Association of Anaesthetists of Great Britain and Ireland (AAGBI),
Group of Anaesthetists in Training (GAT)

Comments on document: Approaches to medical education and training

Thank you for the opportunity to attend and present oral evidence on behalf of the AAGBI Group of Anaesthetists in Training. We have now had the opportunity to look at the document "Approaches to medical education and training" and share this with Council of the AAGBI and the GAT Committee and would like to add the following comments to our evidence.

Caring for patients

There are some valid comments made here that we agree with. In terms of more care occurring in the community we can envisage that in the future chronic pain services and some pre-operative assessment could be provided in the community by anaesthetists. During our oral evidence session we discussed the wider role that anaesthetists and critical care physicians have within the hospital, co-ordinating outreach services and supporting other specialties caring for acutely unwell patients. We discussed that there may be an opportunity for developing further the role of anaesthetists as perioperative physicians. Although this would not be attractive to all anaesthetists many consider that we are in an excellent position to have a more managerial role planning patients perioperative pathways (e.g. from pre-op assessment in the community, admission and surgery, through to enhanced recovery and discharge) and co-ordinating the specialties providing this care. Some however have reservations that this viewpoint is put forward by anaesthetists who have followed a previous training system with much more experience of acute medical specialties as opposed to current trainees who may have started anaesthetic training immediately following foundation training. These trainees may be less well equipped to deal with the complexities of the patient with multiple co-morbidities presenting for surgery.

Education, training and development

We agree that doctors should be prepared to take on management, leadership and education roles and therefore they should receive the relevant training, continuing professional development and mentoring to support this.

More flexibility within training is supported. All anaesthetists who had experienced other specialties prior to commencing anaesthetic training, and who responded to our survey, felt this was useful in gaining relevant experience and also having time to decide on specialisation.

The document states that education and training should be based on the demonstration of capabilities and not just time based. However time based training is required to cover rotas and so that trainees can plan their lives, knowing where they will be placed and for how long. There should be a model developed where true competency based training can evolve in harmony with service commitments.

Implementation

In our view a very important consideration when it comes to implementing changes to training is that these should be piloted so that doctors do not feel like guinea pigs in an untried training programme. Doctors who are taking part in the pilots should have the ability to comment and suggest improvements and the programme should be altered in response (a work in progress). The outcome of pilots should be publicised before wholesale change is introduced.

It is important that the needs of those providing training are also understood and planned for.

Possible approaches to medical education and training (diagrams A, B and C)

Most found these diagrams quite difficult to interpret despite the accompanying text and it was difficult to see how a craft based specialty as anaesthesia would fit in to any of the models.

Approach A: Training more generalists

Doctors moving into general training from foundation training: this may have something to recommend it for those unsure of their career aspirations. A survey of anaesthetic trainees revealed that all those who had commenced training prior to MMC and had spent time in other acute specialties (mostly emergency medicine and medicine) invariably found this useful, both in gaining experience but also in time to make career decisions. Those who have trained via ACCS felt there was a lot to recommend this 3 year programme compared to 2 years of core training. Only a small minority of trainees felt that additional general training may delay and prolong training unnecessarily. Some trainees were uncertain as to the benefits of general training in addition to foundation training believing that the foundation years are supposed to equip trainees with the competencies necessary to manage medical emergencies. It is only when there is an expectation that a doctor in training will take responsibility for a patient that trainees' experiential learning really develops. More time spent as the junior in general training, rotating round several teams, but not truly socialised into the specialty, may not achieve the improved level of skills that this model aims to develop. We therefore feel it would be important that any additional general training was relevant to future career specialisation.

A certificate of generalist training awarded after 4 to 6 years, allowing a doctor to then work independently within a supported environment is unlikely to work within anaesthesia. The current 7 year training programme is required to train an anaesthetist to work independently with only limited subspecialisation. Anaesthesia is a skill and therefore like any skill takes around 10 000 hours of practice to feel sufficiently competent to manage what presents. Unlike medicine and surgery all anaesthetists deal with undifferentiated patients and the seemingly fit can suffer, for example unpredictable catastrophic haemorrhage. Patients expect their care to be delivered by someone trained and competent to manage this.

Following completion of generalist training, this model allows some subspecialisation via credentialing. This is similar to current practice for anaesthetists who undertake post CCT training in subspecialty areas e.g. cardiothoracic anaesthesia. Having this training pre-CCT might be helpful in ensuring that all Deaneries offer such opportunities. There is currently a 'post-code lottery' with some schools encouraging Out of Programme Experiences and others unable to support this because of under-recruitment. These opportunities would be based on patient and service needs.

