

# Working as an Anaesthetic Trainee in the **Private Sector**

The Royal College Of Anaesthetists emphasises that trainees need to be trained in research methodology and participate in a project, a full audit cycle or a published systematic review. Rotations with short modules and European Working Time Directive constraints make this almost impossible for most trainees.

I am an anaesthetic trainee in the London Deanery and have worked

mainly at Barts and The London NHS Trust. I found it hard to complete an audit, let alone start a research project during the modular training of my second year of registrar training. Whilst I was familiar with the theory of study design and methodology, I knew little about the logistics of performing research. I wanted to gain some experience in conducting and presenting research. I applied for a Research Fellow post within our School of Anaesthesia which includes salaried by work within the private sector. I accepted the post to achieve experience in research and I had not really considered that much would be gained from exposure to anaesthetic practice in the private sector.

Before I took up the post, private medicine was a mysterious and largely unknown entity to me. The only previous experience I had of it had been as a relative of a patient. At the time, I was suitably impressed by the environment, the efficiency of the ward and the gourmet food!

## The Clinical Side

I had a formal induction on the intensive care unit, which included the layout, the location of essential equipment such as the cardiac arrest trolley, the case mix and the referral pathways for patients needing critical care. The majority of the patients were planned post-operative admissions. The remainder were referrals from the wards, a large proportion being oncology patients as the private hospital had a busy oncology unit.

Working in the private sector as a trainee has many similarities and differences to working in the NHS. Surprisingly, there is a similar workload in terms of case mix and intensity of work, with 960 admissions a year to the 11-bedded critical care unit. I have learned a huge deal about managing certain cases that I have not yet come across in my anaesthetic training within the NHS, such as liver transplants. I have had access to new equipment and drugs and gained experience using them. I used the LiMON liver function monitor in the post operative care of hepatectomy patients, cardiac function monitors included the PiCCO, LidCO and the oesophageal Doppler, sugamadex and levosimendan were available to use and radiological investigations, ECHOs, insertion of PiCC lines are all done the same day as requested and often without having to plead your case.

The differences between NHS and Private practice vary from being very subtle to the glaringly obvious. In terms of critical care cover, there was the ITU Fellow (my post), the consultant and often an outreach sister. There were daily ward rounds, sometimes twice a day. You could be fairly isolated some of the time, as you may not necessarily meet other trainees working in the hospital. The ward cover was variable in terms of the experience and training of the doctors. During the day, there were two oncology fellows, a general Resident Medical Officer (RMO) and often a surgical and neurosurgical fellow. Overnight, it was just the RMO and the CCU Fellow (my post), which sometimes heralded a busy night! Some of the doctors in similar research posts to myself, others are career grade doctors permanently based in the private sector. Similarly, nursing staff are either permanent or agency staff with varying levels of experience. Patients who are 'becoming ill' get a variable level of care depending on the experience of the ward doctors and nurses. There is a critical care outreach service that is instrumental in facilitating timely intensive care intervention.

The shifts are 24 hours or 48 hours at a time if you choose to do 48 hours. I found 24-hour shifts difficult. I had not done them since my house jobs and was used to 12-hour shifts and then some rest. The intensity of work was unpredictable during the day and the nights were often busy. The elective theatre cases might not be admitted to the intensive

care unit till midnight. Generally, these cases were fairly straightforward and needed routine postoperative care. However, some required more intensive management and time. Pacing myself during the shift, prioritising the workload, eating well and taking breaks when possible ensured continued sanity and good health. Food was provided for us during the 24 hour shift, although not always of the same quality as for the patients!

I had slightly less autonomy than would have been the case in the NHS. The named consultants for patients were directly involved in patient care and could be prescriptive about their treatment. I did not always agree with their decisions! The converse was also true. I was occasionally asked to do something with which I was not entirely comfortable. In these cases, I found it best to follow one's instincts. If I wouldn't normally do that procedure or particular treatment, I didn't feel obliged to do it. Discussion with the covering intensive care consultant was helpful and they were usually very supportive of you.

