.

NIDDG (Northern Ireland Doctors & Dentists) – John B Belfast: 07710 741169, email: drjburton@btinternet.com. He can also give limited legal advice. Dublin contact: 00 353 87 1992488

Support for family members of addicted doctors can be obtained via the Family’s Group of the BDDG http://www.bddg.org/family-group, 0207 485 5231 (London area), or 0114 230 4100 and 07714 331725 outside London.

Narcotics Anonymous is for recovering addicts who meet regularly to help each other stay clean. It is not restricted to those with opiate/narcotic abuse problems as the name may suggest, but any drug including tranquillisers, recreational drugs and alcohol. The website contains some questions and information for those who think they may have a problem.

Do you think you may have a problem? Checklists are available: http://www.na.org/admin/include/spaw2/uploads/pdf/litfiles/us_english/IP/EN3107.pdf

Calls are charged at local rate on BT lines so if you are using a mobile phone, there are cheaper landline numbers for your local office available via www.saynoto0870.com (insert the number above into the search box) which will give a local number.

Do you think you may have a problem? Checklists are available in the newcomers section: http://www.alcoholics-anonymous.org.uk

The majority of AA or NA meetings are ‘closed’ and are only for recovering addicts/alcoholics and those who think they may have a drug problem. A meeting described as ‘open’ may be attended by anyone e.g. professionals working with addicts or family members, friends etc. Meetings lists are on the AA or NA websites with details of open meetings at each venue.

**Healthcare Professionals Recovery Group (HPRG)**
These meetings are attended by doctors, dentists, nurses, pharmacists and other healthcare professionals who have addiction problems.

Currently active groups are in London (Chertsey) 01737 813921 and Oxford (contact details may be found on the AAAGBI website Support & Wellbeing page when available).

**BMA Doctors for Doctors** https://www.bma.org.uk/advice/work-life-support/your-wellbeing
This is a helpful option for mental health concerns, but is not addiction specific. It is not necessary to be a BMA member. Up to six counselling sessions are available for members or helpline support. Callers can also ask to speak to a Doctor Adviser as some of these advisers are anaesthetists. The BMA can help with some of the employment laws and issues surrounding return to work after a period of suspension or ill-health.

**Doctors’ Support Network (DSN)** – email: secretary@dsn.org.uk – or 0871 245 8376 for general enquiries

This is a group with regular meetings throughout the country for help with stress, burnout, anxiety, depression, psychoses and eating disorders. This may be helpful for addicted doctors with dual diagnosis.

**Doctors’ Support Line (DSL)** – 0844 395 3010 or 0870 765 0001, http://www.dsn.org.uk
A confidential and anonymous peer support helpline for doctors who need to talk to someone whatever their concerns. Doctors in the group have themselves been troubled at some stage in their lives, and help is offered to those who are beginning the process of re-establishing themselves after a breakdown or other mental crisis.

**SMART Recovery** – http://www.smartrecovery.org.uk
The 12-step approach of AA and NA may not appeal to everyone. SMART Recovery uses psychotherapeutic techniques that are similar to those used in many treatment services in the UK, being more along the lines of cognitive behavioural therapy. The concept started years ago, with online meetings with a facilitator, which many found helpful, and now there are many meetings ‘on land’ also, extending from Banff right down to Brighton.

**Financial help**

**Royal Medical Benevolent Fund (RMBF)** – 0208 540 9194 http://www.rmbf.org
The RMBF will send an assessor to a doctor’s home. If hardship continues after a doctor has died, long term support is often available to the doctor’s family.

The Royal Medical Foundation – 01372 821010, email: rmf-caseworker@epsomcollege.org.uk
This exists to support medical practitioners and/or their dependents who find themselves in financial difficulty.

**BMA Charities Trust Fund** – 020 7383 6142, email: info.bmacharities@bma.org.uk
This provides help to doctors with financial difficulties who are not working during life crises.
Clinical governance may be the two most overused 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 patients receive the highest possible quality of care. It covers how healthcare professionals treat 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 statutorily 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. Evidence of participation in clinical governance is an essential part of revalidation (GMC domains 2.1 and 2.2) and so should be evidenced at ARCP by trainees and at appraisal for all other doctors. Sadly more recent scandals, such as that at Mid Staffordshire, have still occurred; clinical governance is only effective when the whole organisation, up to and including Board level, is actively involved. Clinical governance is never ‘someone else’s problem’. The Francis Report into Mid Staffordshire made 290 recommendations, many to do with clinical governance.

Clinical governance exists 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, Quality Improvement Scotland, Royal Colleges, or organisations such as the AAGBI.

**Clinical audit/quality improvement**

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 are 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 of training requirements for trainees. All too often audits fail at the last hurdle – a recommendation and implementation of change, and a reassessment of the effectiveness of that change. Clinical audit is being incorporated in quality improvement programmes. This is an area where the details, priorities and processes are different for National Health Services in England, Scotland, Wales and Northern Ireland.

**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?’), while research resolves an unanswered question (‘What should everyone be doing?’). Research increases overall knowledge and seeks to discover best practice. Audit reviews current practice and compares it with best practice, stimulating change to achieve best practice.

**Education and training**

Competency-based training is delivered subject to the curricula and training rules of the various Royal Colleges, and approved by the GMC. The curriculum changes often and any doctor contemplating a change of career status should consult the most recent rules, and a colleague (usually the College Tutor) who has up to date knowledge of them.

**CPD**

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 priorities of the NHS. It is linked to appraisal, where training and development needs are agreed and personal development plans are implemented. Although many Colleges and Faculties have provided guidance on CPD, the quantity, quality and content of CPD is a matter for agreement between an appraiser and appraisee, subject to approval by the doctor’s Responsible Officer and the GMC. Membership of a College or Faculty is not a requirement for revalidation, nor is membership of a CPD scheme organised by a College or Faculty, although some doctors find them helpful. Learn@AAGBI is available free to AAGBI members to help plan and record CPD activity.

**Professional regulation**

This includes pre-employment checks of registration details, qualifications and the 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. Details of personal responsibility go beyond a single article and more information can be found on the GMC’s website.

**Risk management**

This is a process that ensures 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 experience 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, specialty specific reporting system for anaesthesia in England and Wales originally through the NPSA, incorporated in 2012 into NHS England. This does not include Scotland, Northern Ireland or the Republic of Ireland. In Scotland, the Scottish Audit of Surgical Mortality collected data that included anaesthetic considerations from 1994. This audit has now closed, although it is intended that it will eventually evolve into a structured morbidity and mortality review process for all hospital deaths.

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 staff. Useful lessons are learnt from complaints and can reduce occurrence of similar problems. Many complaints, which can be extremely costly to the NHS, arise from poor communication.

Duty of candour

All the clinical governance activities have involved healthcare staff and organisations; they have been about, but not involved, patients. Healthcare is a highly complex process and it is inevitable that things may not go well, or will even go wrong. It has long been good practice to explain and apologise to patients and/or relatives when this happens. There have unfortunately been many examples when this has not happened, and this was certainly a feature of the Francis Report which recommended the introduction of a statutory duty of candour. This statutory duty was introduced for NHS secondary care organisations in England in November 2014; failure to communicate with patients or commissioners may result in criminal sanctions. The GMC and the Nursing and Midwifery Council published joint guidance to all doctors, nurses and midwives on the professional duty of candour (to patients and employers) in 2015. Failure to follow this guidance may result in Fitness to Practise proceedings.

Dr Andrew Hartle
AAGBI Immediate Past President

Dr Ranjit Verma
RCoA Council Member

12. Medical-legal Pitfalls in Anaesthesia and How to Avoid Them

In practical terms anaesthetists may become embroiled with the law in several 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 Inquiries or GMC hearings
• Although at time of writing a case has yet to be brought to Court, anaesthetists may be required to give evidence in cases of corporate manslaughter against a Trust

While the vast majority of claims are either abandoned by the claimant or settled out of court, (see Table 1), the cost – financial and emotional – is such that it is far better to avoid such situations altogether.

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abandoned by claimant</td>
<td>41%</td>
</tr>
<tr>
<td>Settled out of court</td>
<td>42%</td>
</tr>
<tr>
<td>Settled in court (including cases)</td>
<td>4%</td>
</tr>
<tr>
<td>Outstanding</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

NHS Litigation Authority, November 2008.

