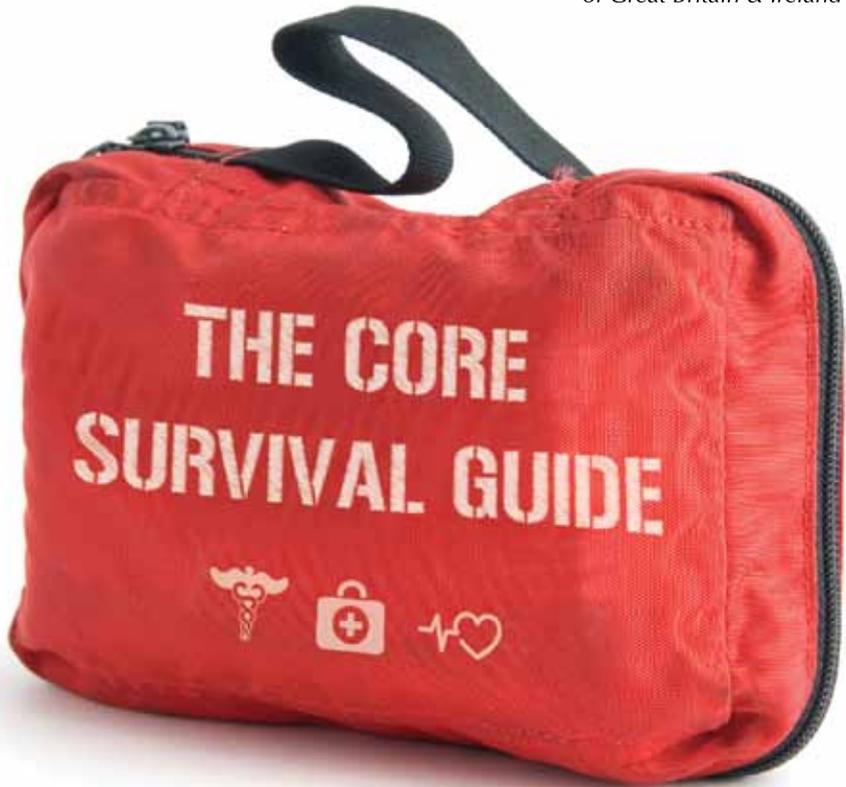




**THE ASSOCIATION OF ANAESTHETISTS**  
of Great Britain & Ireland



*Practical advice from the GAT Committee  
on surviving the first two years as an anaesthetic trainee*

Editor: Dr E H Shewry  
GAT Committee  
AAGBI

October 2009

# Welcome

## *to the first edition of the Core Survival Guide*

I hope this new GAT guide is a useful and enjoyable read. Starting a new specialty can be difficult, so I hope this booklet will answer some of your questions and help you through those first few weeks and months. Postgraduate medical training has changed continuously as this guide has been developed; please let us know if there are any top tips we've missed and we'll aim to add them to the next edition!

Finally, good luck in your new career and enjoy it!



**Liz Shewry**

*Editor  
Vice Chair,  
GAT Committee*

### Acknowledgements

The GAT Committee would like to thank the Medical Protection Society for its generous contribution towards the cost of this publication.

We also wish to thank Dr Nevil Hutchinson for his contribution in producing the original SHO Survival Guide.

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*Disclaimer: The GAT Committee emphasises that this booklet is intended as an introduction to the specialty and the advice provided must be interpreted as guidance. We acknowledge that the rapid changes in postgraduate medical training means that although we have ensured that the guidance in this booklet is applicable and up to date, it may soon need revision. Please use the links for the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland to augment the information provided in this booklet.*

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## Foreword

The GAT Committee has produced the Core Survival Guide as a replacement to the previous 'SHO Survival Guide' – a booklet that most of us found invaluable during our initial training years. Its aim is to help you through those first two years of 'Core Training', as you progress from standing around feeling like a spare part to being able to 'fly solo' and eventually pass the Primary FRCA exam and obtain an ST3 post. It contains many 'top tips' to make life just that little bit easier, and also lists the many benefits of membership of the AAGBI. This update has evolved during the many changes to the structure of medical training over the last two years, but as always these things have a tendency to move quickly and change seems almost continuous. We recommend that in addition to utilising this guide you also visit our web pages at [www.aagbi.org/gat.htm](http://www.aagbi.org/gat.htm).