Although difficult to predict workforce needs, the ageing population and ability to perform ever more complex surgery would suggest that the need for trained anaesthetists is likely to increase. One study demonstrated a 50% increase in the anaesthetic workload of a teaching hospital, while ICNARC data on ICU requirements suggests a significant increase over the next 17 years.

Since each option also allows for a certain number (small?) of run-through posts, will these be exceptionally competitive and attract the best people? Or will these people be at a disadvantage when it comes to consultant posts after CCT? There is a danger that this split will make some trainees more attractive than others at the end of their training. Trainees with generalist training may be concerned that employers will regard them as having no clear career path despite training for up to 8 years.

It would seem appropriate for most trainees wishing to follow a career in anaesthesia to enter specialty training directly. One possible improvement to our current training programme would be for all to enter a three year ACCS type programme following foundation and prior to speciality training. This would allow some flexibility between acute specialities, some further general training and longer to plan for and sit professional exams.

Consolidated period between training

Although there could be seen to be some merit in this with reduction of hours following implementation of the EWTR, we would share concern that this may produce a group of doctors who are neither trained nor in training.

Approach B: Training specialists with more generalist capabilities.

This was seen by most as most similar to the current training of anaesthetists. Again it states that only a small number of trainees would enter specialty training directly. This is therefore unlikely to provide the number of anaesthetists likely to be required to treat an ageing population with increasingly complex medical conditions.

Approach C: Credentialing

If the certificate of generalist training is placed at the current CCT then the subspecialisation via credentialing would be similar to post CCT training e.g. for pain, cardiothoracic, neuroanaesthesia etc.

The possibility of trainees having to travel more is unlikely to be popular. Many anaesthetic trainees have young families therefore it is important that these decisions don't discriminate against those with dependents.

Again there is mention here of training being entirely competency based and not time based. This would require arrangements to be put in place for trainees to move on at different times without serious detriment to service. This is achievable, only, in the context of a consultant delivered service.

There was concern that this approach would only add to the amount of paperwork required of trainees. It would also require a lot of forward planning to ensure the right number of people attain the correct credentials for workforce needs. It could also lead to a situation where there is no defined end to the training period.

Other approaches

The USA approach

This describes a system based on hyper-specialisation. In anaesthesia this might be costly. For example a paediatric patient cared for in this system requiring a neurosurgical procedure would require both a paediatric and a neurosurgical anaesthetist. Each and every anaesthetist should be trained to manage the range of patients likely to present to a district general hospital.

The German Approach

In anaesthesia this would be almost universally unpopular. A previous survey of AAGBI trainee and new consultant membership based on the Centre for Workforce intelligence scenarios showed that trainees would be unwilling to work within a graded career structure where there was no guarantee of progression. This survey revealed that morale was very low, with 2% of respondents either having left the country or with specific arrangements in place to leave. Many others considered that this uncertainty would make medicine a poor career choice. It is our view that we disenfranchise the next generation at our peril. It is the best doctors who will leave – those who innovate and plan.

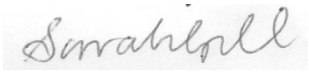
Train healthcare professionals together as a whole

Educational data suggests that there are disadvantages in not being socialised into the roles of the medical profession. Different professional groups within the healthcare system may manage unwell patients in differing ways. For example, nurses will follow a protocol and ask for help while doctors are trained to take action.

Finally, we feel it is important not to underestimate the impact on current trainees of making further changes to training. These people were caught up in MTAS and are naturally suspicious that ideas are not fully thought out before implementation. As they stand, the models presented by the SoTR give insufficient detail for the average trainee to understand fully. For anaesthesia, what would be needed is a clear statement as to where the CCT would be placed and of what is meant by 'general training'.

We have evidence that trainees have left the NHS permanently to work abroad in part as a result of the Centre for Workforce Intelligence's documents on the future of the consultant role. We are concerned that further loss of trainees in a specialty that is currently finding it difficult to recruit may lead to insufficient numbers of anaesthetists to meet the needs of an ageing population. Hence it is vital to describe the detail of the plans in each specialty, and the way in which the SoTR intends to implement.

We look forward to reading the final report of the review in the autumn.



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Vice-Chair GAT Committee

On behalf of the AAGBI GAT Committee