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 offences, 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 responsible 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 advanced life support provider, then they will be expected to undertake adult advanced life support competently. However, inexperience is no defence if the doctor fails to manage a situation without reasonable competence.
3. A recent case has emphasised the importance of ‘the reasonable patient’ test when it comes to gaining consent. What you discuss with a patient should be guided by what a reasonable patient would consider important (rather than what a responsible group of practitioners would be likely to discuss). This brings the law in line with GMC guidance on consent.
4. 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 document and have a reason for this.
5. There must be foreseeable injury arising from the breach of duty of care. Most cases fail on the issue of causation. 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 recently been 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 a third in obstetric patients. Table 2 lists the specific events involved.

Table 2: Common clinical events associated with medical negligence claims*

<table>
<thead>
<tr>
<th>Category</th>
<th>Main clinical event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional anaesthesia</td>
<td>Nerve injury/inadequate blockade/epidural-related problems</td>
</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 neuraxial block/brief 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 respiratory</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>


The preponderance of obstetric cases and those involving regional techniques reflect a growing area of litigation – which involves 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 vs 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. Not just common complications but rare and/or serious ones should be mentioned. For example, the parturient requiring a caesarean section should not only be warned of common side-effects such as nausea/vomiting, pruritis, and motor block, but also of inadequate anaesthesia, the risk of postdural puncture headache and of neurological damage and infection. Whether an estimation of the risk is attempted is still debated. Where robust and especially local data are available, they should be referred to. However, it should be remembered that the patient is only interested in the risk of that complication occurring in your hands to that patient. Specific to obstetrics, it would always be wise to mention general anaesthesia as an option from the outset (rather than just as ‘plan B’ if things go wrong with regional anaesthesia). It is perfectly acceptable to then discuss why the preferred option is regional anaesthesia.

The use of faulty equipment and faulty use of equipment are common themes. Meticulous checking of equipment (using guidelines where they exist) and familiarising yourself with equipment you are unfamiliar with are mandatory. Injury to teeth and eyes, due to positioning or due to invasive procedures, are also common causes of claims. Thorough attention to detail and ensuring competency in 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 the patient was experiencing anxiety instead. This is hard to defend especially if there are witnesses (e.g. other healthcare professionals or the partner in obstetric cases) stating the opposite. If a patient complains of pain, it is wise to believe them and offer treatment including general anaesthesia. Poor communication between professionals can give rise to injury, especially in an emergency situation. Again obstetrics provides an example: the section for fetal compromise where the anaesthetist has not been informed of the degree of urgency. In one series, anaesthetists were either given no information (11%); or incorrect information (20%) about cases requiring the most urgent delivery and this resulted in the ‘incorrect’ anaesthetic technique on several occasions. [1]

Avoiding medico-legal outcomes:

- Practise within your limits of competence and expertise
- Adhere to guidelines and protocols unless there are good clinical reasons not to (and preferably after consultation with a colleague)
- Listen carefully to the patient and communicate clearly with other healthcare professionals
- Be a team player (you are more likely to get support if things go wrong)
- Ensure your knowledge and practice are up to date
- 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 medico-legal context, if 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 of options 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 deprecated, defensive documentation is just good sense.

Dr Felicity Plaat
AAGBI Past Honorary Membership Secretary

Reference

Recommended reading
- Cook TM, Bland L, Mihai R, Scott S. Litigation related to anaesthesia: an analysis of claims against the NHS in


13. HANDLING PATIENT COMPLAINTS AND STAYING OUT OF TROUBLE

Handling complaints

‘He who avoids complaint invites happiness’
Abu Bakr

‘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 or Independent Complaints Advocacy Service.

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 be properly investigated
• Know the outcome of any investigation into the complaint
• Take the complaint to the independent Parliamentary and Health Service Ombudsman 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 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 Chief Executive Officer are acknowledged within 48 hours and responded to properly within 25 days. Even if you are not the direct subject of a complaint, you may be involved in writing reports relating 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 under considerable time pressure while grappling with hospital bureaucracy and trying to translate medical jargon 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 where they become written complaints. Indeed, most complaints should be dealt with when they are at the stage of being both informal and verbal, and doctors 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 complaint is of a serious nature, you may wish to inform or involve your clinical manager. However, if it is of a minor nature or one you feel you can handle satisfactorily, you should arrange a meeting to discuss matters, remembering that you should not discuss the treatment of a patient with someone who is not the patient without their express (and I would advise written) permission. Make sure the patient is in a fit condition to talk about their complaint, and ensure the environment in which you meet is quiet and private. If appropriate, involve members of the nursing staff or others involved in the patient’s care. Dress appropriately, i.e. neither scrubs nor tracksuit, turn off your beep and mobile phone, don’t place a desk between you and the complainant, and have a witness to the conversation. Offer the complainant the opportunity to bring someone to the meeting with them.

Handling complaints in this setting involves a lot more listening than talking. Let the complainant describe the problems 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 escalating problems, so be patient and let them speak first. If you need more details about what happened, ask simple, open questions to ascertain the exact nature of the complaint. Once you think you have grasped the nature of the complaint, 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 relating 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 am in no way saying 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. If the patient accepts your explanations 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 appropriately. You should then take the advice of the person to whom you have referred the complaint. Whatever the outcome of the meeting, you should make accurate notes as soon 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 that seem vexatious to you can seem 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. Treat the matter as seriously and as empathetically as possible, and be scrupulously honest about any failings or mistakes. Write your report clearly and succinctly and, if mistakes were made, try to identify how they might be prevented in the future. Remember, most patients who complain want simply this: an apology, an explanation and a description of how you will stop the same thing happening to other patients.

Now go and read your hospital’s complaints policy!

**Staying out of trouble**

First of all, let me start with an ‘Alcoholics Anonymous’ style confession.

Hello, my name is William and I have been in trouble. I was once responsible for the separation of four upper incisor teeth from their lawyer owner. I once made up some flucloxacinillin 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 haulied up in front of the Chief Executive Officer of the hospital in which I was working and was accused of gross professional misconduct.

Although I openly admit to these, 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 in trouble and they will tell you that they have. They will also readily tell you that if they had they time over again, they would rather not have paid the visit. Nothing I can tell you will stop the same thing happening to you.

**Look after your patient by looking after yourself**

Although a relatively recent novitate into the motorcycling fraternity, I have already learnt some of its mantras. One of my favourites is: ‘don’t ride drunk, don’t ride tired, don’t ride hungry, don’t ride sick, and don’t ride upset.’ The principle is that riding a motorbike requires a great deal of concentration if you are going to stay on it and avoid an impromptu flying lesson that will undoubtedly end in pain and physical damage. You cannot concentrate on this important task if you are drunk, tired, hungry, 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 feel 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 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 judgements of the Fitness to Practise panel, will show you that many doctors who go off the rails ignore these simple 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 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, Specialty Doctor or 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 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 satisfy the patient and persuade them not to take any further action.

**No one’s perfect**

This follows on from the above point. No one is perfect; everyone makes mistakes. Making a mistake doesn’t usually mean you are a bad person or a bad doctor, it just means you are human. By all means make every effort to avoid mistakes, but do not let 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 proud**

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

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

Treat consent seriously

From both the ethical and legal viewpoint, the process of consent is becoming increasingly important. You are responsible for explaining what you are going to do to your patient, telling them what you hope to achieve by it, what might go wrong, and what the alternatives are. 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 Consent for Anaesthesia), but the most important precaution is to keep a record 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 off from retirement. This latter group has often failed 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 journals and keep up to date.

Communicate

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

Be nice

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 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 want to stay out of trouble: treat others as you would wish to be treated yourself – and this holds true for both your patients and those with whom you work.

Dr William Harrop-Griffiths
AAGBI Past President
RCoA Council Member

14. DIGNITY AND RESPECT IN THE WORKPLACE

If you believe you are being bullied, the chances are, you are.

A BMA survey in 2015 indicated that a significant number of SAS doctors reported being bullied at work and that this was more likely to affect black and Asian doctors and those doctors who raise concerns. The Annual GMC trainee survey also reports doctor’s experience of bullying in the workplace.