Hard copies of this booklet are being distributed to anaesthetic departments and it is available online at [www.aagbi.org/gat/publications.htm](http://www.aagbi.org/gat/publications.htm).

I would like to thank our Vice Chair, Dr Liz Shewry, for all her hard work in leading this project, the authors who have contributed articles to this booklet, the GAT Committee for their help with the editing process and the staff at Portland Place for all their help and support.



**Dr Felicity Howard**  
**GAT Committee Chair**



## Introduction

Anaesthetics has traditionally been a specialty which junior doctors entered after two to three years of postgraduate training. The broad clinical base developed in those pre-anaesthetic years has always been a great fallback to help meet the challenging demands of the specialty. However, the ongoing changes in postgraduate medical training mean that the majority of junior doctors are now entering anaesthetics directly following the Foundation Programme. This means that appropriate support and guidance are even more important to ensure the welfare and success of future anaesthetic consultants.

The Group of Anaesthetists in Training (GAT) Committee is formed of elected representatives from the anaesthetists in training in the United Kingdom. We have produced this booklet as an introduction to the specialty, aimed at the early training years, and hope you may gain from some of our personal experiences. This guide starts from day one and leads to obtaining a ST3 post. We hope it will provide some useful pointers and be an interesting read at the same time.

## The Association of Anaesthetists of Great Britain & Ireland and the Group of Anaesthetists in Training

The **Association of Anaesthetists of Great Britain & Ireland (AAGBI)** was established in 1932 *‘to promote the development of anaesthesia; to coordinate the activities of anaesthesia; to represent anaesthetists and their interests; and to encourage friendship among anaesthetists’*. It was responsible for the development of the Faculty of Anaesthetists of the Royal College of Surgeons in 1948. This led ultimately to the formation of the separate College of Anaesthetists, which received its Royal Charter in 1992.

Trainee anaesthetists were first permitted to become associate members of the AAGBI in 1956, but they had no representation or voting rights. The **Group of Anaesthetists in Training (GAT)** was established as the Associates in Training Group in 1967 and was the first single-specialty trainee representative body in the country. In 1971 it became the Junior Anaesthetists Group, before changing its name to GAT in 1991. The membership of GAT continues to grow year on year and currently stands at over 3900, accounting for approximately one-third of the Association’s membership. GAT is the only elected body that represents trainees in anaesthetics at a national level. All trainee members of the AAGBI

are automatically members of GAT, and all members of GAT are given the opportunity to nominate and vote for members of the GAT Committee.

Besides organising the GAT Annual Scientific Meeting (ASM), the Committee represents trainees’ views on Working Parties, Committees and Councils of the Association and the Royal College of Anaesthetists. GAT is also represented at meetings held by the Postgraduate Medical Education and Training Board (PMETB), the British Medical Association (BMA) and the Department of Health (DoH). Our role at these meetings is to represent the views of anaesthetic trainees and to pass information back to GAT members. The GAT Committee runs a number of seminars aimed primarily at trainees, such as the Consultant Interview Seminar. These are continuously evolving to meet trainees’ needs. We also hold the flagship ASM at a different location within the UK each summer. Other GAT publications include: ‘The GAT Handbook’ (9<sup>th</sup> Edition), the GAT ‘Organising a Year Abroad’ handbook and ‘Your Career in Anaesthesia’ (for medical students and FY trainees).

Further information can be found at [www.aagbi.org/gat.htm](http://www.aagbi.org/gat.htm).



**THE ASSOCIATION OF ANAESTHETISTS**  
of Great Britain & Ireland

## JOIN THE ASSOCIATION OF ANAESTHETISTS AND YOU'LL BE IN GOOD COMPANY

**10,000 members are already benefiting from the Association's unique membership package:**

- Personal injury and life insurance cover of up to £1 million for patient transfer
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- Special rates for scientific meetings
- Priority booking and special rates for seminars at Portland Place
- Free advice and information
- Free information handbooks for trainees & SAS Grade Doctors
- Representation at Westminster and the DoH
- New AAGBI website with up-to-date news on the Association and anaesthesia
- Private members' forum hosted by Doctors.net
- Opportunities to apply for grants and awards
- 20% discount on textbooks from Oxford University Press and Wiley-Blackwell Publishing
- AAGBI subscription is on the HMRC approved list of professional organisations for tax relief