A large percentage of patients were foreign nationals. This poses challenges in terms of language, communication, and understanding cultural beliefs and manners. The patients may be considered for any treatment, which may or may not work. There is a different paradigm to the NHS. On the converse, is this a flaw of the NHS, in which better, albeit more costly treatments may not be considered? I initially found this difficult to understand. A strategy which I found helpful was to discuss the case with the intensive care consultants and a mentor. It helped me gain perspective on the situation and deal with my preconceptions.

### The Practicalities

On a practical note, if you are planning to do a similar post, you need to do a few things before you start. Make sure you inform your medical defence organisation as your subscription may change. Check the contract thoroughly, especially your annual and study leave allocation. If you are

planning a pregnancy, check if your contract covers maternity or paternity leave.

For the research post to count towards your training, it must be covered by the same arrangements for study leave and supervision that apply to trainees in PMETB approved posts. The regulations regarding research posts have changed recently, and you will need approval from both The Royal College of Anaesthetists and PMETB. Ensure that your life support courses are in date, especially Advanced Life Support and Advanced Paediatric Life Support. You may be the only person on the resuscitation team who is trained and up to date.

It is important to check who will pay your salary. If it is paid directly by the private hospital, you will lose your superannuation for the duration of the post. If your salary is paid via your NHS trust, you can maintain your superannuation and your pension contributions. My salary was comparable to what I earned in the NHS, but I was not able to contribute to my NHS pension. You will need to be cleared by the Occupational Health Department of the hospital you are about to start at, and they may have slightly different requirements than your previous trust.

I was primarily responsible to the academic department in my school of anaesthesia for the research side of the post. The on call commitment was solely in the private sector, and consisted of six to seven 24-hour shifts per month covering the intensive care unit. The working week would consist of 1-2 24 hour shifts and research commitments on the other days. I was expected to go in to fulfill my research commitments at the end of a 24 hour shift if it was not too busy.

When considering such a post it is worth thinking about what you want to gain from the post, and whether the post will be compatible with your research commitments. Do you want quiet on calls (may not be possible depending on where you work!) so that you can write up your research? If you were doing lab-based, hypothesis-generating work, this is possible to continue whilst doing this post. If you were doing a busy clinical research post in which you had to

be in at 7am to recruit patients after a busy night on call, this may be difficult. If you are considering doing a part-time MD or PhD, you may need to be 'super-doctor' to fulfill your clinical duties, academic commitments and on calls whilst doing such a post. It may be more appropriate to do such a post in your last year of writing up your thesis.

I was assessed during my research post by my research supervisors, and subject to the same assessment requirements as other trainees in our school of anaesthesia. I kept a comprehensive logbook of all the cases I was involved in. I was also assessed by the intensive care consultants in the private sector, and had regular feedback about my progress. Six months of the post counted towards my training, approved by the RCOA and PMETB. Upon completion of the post, I had to submit my assessments and OOPPE report to the RCOA to gain final approval and my updated CCST date.

On the whole, the experience has been fantastic. The intensive care unit I worked in was very supportive, friendly and forward thinking. I have learned a huge amount, not only clinical management, but people skills, managing difficult colleagues and being assertive. I was apprehensive at first, but I am glad that I did it. As trainees, we don't often see private healthcare till we become consultants (even then, we may not!). This post has given me a valuable and informative insight into it.

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### References

The CCT in Anaesthetics IV: Competency Based Higher and Advanced Level (Years 5, 6 and 7) Training and Assessment. RCoA, April 2009 ([www.rcoa.ac.uk/docs/CCTptiv.pdf](http://www.rcoa.ac.uk/docs/CCTptiv.pdf)).

A National Strategy for Academic Anaesthesia ([www.niaa.org.uk/docs/Academic\\_full.pdf](http://www.niaa.org.uk/docs/Academic_full.pdf))

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