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 difficulty in defending themselves 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. Harassment is held to be discriminatory under the 2010 Equality Act. Harassment is also prohibited under the Criminal Justice and Public Order Act 1994 that means that intentional harassment is a criminal offence. Employers should have mechanisms to help employees deal with concerns as this issue is now 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 the GMC’s Good Medical Practice and could therefore 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 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. If the situation is making you unwell you may wish to access your employers Occupational Health and counselling services (these are confidential). Some employers have also 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 BMA will be able to help. Other organisations who may be able to help are signposted from the AAGBI website. Talking about what happened is never easy but is the first step in taking control of the situation.

If you feel bullied and harassed it has usually happened more than once. Is there a pattern? Keep a diary as evidence of repeated episodes of bullying and harassment. 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. 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 that you can use. If this seems like the correct way to resolve the situation then 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 they are not powerless and have choices in dealing with the situation.

Resources
- AAGBI Wellbeing and Support
- British Medical Association
- ACAS. Bullying and harassment at work: Guidance for employees

Dr Melanie Jones
Director, Medical Career Support, Past Chair of Anaesthetists in Management

15. GOOD PRACTICE GUIDANCE FOR SAS ANAESTHETISTS

In 2010, a survey of SAS doctors working as anaesthetists highlighted some concerns about aspects of their job plans and terms and conditions.

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

- Out of hours work
- Ageing doctors and residency on-call
- Minimum elective or daytime work (anaesthetic sessions)
- CPD activity (see Chapter 8)
- Career progression opportunities and criteria for pay thresholds
- Clinical governance and supervision (see Chapter 11)
- Health and welfare (see Chapter 10)

Out of hours 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 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. out of hours (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. 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 balance between work scheduled in weekday hours and that scheduled OOH should be similar for SAS doctors and consultants in the same department, and 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 Occupational Health (OH) department is appropriate. If OH recommends the SAS doctor be removed from the on-call rota for health reasons, employers must make every effort to make this possible. The AAGBI has recommended that ‘there should be a review of on-call responsibilities for anaesthetists over 55 years of age’ [1]. Special consideration should be given to SAS doctors who participate in resident on-call rotas or whose duties include attending acute emergencies and cardiac arrests – the physical demands made by these duties may become difficult for the ageing doctor.

Regular anaesthetic sessions

The job plans of many SAS doctors include a large proportion of flexible working. Although this flexibility may benefit the department in terms of service delivery, a lack of regular anaesthetic sessions does not allow anaesthetists to develop subspecialty interests and denies them the satisfaction of working as part of a regular theatre team. The balance between fixed and flexible sessions in the job plans of SAS doctors and consultants in the same department should be similar, and there 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 are involved in that it is difficult to determine criteria for thresholds. The basic principle is the ability to take independent decisions and cover for some of a consultants’ work without supervision. The NHS Employers website deals with this issue.

The Clinical/Medical Director is responsible for ensuring processes are in place to sign off the incremental progression assessment. Where one or more of the criteria are not achieved in any year, the Clinical/Medical Director, or designated person, has discretion to decide, where appropriate (for instance, because of personal illness), that the doctor should be regarded as having met the criteria for that year.

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
- 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 doctor’s control, made every reasonable effort to do so
- 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° appraisal/feedback (in the year preceding Threshold one) and for those doctors undertaking private practice, taken up any offer to undertake Additional Programme 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

Progression through Threshold Two

The criteria for passing through Threshold Two recognise 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 above
b) Doctors should be able to demonstrate an increasing ability to take decisions and carry responsibility without direct supervision
c) Doctors should also provide evidence to demonstrate their contributions to a wider role, for example, meaningful participation in or contribution to relevant:
   - Management or leadership
   - Service development and modernisation
   - Teaching and training (of others)
   - Committee work
   - Representative work
   - Innovation
   - Audit

The 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 judgement about whether a doctor has met the requirements for Threshold Two, there will not be an expectation that the doctor will be able 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 they have complied with the criteria to pass through a Threshold, this should be signed off by a Clinical Manager. The Clinical/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 [2,3].

Career progress and development

The RCoA Council recommendations on Career Development for Specialty/SAS Doctors in Anaesthesia, Critical Care and Pain Medicine deals with this issue adequately.

The SAS survey clearly indicated that SAS doctors felt there are limited or no opportunities to obtain career progress. The RCoA recommends that all the departments employing SAS doctors identify a named consultant as Educational Supervisor 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 Educational Supervisor should link with the College Tutor. There is a move towards appointing SAS Tutors in hospitals and appointment of Associate Deans in deaneries who will oversee the career development needs of the SAS doctors.

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 subspecialty interests such as obstetric anaesthesia, chronic pain and critical care. There are very limited opportunities to develop and nurture these skills. Annual appraisal should be the means by which career development needs are identified and these needs should be addressed by an appropriate personal development plan. The personal development plan can and should be a powerful way of ensuring that development needs are resourced.

Opportunities for top-up training must be available for SAS doctors to develop these specialty skills. Employers and postgraduate 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. SAS doctors who fail to reach agreement with their Clinical Managers on the details of contracts, job plans, working arrangements and terms and conditions should follow mediation and appeals processes within their hospitals and should consider seeking the support of their Local Negotiating Committee. The AAGBI recommends that all 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 time spent working and the payment for this work. All the allocations of time spent working should be discussed in job-plan meetings.

Dr Ramana Alladi  
Former AAGBI SAS Committee Chair

Dr Anthea Mowat  
Chair BMA Representative Body

Dr Paul Clyburn  
AAGBi President

References
CAREER PROGRESSION AND DEVELOPMENT
Introduction

To be a substantive consultant in the NHS in the UK, a doctor 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 Register. For the majority, entry will be through the award of the Certificate of Completion of Training (CCT) in anaesthetics (including the former versions issued on the completion of UK training). Entry is also possible following award of the Certificate of Eligibility of Specialist Registration (Combined Programmes) (CESR(CP)), to holders of a recognised European specialist qualification or by the award of the Certificate of Eligibility for Specialist Registration (CESR).

The CESR route is open to applicants who have not completed the UK training programme, completed a European programme which is not recognised by the European Union or have completed specialist training outside of the European Union. There is actually no requirement to have ‘completed’ any training programme. Many applicants will be working in the UK at SAS grade, or in similar posts, and will have undertaken some training before moving into a substantive post. The experience gained in these posts may be submitted for consideration (along with evidence from formal training) but must fulfil the equivalence requirements (discussed below) in totality if the application is to succeed. 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 that demonstrates the individual’s training and experience when considered together are equivalent to a new CCT holder.

A few words of caution. Evidence of training in the distant past (for practical terms, more than than 10 years ago) will be difficult to obtain and unlikely to remotely satisfy current training requirements. If no evidence is provided in a specific domain or against a mandatory training requirement, the application will fail, whatever the seniority or position of the applicant.

It is important to understand that obtaining a CESR enables doctors to be eligible to apply for a substantive consultant post in the UK. The consultant appointment process is a competitive process, which may not result in a successful outcome.

The spiral of learning

The spiral of learning is reflected in the curriculum by dividing it into core, intermediate, higher and advanced training.

To assess the breadth and depth of training and experience it is critical that the evidence submitted demonstrates competence in the subspecialties listed in the curriculum to the mandated level, e.g. ICU to intermediate level, cardiothoracic to higher level. It is therefore important that the application in all its component parts delivers evidence at the appropriate level. It would be expected that an application demonstrates a continuum of learning with increasing competence and responsibility, leading to readiness for independent practice.

Demonstrating equivalence

This process is a paper exercise, conducted by the GMC. The RCoA, acting as the agent of the GMC, 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 800–1000 pages. Good evidence can be characterised by its ability to provide a positive answer to the questions posed by the Good Medical Practice (GMP) sub-domains when considered against the requirements of the 2010 CCT in anaesthesics curriculum.

The GMC requires the application to be assessed against the four domains of Good Medical Practice. 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?

g) Has the applicant demonstrated that they put 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 protect 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 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 protect 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. is polite, considerate and honest with patients and has 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 colleagues and writing references, 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.