**For further details please refer to the application form at the centre of this guide.**

**Or contact:**

*Membership Department, Association of Anaesthetists of Great Britain & Ireland  
21 Portland Place, London, W1B 1PY  
t: 020 7631 8801  
e: [members@aagbi.org](mailto:members@aagbi.org)*

## The Royal College of Anaesthetists

The Royal College of Anaesthetists (RCoA) is the professional body responsible for the specialty of anaesthetics throughout the United Kingdom. The Royal Charter gives the RCoA responsibility for ensuring excellence in anaesthesia, critical care and pain management through setting and maintaining standards of patient care. In addition to safeguarding excellence in clinical care, the responsibilities of the RCoA include the maintenance of standards of postgraduate training, governing examinations and the ongoing continuing medical education and professional development of all doctors working within anaesthesia, pain management and intensive care. Their website is: [www.rcoa.ac.uk](http://www.rcoa.ac.uk).

The RCoA Tutors ('College Tutors') are trainers who represent the RCoA and ensure that training is properly organised, occurs when time-tabled and is accessible to the trainees. The College Tutors act as the organisers and co-ordinators of training. The delivery of high quality training requires contributions from all consultants but the College Tutors are the prime points of contact for the trainees with the RCoA.

All UK training hospitals are contained within schools of anaesthesia. Within each school an anaesthetist is appointed as a Programme Director - this is a

deanery appointment - and another as Regional Advisor, a RCoA appointment. The Programme Director organises rotations to ensure exposure to all appropriate anaesthetic specialities. The Regional Advisor ensures that standards of anaesthetic training are maintained, and represents the policies and views of the college.

Finally, we recommend that you register with the RCoA as soon as possible. Failure to register means you are unable to apply for the FRCA examination.

### Preparing for the first day as an anaesthetist

Anaesthetics can be an extremely challenging specialty for any trainee. With this in mind, there are some simple things you can do to ease yourself into this new environment.

Your new hospital should provide you with an induction pack before you start and it is perfectly reasonable to ask for one if you have not received it. This will give you an idea of the structure of the department and hospital. The month before you start is a good time to contact the College Tutor, the rota co-ordinator and the 'novice' trainees in the anaesthetic department. The best person to contact to arrange a time for this visit is the anaesthetic department

co-ordinator or secretary. It always helps to befriend them and get them 'on your side', as they can make your life easy, or difficult, depending on your attitude. Although you should be shown around on your induction day, if you time a pre-visit correctly, you may be able to spend time talking to the current incumbent in your position.

### **The first day...**

Your first one or two days are for 'induction' into the Trust and the Department.

### **Trust induction**

Trusts require all new staff to undergo a hospital induction. This may be in the form of lectures or it may be available online. Some Trusts expect trainees to complete online modules before their first day. There are also other competencies that you are obliged to complete yearly, such as manual handling, fire safety and child protection. You may be expected to attend a Basic Life Support update. In addition, you will need to:

- Obtain a security / ID card and a parking permit when given the chance as the opening times are often limited. This may require having your photo taken.
- Deliver all your personal details to Human Resources and Payroll including payslips, GMC Certificate, P45 / P60. Take the originals along yourself and ask them to photocopy

them whilst you wait so you can take the originals away again. If they get lost you will have to pay for replacements and the chances are the Trust will not be forthcoming to reimburse you for this.

- Attend Occupational Health bringing a 'smart card' if available and evidence of up-to-date vaccination status.
- Submit signatures for pharmacy and pathology.
- Visit the IT department for hospital login / passwords and to access email and lab results.
- You may need to attend specific training sessions to access online radiology.
- Register with the data controller before you start an electronic logbook. (Chapter 6)

### **Departmental induction: some suggested aims**

**Staff** - Find out who the following individuals are: College Tutor, Rota Co-ordinator, Clinical Lead / Director, Educational Supervisor.

**RCoA Tutor** - Every department with trainees has at least one College Tutor, who is responsible for overseeing training according to the guidelines laid out in the various training documents. The College Tutor may also act as your Educational Supervisor or you may be allocated a separate consultant to undertake this.