**Evidence breakdown**

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domains 2 and 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>5%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Types of evidence

The GMC defines evidence as either primary or secondary. The important thing to consider with primary evidence is that it can stand on its own. Examples of primary evidence are a logbook, case diary, logbook summary, appraisal, qualification certificates (e.g. a degree), curriculum (validated by the Institution) and CPD certificates. In all cases, evidence must be formally validated, preferably by the institution where the evidence originated from. Secondary evidence covers structured references, rotas, teaching contributions, 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 satisfied the requirements for 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 their training programme, supporting evidence from the institution where they completed the training programme and, if available, copies of assessments. A breakdown of duration of actual time spent in subspecialty training is essential to demonstrate appropriate training in all essential areas.

### 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 must 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 obtained. The age of the patient is crucial when looking for evidence of paediatric training and experience.

Logbook collation of subspecialty experience is essential to support competence equivalence and populate the evidence template for all mandated curricular requirements. However, an extensive logbook with large numbers of cases but limited to a few specialist areas will not demonstrate the breadth of experience equivalent to a UK trainee holding the CCT.

Logbooks or theatre records do not always provide evidence of caseload in intensive care and pain medicine. Caseload evidence in these subspecialties should be specifically addressed by applicants.

### Letters of support/testimonials

Letters of support from anaesthetists practising within that specialist field strengthen an application but are not sufficient alone. The letters of support should indicate the level of competencies attained, i.e. core, intermediate, higher and advanced.

More information on types of evidence is available on the RCoA and GMC websites.

### Triangulation of evidence

The triangulation of evidence is important in the assessment of equivalence. Evidence should indicate the breadth and depth of experience obtained in each unit 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 subspecialty indicating duration of training and experience, and the level of training reached

b) Logbook/electronic record and summaries of the cases undertaken indicating the age spectrum, surgical procedure, complexity and level of supervision

c) Testimonial letters from supervising consultants indicating the level of competencies reached and, in this example, relating to the higher competencies in the subspecialty of paediatrics

### Test of knowledge

All applicants have to demonstrate 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 CESR and Equivalence section which has been assessed as acceptable tests of knowledge for a CESR application. It is theoretically possible to demonstrate equivalence to the knowledge demonstrated by passing an approved examination. This has not happened to date.

### The RCoA process

When the GMC considers sufficient evidence for an assessment has been provided by the applicant, it 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.

More information on 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 specifically advised where there was inadequate evidence and what they would need to do to demonstrate equivalence. For example, if the applicant had...
failed to demonstrate higher level cardiothoracic competence, 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 2010 CCT in anaesthetics 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 2010 CCT in anaesthetics curriculum carefully to understand the mandatory training requirement
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 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 GMC domains

Aspects of the equivalence process are currently under review. The GMC is considering a number of fundamental changes including mandating a period of UK practice. In parallel with this, the GMC and RCoA are revising the application paperwork. Training evidence, particularly in Domain 1, will be mapped to the 2010 curricular requirements, with explicit advice on how these may be satisfied. A checklist for CESR application can be found in Appendix 1.

Dr Simon Fletcher
RCoA Council Member

17. THE RCoA FELLOWSHIP EXAMINATION

The Career Grade Committee at the RCoA has continued to ensure that SAS anaesthetists are able to sit the FRCA examinations with the proviso that they meet certain criteria. Indeed the RCoA wishes to encourage anaesthetists who have not become members or fellows of the RCoA to sit the examination. It consists of two parts, a Primary and a Final component, taken at different stages of your career. Success in the Primary examination is one of the key criteria to become a Member of the RCoA.

The eligibility criteria are published with the examination regulations available for download from the RCoA website (most recently published September 2016).

In order to be eligible to enter the Primary examination, the key criteria for SAS anaesthetists are:

- Hold full registration with GMC
- Be registered with the RCoA in a recognised membership category (such as Associate Member)
- Be working as a practising anaesthetist
- To be able to sit the objective structured clinical examination (OSCE) and structured oral examination (SOE), a prospective candidate needs to have been awarded an Initial Assessment of Competency (IAC). An SAS doctor who does not have an IAC may submit a satisfactory NHS appraisal at a standard equivalent to that of a deanery ARCP

To be eligible to enter the Final examinations candidates must meet the following criteria:

- Have left approved training more than five years ago
- Currently be practising anaesthesia in the UK
- Have membership status of the RCoA
- Hold a satisfactory NHS appraisal
- Have passed the Primary FRCA examination or an exempting qualification within seven years of the date of the examination sitting
- Those SAS doctors who have left approved training within the last five years are eligible to apply as former trainees

For the full conditions and explanations of the various sections of the FRCA as well as recognised exempting qualifications you are advised to read the most up-to-date regulations available from the RCoA’s website.

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

Reasons for obtaining the fellowship diploma might include:

- Personal satisfaction
- Career progression
- To facilitate becoming a Member of the RCoA after successfully passing the full Primary examination
- Entitlement to use post nominals, MRCA for members and FRCA for fellows of the RCoA
- Opportunity to stand for College Council. There are two nationally elected full council seats for SAS members and fellows
- 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 GMC Specialist Register is an essential requirement in order to apply for a consultant post.

While not a pre-requisite when teaching anaesthetic trainees, the process of studying and passing the Fellowship exam confers a good scientific and clinical basis on which to train others. Indeed, it is especially desirable when teaching post-Fellowship trainees. An 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 becoming accepted for such a prestigious role would be tremendously rewarding. As mentioned previously, the FRCA continues to be a two part examination; however there have been many changes to the regulations over the past few years. 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 OSCE
- a 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 three 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, while if both sections are failed, they must be retaken at the same sitting. A pass in the OSCE or SOE will be valid for three years, after which time if the whole examination has not been passed, the relevant section(s) must be re-taken. Candidates will now be allowed six attempts at the MCQ paper, the OSCE and the SOE.

A pass in the whole Primary FRCA examination is now valid for seven years to the date of the sitting applied for entry to the Final FRCA examination.

**Final FRCA**

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

- a written section consisting of a MCQ paper and a short answer question paper
- a SOE

Candidates must pass the written section before they can apply to sit the SOE.

A pass in the written section will be valid for three years after which time, if the whole examination has not been passed, the written section must be re-taken. Candidates are currently allowed six attempts at each section (subject to remaining eligible).

The RCoA is committed to maintaining the highest possible standards for the fellowship examination and has a rigorous quality assurance process to ensure it remains fit for purpose. The examinations review group proposed a number of changes in March 2015. These proposals for change will be required to go through a process of approval by the GMC and therefore there is as yet, no set timeline for introduction of these changes. Among the proposals will be the need for an applicant to provide a statement from their educational supervisor that they are appropriately prepared to sit the final examination having had suitable opportunity to acquire the required knowledge and additionally received adequate clinical exposure across the range of the intermediate curriculum.

In summary, the fellowship examinations continue to involve comprehensive and rigorous assessment that requires determination and intense study as well as broad clinical training across the breadth of the curriculum in order to succeed. As an SAS doctor, opportunities for training can be difficult and in part this may reflect lower pass rates for non-training grades compared to those in a deanery-approved training post. It is highly recommended you make the most of support and guidance from an educational supervisor. The award of the Fellowship of the RCoA is a justly proud achievement and has the potential to facilitate career progression.

**18. PERSONAL DEVELOPMENT PLANNING FOR SAS ANAESTHETISTS**

It is the responsibility of each individual anaesthetist to engage and complete their appraisal and revalidation. An essential component of this is the personal development plan (PDP). This is an opportunity for the individual anaesthetist to highlight areas they want to develop within their specialty and job plan, for the mutual benefit of themselves, their departments and their patients. In addition, the PDP allows the individual anaesthetist to develop within their specialty and team to meet their needs as well as that of their department and their patients. In conclusion, a PDP begins with reflection and is mutually agreed.

The RCoA PDP guidelines for SAS doctors state ‘All career grade doctors have CEPD and PDP requirements and should have equal access to protected time, funding and study leave for these activities’.

Peter Hutton, RCoA President, March 2003

All anaesthetists should maintain a personal portfolio containing evidence in support of their CPD within their appraisal folder. Ideally this is done electronically so as to allow ease of access for their appraiser. Responsible Medical Officer and the GMC. The CPD matrix allows you to quantify the level of CPD training. For example, CPD matrix 1 covers the core skills required by all anaesthetists, and CPD matrix 3 covers more specialised advanced areas such as regional blocks etc.

Therefore, when embarking on personal development planning at the appraisal meeting, particular areas for future training can be discussed. These should be mutually agreed. The CPD matrix framework can be used to plan this proposed training and the level of training that is required. Specific training areas that need to be developed are set out clearly for completion within an agreed timescale.

The PDP should be used proactively within the appraisal process to develop special interests and requirements for your job plan. It is essential to be realistic when planning and it is better to develop slowly and have achievable goals so that on annual review at appraisal you can demonstrate progress. If done well, a PDP should empower the individual anaesthetist to develop within their specialty and team to meet their needs as well as that of your department and their patients. In addition, the PDP allows the appraiser to feedback progress achieved and, if required, areas to develop. The annual cycle of personal development planning is completed at the appraisal meeting with feedback and the next year’s PDP is discussed and agreed (Figure 1).

In a good PDP there is an opportunity to explore self-improvement and allow possible changes in direction if desired, providing it still meets the needs of the department and patients and, importantly, is mutually agreed.

To conclude, a PDP begins with reflection and is mutually agreed within the appraisal process to allow the anaesthetist to develop perspectives in their career pathway and allow growth or changes as required. This must be done in order to complete appraisal and revalidation. A PDP has to be supported and adequately resourced. Any areas of weakness need to be sensitively highlighted and supported positively and confidentially.

Dr Emma Stiby
Associate Specialist in Anaesthesia

Dr Olivera Potparic
AAGBI SAS Committee Chair

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**Figure 1 Annual cycle of personal development planning**

In a good PDP there is an opportunity to explore self-improvement and allow possible changes in direction if desired, providing it still meets the needs of the department and patients and, importantly, is mutually agreed.

To conclude, a PDP begins with reflection and is mutually agreed within the appraisal process to allow the anaesthetist to develop perspectives in their career pathway and allow growth or changes as required. This must be done in order to complete appraisal and revalidation. A PDP has to be supported and adequately resourced. Any areas of weakness need to be sensitively highlighted and supported positively and confidentially.

Dr Roger Laishley
Former RCoA SAS Council Member

**Dr Olivera Potparic**
AAGBI SAS Committee Chair
Clinical audit is an indispensable part of every healthcare professional’s career. Everyone (trainee, SAS or consultant) gets asked about it at interviews, assessments (Annual Review of Clinical Progress), appraisal and revalidation.

This chapter aims to clear the mist around ‘clinical audit’ and to provide practical and useful tips on how to do a successful audit. We have avoided giving specific examples, which are best left to your own practice, circumstances and preferences.

In August 2014, the RCoA recommended demonstrating active engagement in completing at least one audit cycle once in five years. If audit is not possible, other ways of demonstrating quality improvement activity should be undertaken [1]. All doctors are expected to produce such evidence of clinical audit and review of clinical outcomes. Audit and other quality improvement activity should reflect the breadth of professional work. Depending on the size of the department, one or two audits should be undertaken per year based on the topics selected from the RCoA audit recipe book. This RCoA guidance is based on the GMC document, which is the work done by the Academy of Medical Royal Colleges.

Almost everything we do in our daily practice (procedures, pathway, drug administration etc.) has certain set standards. These are described by the Royal Colleges, Department of Health or in peer reviewed literature. Occasionally there may not be set standards but there are certain expectations or guidelines. Sometimes, the standard can be derived from overseas work. In its most simplified form, clinical audit is comparing current/your 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 practice meets or exceeds the standards, then only periodic re-audit is required to ensure that the standards are consistent. An effort can be and should be made to exceed the standards. If this happens consistently, then the standards may have to change
  - If the practice falls short of standards, then deficiencies have to be identified, specific time bound recommendations made and the changes have to be implemented
- Re-auditing to make sure the outcomes have improved
- Continue re-audit to ensure the standards are continually met
- This process of implementing change and re-audit is also known as completing the audit loop/cycle
- Presentation 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

It must be emphasised that audit is not research. Research answers the question: ‘What is a good practice?’ whereas audit answers: ‘Is our practice good or not?’ A research project requires ethics committee approval and an audit project does not. However, an audit needs to be registered with the local clinical governance committee. This ensures a centralised record of all the projects and helps avoid duplication. It also provides ideas for re-audit where previously a change was introduced, thus completing the audit cycle.

The following are the possible steps of an audit project. They may appear somewhat comprehensive but are borne out of experience.

1. Decide a topic/project: a good audit is one which is relevant to your own practice and one that can be completed and presented. Topics requiring access to clinical notes often get delayed. Do not take up a new project if you already have other incomplete projects!

   **Topics for audit can be found:**
   - in the RCoA audit recipe book
   - in local audit committee records
   - as ideas from literature/meetings
   - by talking to colleagues/seniors

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 and get on as a co-author! A supervisor (sometimes more than one) should also be identified at this stage. This could be you. Some projects can be done single-handedly and you can get credit for all the work.

3. Distribute the workload. Each member’s role must be clearly defined. This is even more relevant if you are doing a multicentre or multispecialty audit.

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 local clinical governance unit. Usually the forms are available on the Trust intranet. It is also good practice to send a copy of the same to the departmental audit lead.

6. Data collection. Is your audit going to be retrospective (looking back at what has happened in the past) or are you going to collect data prospectively (at the time care is delivered)? In reality, this does not matter much to the eventual outcome. These two phrases are more relevant in research than audit.

   - Prepare a data collection form
   - This can be in paper format where a form is completed and then, for each data set, the findings transferred to a spreadsheet
   - 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 shared spreadsheet is very convenient
   - Always keep multiple backup copies of the data
   - Make sure there is no patient identifiable information on your devices and that you are strictly complying with the local data protection regulations/IT governance

**Surveys**

An 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 one side of A4 paper. Remember, we all hate completing surveys. 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 setup online surveys by using websites like SurveyMonkey. 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 need multivariate analysis. This is often the stumbling block. Most NHS Trusts have decommissioned their statisticians to save costs. Private statisticians are known to charge around £1,500–£2,000.
- If your Trust still has a statistician, they may expect to be included as an author on the poster/paper. If you anticipate the need for such help, talk to one at very early stage. They can give you an idea about how many cases are required to make the project statistically robust.
- At this stage, do not forget the very basic 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 an audit poster competition? (the AAGBI runs this annually)
  - 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?
- If this project is finished, get on with the next one.

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. A good audit is one that is relevant to your practice and one that can be completed and presented. As a rough guide, do not aim for more than 1–2 projects per year, but this will vary depending on the complexity of the topic, level of your involvement and most importantly, your ability in terms of time commitment.

Dr Smita Oswal
AAGBI SAS Committee Member

(with contributions from Dilip Oswal, Consultant Radiologist, Mid Yorkshire NHS Trust. He was a member of the Audit Committee of the Royal College of Radiologists, 2008–2010)

Reference

20. HOW TO CONDUCT A QUALITY IMPROVEMENT PROJECT

‘Every system is perfectly designed to get the results it gets, the only way to get real change is to change the system; to do this you need will, ideas and execution.’

- You must have the will to make the system better – this may be because you have identified poor performance or outcome through audit or patient experience
- You must have ideas about how you could change things for the better
- You must have skills to make it happen – execution

Paul Batalden, Institute for Healthcare Improvement

What is quality improvement?
Quality improvement is by no means a new concept. However, it is a concept which is currently being, and will continue to be, embraced within anaesthesia. Continuous quality improvement methodologies focus on making improvements in outcomes. This is in contrast to audit, where making a change is one of the key cornerstones in the audit cycle, regardless of whether there has been any real improvement in outcome. Although, within quality improvement changes are often made, these are less important than the improvement itself [1].

The RCoA recognises this shift away from audit towards quality improvement, such that the concept of improvement was introduced in the latest edition of Raising the Standard: a compendium of audit recipes for continuous quality improvement in anaesthesia.