## **Educational Supervisors** - An

Educational Supervisor is defined by PMETB as *'a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specific trainee's educational progress .....The educational supervisor is responsible for the trainee's educational agreement.'*

You will need a signed educational agreement to obtain study leave. Their role is to help plan your training and reach your personal objectives. You should arrange to meet them to formulate an educational plan, preferably within the first two weeks. As a novice you will follow a set route, but if this is a subsequent post then you should have already considered how your training should progress. Most departments have a series of three to four meetings / appraisals per post, so at the end of your first meeting you should make plans for the next. It is important to keep a signed record of each meeting. They can assist you with finding and starting a logbook, joining the RCoA and understanding the workplace assessments that you are required to undertake. Most of this information can be found on the RCoA website, but your educational supervisors may be better able to help you locate it. It is worth considering the appropriate time for you to undertake the Primary FRCA examination early, as options are now more limited

**Study leave** - Make sure you are aware how the annual and study leave application processes work. Most departments have rules about

how many trainees of each grade can be away at one time and keep a log of current bookings that allows you to determine availability. It is important to keep a record of study leave taken in a Portfolio or Continuing Professional Development (CPD) diary as this information may be required at appraisals and at the Annual Review of Competence Progression (ARCP).

**Annual leave** - Planning annual leave can be very frustrating as a first-come-first-served system invariably operates. Check whether the department requires prospective cover as if so, you must swap any on-calls within your leave period.

**Meetings** - Obtain lists of departmental audit, morbidity and mortality meetings, journal clubs and teaching sessions / tutorials.

**Lockers** - As an anaesthetist you will spend most of your working time in theatre scrubs. Obtaining a locker is vital and you should also be issued with 'theatre shoes'. Be prepared to stand your ground on this one, and put your name on the waiting list if required. Take a padlock/combination lock along on your first day in case this is required

**Access codes** - Obtain access codes to changing rooms and for other doors that are locked out of hours.

**Theatre lists** - Discover how to access theatre lists, whether via email, electronically or paper, e.g. theatre reception/secretaries office.

**Equipment competencies** - You may be required to undergo training to ensure safe use of equipment such as IV, PCA and epidural pumps, and anaesthetic machines. These will need to be signed off and a copy kept in your portfolio.

**Computers** - Each department will provide computer access to the internet, including the GAT website at [www.aagbi.org/gat.htm](http://www.aagbi.org/gat.htm). Find out how to do this, so you can keep yourself up to date by visiting the website regularly. The AAGBI has recently introduced online accounts for members to allow them access to specialist facilities such as *Anaesthesia*. Signing up with Oxford Journals will permit free access to the *British Journal of Anaesthesia* (BJA) and its educational supplement (CEACCP).

**Medical indemnity** - Trainees are often unsure of the differences between Crown Indemnity provided by the NHS Trust and the cover that medical defence organisations offer. Whereas Crown Indemnity may cover you for negligence claims incurred during your work in the Trust, the defence organisations will actually support you by representing your interests at Fatal Accident Inquiries, Coroners' Inquests and GMC hearings. The GAT Committee consider it essential to maintain personal medical indemnity cover with a medical defence organisation. The AAGBI will insure members against death and personal injury for up to £1 million when involved in patient transfers. This level of cover is not provided by the majority of medical defence organisations or by the NHS.

Finally most trainees remember feeling exhausted during their first few weeks of anaesthetic training, so you won't be alone if you do too!

### Induction: orientation

During induction there are certain places and things that you should be made aware of. Here is a checklist:

<b>The hospital</b>
• Canteen facilities and opening times
• Library – times and access
• Parking
• Accommodation
• ID page and access
• Hospital facilities, e.g. sports centre
• Occupational health department
• Doctors' Mess
<b>Anaesthetic department</b>
• On-call room
• Administrative staff
• Rota
• Access codes and telephone numbers
• Annual and study leave
• College tutor
• Educational Supervisor / Mentor
<b>Theatres</b>
• Department protocols
• Changing room
• Recovery
• Difficult airway trolley
• Paediatric trolley
• Arrest trolley
• Dantrolene – treatment for malignant hyperthermia
• Intralipid – treatment for LA toxicity

## Other departments

- Day surgery units
- Radiology
- Obstetrics
- Emergency department
- Intensive care unit
- Remote theatres - eye, ECT, angiography suite

## Health and safety

As an anaesthetist patient safety is paramount. However it is equally important to ensure your own.