Improvement science and models for improvement
Similar to the well-recognised audit cycle as a model of the process, several models exist for continuous quality improvement. However, it is imperative to remember that models only provide a structured approach to facilitate improvement. The most commonly quoted model is the Model for Improvement which was developed by Associates in Process Improvement. Part of the model uses a simple ‘Plan-Do-Study-Act’ (PDSA) cycle. This cycle is analogous to a rapid-cycle audit. You begin with a short cycle of data collection, then analyse the data looking specifically for immediate flaws and obstacles. Changes which may involve structures or processes can then be made before repeating the cycle. Larger quantities of data are collected by repeating the PDSA cycle numerous times. These small, frequent samples allow more proactive changes to be made regularly until improvement in outcome is attained.

A comprehensive description of improvement science and models for improvement are beyond the scope of this chapter. However, the Institute for Healthcare Improvement website and the RCoA’s Raising the Standard provide valuable resources for those interested.

How to get involved in a quality improvement project
Similar to a clinical audit you may decide to get involved in an ongoing quality improvement project within your department, or start a new project.

When thinking of a new topic, try to choose an area that has been identified as being a problem within the department, poses a risk to patient safety, or where processes are inefficient and waste resources. Also, choose a topic area where you as an anaesthetist can have the most influence. It may be helpful to discuss your project with a more experienced colleague who may be able to help drive the needed change.
Unlike an audit, the key to a quality improvement project is an understanding that each project is unique to the hospital it takes place within, and that what works well in one hospital may not in another.

The most important factors in success of your quality improvement project are your perseverance, motivation, commitment and ownership of the project. Although the PDSA cycle requires organisation and resources, the improvement in outcome should lead to the sustained success and ultimate longevity of the project.

Satinder Dalay
ST5 Anaesthetics, Birmingham School of Anaesthesia
GAT Committee Elected Member

Reference

21. 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 idea

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

The question

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

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 retrospective? The latter is weaker as 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

Many a good idea has to be abandoned because the study is just impractical in that setting. For example, anything involving extensive data collection by other parties (e.g. ward nurses, midwives) 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. Every study has easy bits but at least one 'painful' bit will drive you mad – this may be collecting the data, taking the samples, doing the follow-ups, etc. You have to be realistic about being able to complete the study before starting, since giving up halfway through is a waste of everyone's time.

The numbers

This isn’t the place for an account of statistical methods but it’s worth considering a few basic questions. The first is ‘How many participants?’, and for a comparison study, 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 questions, such as 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 guidance from someone who has done it before. In general, studies require ethical approval, hospital R&D approval, directorate/department approval, and possibly MHRA approval, depending on the type of study. Funding requirements add another layer of paperwork.

Prof Steve Yentis
AAGBI Vice President

22. 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 you should first give careful consideration as to which journal you intend to submit to; take advice from experienced colleagues on this question. Also ask yourself who is the intended audience for your paper? Is it for a broad church of anaesthetists (think Anaesthesia, British Journal of Anaesthesia or European Journal of Anaesthesiology), or only of interest to a small subspecialty group (either an anaesthetic subspecialty 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 BMJ or Lancet)?
Once you’ve chosen the journal, read it, get an idea of its style and layout and, most important of all, carefully read the journal’s guidance for authors. Then... read the guidance for authors again and keep a copy handy to consult frequently during writing; it should become worn and dog-eared by the end.

Although acceptance of your paper will depend on its scientific value, it is helpful to make a good impression with reviewers. A poorly written paper with careless typos, misspellings and a disregard of the guidance for authors will leave a bad impression on reviewers. A sloppily written paper will suggest the study has been carelessly conducted, lowering its scientific value.

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 the paper easier to read.

Now it’s down to the writing. Start with the Introduction, which should have three clear messages: what is already known about the subject, what 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 to repeat your study. If someone has described part of the methodology before, you do not need to repeat the description but clearly reference it. Include at the end a succinct but accurate description of the statistical methods you used for your analysis. Where relevant, you should include enough detail of your power analysis to allow the reader to confirm how you arrive at your sample size.

Clarity is essential in the Results section. Use clear group names (e.g. group morphine and group fentanyl rather than groups A and B or groups M and F). Make sure 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). Most journals reproduce images in black and 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 believing that a long discussion is more impressive. You should consider what your results mean, how they fit in with existing knowledge, and if they don’t fit then why. It is important to be up-front and point out the flaws in your study as no study is perfect and it is better to 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, reinforcing the main findings and suggesting areas for future research.

Inserting references should be straightforward, especially if you’ve been entering the results of your literature search into Reference Manager or Endnote, which should allow you to format the references correctly for any journal with the click of a mouse. Don’t feel you have to use every reference in your search; keep to those that are directly relevant to your paper and discussion.

Finally, think of a simple, accurate title (avoid newspaper headline style titles) and write the Abstract using a structured or unstructured format as prescribed by the journal. Your Abstract 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 have 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 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 one 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. Use these comments to revise your paper and prepare for submission elsewhere, but only after you’ve carefully read the new journal’s guidance for authors!

Dr Paul Clyburn
AAGBI President

23. PENSIONS AND FINANCIAL PLANNING

This chapter covers a number of topics that are often at the top of the FAQ list. However, it is recommended that when considering your individual situation you should take financial advice as this section only gives a flavour of the issues.

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

There are various types of financial advice currently available. There are two types of financial adviser; those representing one organisation (thus acting on behalf of their company/bank), and an independent financial adviser, able to draw on the entire market (thus acting on behalf of their client). The distinction between the two and benefits of the latter has increased even further as part of regulatory changes imposed by the Financial Services Authority that took effect in 2013.

It is said that doctors tend to favour an independent adviser who works on a fee basis rather than those advisers being remunerated by commission. The fee basis ensures you are paying to receive independent, professional and impartial advice, not the sale 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? Professional independent financial advisers are able to create bespoke financial planning solutions that are right for your individual circumstances.

Pensions – your exit strategy

The NHS pension scheme changed as of 1 April 2015 when a new pension scheme was introduced. Approximately 75% of existing NHS employees and all new employees will have joined the 2015 NHS pension scheme (2015 NHSPS). The 2015 NHSPS provides career average related earnings (CARE) benefits for all doctors, and is no longer a final salary scheme.
Will you have to join the new scheme?

- Some members will not have to join the 2015 NHSPS because they have full protection. This means that they were within 10 years of their normal pension age on 1 April 2012.
- Others, who were between 10 and 13.5 years of their normal pension age on 1 April 2012, will get tapering protection. This means that they will still have to join the 2015 NHSPS but their joining date will be delayed, depending on how close to their normal pension age they were on 1 April 2012.
- Members who were more than 13.5 years away from their normal pension age on 1 April 2012 will join the 2015 scheme.

The 2015 NHSPS differs in many ways to the previous sections of the NHSPS. The previous NHSPS had two sections: the 1995 and 2008 sections, which provided final salary benefits for doctors working in secondary care. The new Scheme was introduced on 1 April 2015 and is called the NHS Pension Scheme 2015. The 1995 section has a normal pension age (NPA) of 60. This means that at age 60 doctors can draw their pension and lump sum benefits at an unreduced rate. In the 2008 section the NPA is 65. However the 2015 Scheme NPA will be linked to an individual’s state pension age (SPA). Benefits drawn prior to NPA are usually subject to an actuarial reduction because they are being paid earlier than anticipated and for longer.

Career average revalued earnings

CARE pension schemes differ from final salary in that they take account of pensionable earnings in every year of scheme membership rather than just prior to retirement. The accrual rate in the 2015 NHSPS will be 1/54 (equivalent to 1.85%), this means that every year a member will accrue 1/54 of their pensionable earnings. The total of all the annual pension accrual amounts is added together at retirement to calculate the final pension.

When basing pension accrual on lifetime earnings, it is necessary to have in place a mechanism for revaluing previous years’ earnings so that they do not lose value. In the 2015 NHSPS the revaluation rate will be the Consumer Prices Index (CPI) plus 1.5%.

An example:

- Let’s say you earn £75,000 in pensionable income this year and the CPI rate is 3%.
- Your pension would be $75,000 * (1 + 3%) = £78,750.

- Every year the total of the previous years’ pension accrual would be increased by the relevant rate for that year.

The NHS pension still remains an enormously valuable asset.

Those who wish to make contributions over and above the NHS pension have typically invested additional funds into personal pensions, benefitting 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 an individual may have in tax allowable pension savings in his or her lifetime. Now limited to £1.25 million, the rules state that benefits in excess of this LTA amount can be taxed up to 55%, which is a punitive rate. It is likely to be reduced to £1 million in 2016, as announced in the 2015 budget statement. For many SAS doctors this will not represent a threat until later in their career, but whatever your circumstances you should take professional advice in respect to your retirement/pension planning as using the correct strategy in the beginning makes a big difference in the end. Expert advice is needed regarding this.

Financial protection – what do I need?

Thankfully the NHS offers some good in-house benefits. If you die while you are 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 enhanced pension.

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

The first choice is often income protection, tailored around your NHS sick pay scheme. This ensures that if you were still unwell enough to work once the NHS sick pay runs out, you would receive an ongoing income until 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 inability to perform your normal duties due to ill health, critical illness cover pays a one-off tax-free lump sum on the diagnosis of one or more ‘critical illnesses’. However, 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 have debts and/or mortgage liabilities greater than the death-in-service lump sum mentioned above, you should take out life cover to ensure these are repaid if you die. You will need more still if you have a family, and there are a number of specialist types of life cover that are suitable for this function.

Finally, make a will – especially if you have a family. While you might think that when you die 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 Anthea Mowat
Chair BMA Representative Body

24. LEADERSHIP AND MANAGEMENT

GMC guidance [1] reminds us that ‘Being a good doctor means more than simply being a good clinician.’ We all work in multidisciplinary teams where we have a duty to work with others, including managers, to ensure that the services patients receive are safe, effective and efficient. The GMC requires us to ‘be competent in all aspects of your work, including management’ [2]. To do this well, all doctors (consultants, Associate Specialists, Staff Grade and Trust doctors, and trainees) will benefit from developing leadership and management skills.
The Medical Leadership Competence Framework [3] describes five general areas (domains) in which doctors need to be competent. These are

- Demonstrating personal qualities
- Working with others
- Managing services
- Improving services
- Setting direction

The extent to which each doctor uses these skills in daily work varies. However, for a service to be effective there must be a shared sense of responsibility for the success of the organisation and its services. Leadership is everyone's business; it is not restricted to people who hold designated leadership roles. This chapter will concentrate on the first three areas of the Medical Leadership Competence Framework.

**Demonstrating personal qualities – managing oneself**

**Self-awareness**

To be effective, we must first understand our own values and principles and what motivates us to do a good job [4]. We should also know what our strengths and weaknesses are and what is likely to ‘derail’ us.

There are a number of ways in which we can develop our own self-awareness. Feedback from colleagues can be very useful, as can attendance at leadership development courses and use of self-assessment tools. A number of suitable questionnaires are available. One widely used and well-researched example is the Myers-Briggs Type Indicator [5], a psychometric questionnaire designed to identify preferences in how people perceive the world and what information they use to make decisions.

**Self-management**

We should demonstrate our core values in everything we do at work, always behaving in an open and ethical manner as a positive role model [4]. Whatever our level of seniority, our behaviour should always be empathic and show appropriate humility. We should encourage and respect the contribution of others and have the moral courage to do what is right, challenging when the system does not seem to work to the benefit of our patients and colleagues.

Doing this is not always easy. Paying attention to how we behave comes more naturally to some than others, but these skills can be learned and developed.

**Resilience**

Resilience is the ability to recover from setbacks, adapt well to change, and keep going in the face of adversity [6]. Training can help people to become more resilient by focusing on the practicalities of addressing problems and on managing their emotional response to events. There is currently an emphasis on training doctors to become more resilient. Factors that contribute to resilience include self-confidence, optimism, a strong sense of purpose and being good at judging when to (and when not to) seek support from managers and colleagues [7]. However, an individual's ability to be resilient depends on their work environment and the organisational culture as well as on the person [8].

Resilience training can cover a wide variety of topics. These might include how to recognise and control your feelings, ways of tolerating ambiguity, being good at defining boundaries, and problem-solving strategies. Problem-focused coping refers to dealing with characteristics of the situation while emotion-focused coping involves dealing with the feelings provoked by the situation. Sometimes it is not possible to control events; all that can be done is to manage your emotional response. This aspect of resilience training might draw on positive psychology used in cognitive behavioural therapy, to help identify positive ways of thinking and challenge negative thought patterns, or cover techniques of ‘mindfulness’, which focuses attention and awareness on the present moment.

**Time management**

Doctors have busy lives and it is important to balance work commitments with responsibilities outside work, including family and time for themselves. There are many books and courses on time management. It is possible to learn to work ‘smarter’ rather than longer, getting the right balance between planning, doing and interacting with others. Jobs can be divided into:

- Urgent tasks (your priority/others priority)
- Important tasks (important to you/to others)
- Active jobs (which will not get done unless you do them)
- Reactive tasks (which you do with others)

There is a temptation to postpone active jobs and just do the reactive ones. Good time managers put time aside to get important tasks done and spend time appropriate to the job’s importance. They allow enough time for everyday jobs (writing up notes, opening post) and leave time to think, and for the unexpected. Some important tasks are very big, and may be easier to achieve by splitting them up into smaller parts.

**Working with others**

To be effective, leaders and managers need to work with others. It is important to build and maintain good relationships both within the teams in which we normally work, and in the wider hospital network. It is increasingly recognised that people who work collaboratively with networks of colleagues are able to achieve significant change, in a more relaxed way than happens in a formal management hierarchy. Leadership is not only exercised when the leader is in a position of authority. We can also lead ‘across’ to other teams, using ‘expert power’, and we can lead ‘up’, getting more senior people to do tasks for us. How we do this, our ‘leadership style’ will influence how effective we are. Whatever our position in the hierarchy it is important to be able to use a number of different leadership styles.

**Leadership styles**

Daniel Goleman [9], who studied many leaders in the public and private sector, noticed that the leaders who are really successful all have something he describes as emotional intelligence. This is much more important than intellectual intelligence in terms of success. There are three self-management skills, Self-awareness, Self-regulation and Motivation, and two components that others notice, Empathy and Social Skill. Goleman went on to define several different styles of leadership. These are:

1. Affiliative
2. Participative
3. Coaching
4. Visionary
5. Directive
6. Pacesetting

AFFILIATIVE leaders emphasise good personal relationships and strive to achieve harmony. People who are happy and feel their contribution is respected, tend to be more productive. This style is useful when tasks are routine. It can be useful in managing conflict.

The PARTICIPATIVE (Democratic) style builds commitment and consensus among employees. The leader listens to everyone and encourages everybody to have an input into discussion, so decisions result from a group consensus. Because of this, staff are more realistic about what is possible. This style fosters responsibility, flexibility and high morale. Once trust has been
Delegation

Good delegates achieve more and are appreciated by the teams in which they work. People delegate tasks for many reasons; to free up time, to use others’ expertise, to develop others’ skills, to encourage open communication, trust, creativity, initiative, and to make sure a task is seen as a team success and not that of an individual.

The first thing to decide is which tasks to delegate and to whom. It is sometimes worth asking ‘Why do I have to do the task?’ Jobs can be delegated to more junior people, peers and seniors. Questions to consider include ‘Who is better at it than you?’ and ‘Who will learn from it?’ Before someone else takes on a task, be sure to explain why you have selected them, explain the task, the background and context, answer their questions and, if needed, train them to do what is required.

When you have delegated a task, be available to support and advise the person who has taken it on, show interest, monitor their progress, and praise success. If matters are not going well, help the person to resolve difficulties or offer to take the job back.

Negotiating skills and conflict resolution

All teams have to face challenges and manage conflicts from outside and from within the team. Eighty percent of conflict is caused by misunderstanding, in which people have different knowledge or interpretations of ‘facts’, different assumptions, different individual perspectives, strong feelings or a difference between their intent and impact. There are several perceptions of what the problem is and how to resolve the matter.

Training in negotiating skills assists us to become more effective at resolving matters, both during formal conflict resolution (for example a formal disagreement about job planning) and in day-to-day negotiations with colleagues (over leave, rota, lists etc). Before entering a negotiation it is useful to work out what you are prepared to trade and what you might expect to receive in return, and your break point (the point at which you will walk away from a situation leaving it unresolved).

Skilled negotiators [12] demonstrate they appreciate others have valid perspectives that are distinct from their own views. They seek information from different people involved in a situation, and test their understanding of what they are told by paraphrasing and summarising the other person’s perspective. They put their strongest argument first and do not dilute it. They often offer a feelings commentary, describing what they feel about a situation. A negotiator might say, ‘I am worried that this approach has some serious disadvantages. It would be helpful to review why we feel so differently about…’

Skilled negotiators also use behaviour labelling, describing what they are going to do, or what they notice the other person doing. The skilled negotiator might say ‘I am going to ask you a question’, or ‘I notice that you have raised your voice and folded your arms.’
Less skilled negotiators might put immediate counter proposals, instead of demonstrating that they have heard and understood the other person’s views. They use ‘irritators’ (phrases such as ‘When you’ve been here as long as me…’), argument dilution or defend/attack spirals. Argument dilution refers to giving several different reasons at once to back up their position. Weak arguments generally dilute strong arguments. Skilled negotiators start with their strongest argument and only add others if they need to. In a negotiation, a skilled person will use about half the number of arguments than a less skilled negotiator.

Dealing with colleagues in difficulty
There are many reasons why colleagues might seem ‘difficult’ and it is important that the appropriate person explores the underlying causes with the struggling colleague and acts appropriately. Colleagues in difficulty sometimes choose to speak in confidence to another team member whom they trust, rather than to approach ‘management’. If this is you, start by listening carefully to what the person says, helping them to summarise and potentially to identify an aspect that they might be able to change. It is rarely useful to give advice on the matter being raised; helping the struggling colleague to identify where they might best go for support is of more use. If the colleague might be unwell, a confidential appointment with the consultant occupational physician can be a useful starting point. Stresses caused by life events outside the work environment, such as family or financial difficulties, and psychological and physical health problems, may present as ‘difficult behaviour’. Other difficulties arise from failure to keep abreast of best practice. The remedy must address the underlying problem and assist the colleague to get back on track. The advice of senior medical managers should be sought.

Managing services
Managing the services in which we work so that they deliver high quality care to patients requires planning, managing resources, managing people, managing performance, and designing and delivering improvements to services. All of us are involved in this; sometimes as part of a theatre team and sometimes in the wider trust.

Business planning and business cases
The work of an organisation is aligned with the requirements placed on it by commissioners of healthcare (which are in turn aligned with Government priorities) through the business planning process [13]. Each year, an organisation sets out its plan for achieving its targets, prioritising its work and service developments of the plan. Each directorate and department will contribute its part and this is one way doctors can influence service development. The effectiveness of the directorate and its medical and non-medical managers will be judged against the priorities and targets laid out in the business plan.

Business cases, which are the means by which the need for service developments/new equipment, etc. are costed and appraised, are more likely to find support if they are allied to the business plan. An organisation’s business plan is usually available to all (often on the intranet) and it is worth scanning it to appraise, are more likely to find support if they are allied to the business plan. An organisation’s business plan is usually available to all (often on the intranet) and it is worth scanning it to

Financial management
While it is not necessary to understand health service finances 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 differs in each devolved healthcare system so it is worthwhile asking the Clinical Director or approach the directorate’s Finance Officer for advice.

Formal training in management
As well as the informal ways of acquiring management skills, most employers and many deaneries run management courses. Some relate to a specific skill, e.g. appraiser training, while others are more general. Outside the hospital there are development programmes run by the NHS Institute for Innovation and Improvement, The King’s Fund and others. The AAGBI and the RCoA run leadership programmes.

Dr Nancy Redfern AAGBI Honorary Membership Secretary

References
Executive summary

Associate Deans in England are instrumental to the training and development of SAS doctors and, where appointed, oversee the allocation of development funding at a regional Health Education England (HEE) level, via Local Education and Training Boards (LETBs) that were established under the Health and Social Care Act. As the SAS representative to LETBs, Associate Deans should work with local SAS doctors to identify and recommend priorities for SAS development and lead on their delivery.

Development funding

The Department of Health made £12 million of funding available 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 funding and contract implementation funding. HEE no longer provide specific funding for SAS doctors and dentists, but there is an expectation that LETBs will consider continuing SAS funding to employing bodies. This funding, commonly referred to as development funding (when provided), is allocated to Trusts.

Each Trust should seek agreement with its SAS doctors in regard to the priorities for the distribution, allocation of funding and the monitoring, reporting and audit thereof. Such agreement may be via the Trust’s SAS representatives or Local Negotiating Committee (LNC) where there is no separate SAS representative body.

There is currently some equivalent funding in Scotland and a programme of SAS development in Wales. There is no such funding in Northern Ireland and the BMA continues to lobby for devolved nations to have access to development funding.

HEE, LETBs and Associate Deans, SAS tutors and Clinical Leads

LETBs are responsible for the management and delivery of postgraduate medical education and for the CPD of all doctors and dentists. There are 14 deaneries in England, 1 in Northern Ireland, 1 in Wales and 4 in Scotland. Further information about the UK deaneries can be found here.

SAS doctors have SAS specific representation in regional HEEs 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).

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 Staff, Associate Specialists and Specialty Doctors Committee (SASC) have 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 ideally be a BMA 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 Adviser): This is an educational role for a SAS doctor who oversees educational placements, arranges tutorials, lectures etc. They could be known as an SAS Lead for Professional Development or Professional Development manager for SAS, etc. This person should independently manage the local SAS development budget and usually have an educational background with line management through the Director of Medical Education (DME) or Postgraduate Director. The SAS Educational Adviser should liaise closely with the SAS Representative and Associate Dean (where appropriate) but, where possible, should not be the same person. The SAS Educational Adviser 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 not be feasible everywhere and some Educational Advisers do perform the role of SAS Representative) but the above is an indication of what the BMA would suggest for the majority of situations.

**Person specification for an SAS Tutor (Educational Adviser)**

To aid employers in the appointment of SAS Tutors (Educational Adviser), the BMA SASC has devised a person specification and advice for a SAS Tutor. The specification 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. 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 a 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

**Facilitating access to training for SAS doctors**

SAS grade doctors need improved access to training in order to further develop 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 cover gaps in the service caused by maternity/fellowship or career breaks). Associate Deans with a remit to assist SAS doctors in their development may be able to advise on local opportunities. A key part of their function should be in spotting gaps and offering training to SAS doctors who could fill these gaps. These secondments can be invaluable for those that require top up training (either as recommended by the GMC after a CESR application or for more general development of skills).

Dr Anthea Mowat
Chair BMA Representative Body

26. 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 postgraduate 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 while 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 subspecialty to have enough confidence to practise.

However, I believe 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 subspecialty that figures prominently and has scope in the department already. There is no point having knowledge of a specialty in which no consultant in the department has expertise. For example, I have knowledge of acupuncture, neuro-linguistic programming, hypnosis and other techniques used in chronic pain, and yet I was not able to practise any of these skills for some time. It was only possible when a consultant interested in chronic pain was appointed. It was frustrating. It is most important to have the full support of consultants in the department. It is also essential to keep in touch with current trends by studying appropriate literature and attending update courses. The best way to do this is to join the appropriate professional association and specialist society, and attend regular symposia, refresher courses and conferences organised by them. I find that meeting colleagues in this way helps one to compare notes and develop good contacts.

One might show commitment by getting involved in some aspect of research and taking part in a project. It is also useful to carry out an audit to assess some aspects of your work and performance. This can be incorporated into one's personal developmental plan. Regularly teaching colleagues, trainee doctors, general practitioners, medical students and nurses is another way to keep in touch and encourage and inspire others in the specialty. Organise presentations and lectures in the hospital. An anaesthetist has a wide range of subspecialist interests available to pursue. We are very fortunate in that each of these is represented by a specialist society, many affiliated to the AAGBI, which holds recognised courses and meetings.

Dr Ramana Alladi
Former AAGBI SAS Committee Chair
**APPENDIX 1**

**CHECKLIST FOR CESR APPLICATION**

**Note:** This list is not a conclusive list but an aid. Provision of the evidence below does not guarantee the success of an application.

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**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

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

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

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