- Whatever your normal practise, it is vital to become accustomed to wearing gloves for every patient contact. Anaesthetics has a high incidence of exposure to patient saliva and blood. For certain procedures a full aseptic technique is also required, including a mask, hat, gloves and gown.
- If you suffer a needle stick injury it is important to follow Trust protocol. This may require attending occupational health department or the emergency department out of hours.
- Working in theatre involves transferring patients. Attending a manual handling course will help protect you during these manoeuvres.
- It is important to look after your mental, as well as physical wellbeing. Training in anaesthetics, as with all specialties, can be stressful at times. Please see Chapter 15 on how to obtain support and advice.

## Portfolio and logbook

The RCoA states that *'at the commencement of Core Training the trainee should create a Personal Training Record or portfolio into which he/she places all documentation relevant to training, including details of assessments completed.'*

It is vital to keep detailed documentation of your training using a training portfolio. The aim of the portfolio is to provide factual data of the training and the professional development exercises undertaken. This will ensure that you have all the required information for your formal record of assessment and achievement with your educational supervisor both at the start of and end of the post.

It should contain the following as a minimum:

- Up-to-date CV
- Up-to-date logbook summary as per RCoA recommendations
- All workplace assessments / DOPS / MiniCEXs / CBDs.
- Appraisals and signed Educational Agreements
- Training certificates and certificates of attendance at meetings / conferences
- Record of audits / surveys / research or other ongoing projects
- Summaries of MSF (Multi-Source Feedbacks)

The portfolio will also help you to

summarise your training, assessment and achievements before starting formal training in anaesthetics. The RCoA provides an example of a portfolio, the ***Appraisal Portfolio for Anaesthetists in Training in the NHS*** which is available to download on its website.

You should read the RCoA publications, ‘**The CCT in Anaesthesia I: General Principles**’ and, ‘**The CCT in Anaesthesia II: Competency Based Basic Level Training**’ at the start of your post. Both of these are available at [www.rcoa.ac.uk](http://www.rcoa.ac.uk). Knowing what is expected of you places you in the best position to formulate a career plan with your Educational Supervisor. The conflict between service provision and training can be fierce, and as a trainee you must be prepared to act if your training requirements are not met. If you are unaware of the requirements you may discover the shortcomings of your training too late. Novice anaesthetists will tend to follow a specified path, details of which are given in Chapter 7.

### **Logbooks**

An up-to-date logbook is an essential requirement for the portfolio as it provides the evidence of training exercises undertaken. This should include all cases in whose anaesthetic care you were actively involved. The logbooks will provide a detailed summary of the cases, level of supervision, procedures undertaken

(central lines, arterial lines, regional anaesthesia) and the experience gained.

The link: <http://rcoa.ac.uk/index.asp?PageID=968> lists the electronic logbooks that are supported by the college. They include programmes that are compatible with commonly available IT platforms, including Windows, Macintosh, handhelds and netbooks.

The logbook is a vital part of both the appraisal and assessment processes. Keeping up to date with entries is the only way of maintaining a correct logbook. Once all the data are entered, the logbook programme allows you to produce summaries and reports (Diagram 1). No identifying information should be kept within this record, e.g. hospital number or date of birth. Trainees should be aware that if taken off the Trust premises, such electronic documentation renders them liable under the Data Protection Act. You are advised to register as Data Controllers with the Data Commissioner’s Office if this applies to you. The cost of this registration is an annual notification fee, which will be a lot less than a fine.

# Royal College of Anaesthetists

Record of Training  
Sample Report  
ST Years 1 & 2

Period 09/08/07 to 28/08/09  
Random Hosp NHS Trust

Number of Cases	Total	%	Supervised	Solo	Teacher	<6m	6m-3y	3-7y	7-80y	>80yrs
Cardiothoracic	0	0%	0	0	0	0	0	0	0	0
Dental	46	6%	40	6	0	0	0	12	34	0
ENT	42	5%	37	5	0	0	3	8	30	1
General	234	29%	127	107	0	2	1	5	189	37
Gynae	100	12%	23	77	0	0	0	0	98	2
ITU	0	0%	0	0	0	0	0	0	0	0
Maxillo-facial	10	1%	9	1	0	0	2	2	6	0
Misc	29	4%	6	23	0	0	0	0	25	4
Neuro	0	0%	0	0	0	0	0	0	0	0
Obstetrics	112	14%	20	92	0	0	0	0	110	2
Ophthalmics	10	1%	9	1	0	0	0	0	3	7
Orthopaedics	108	13%	17	91	0	1	0	0	98	9
Pain	2	0%	2	0	0	0	0	0	2	0
Plastics	1	0%	1	0	0	0	0	0	1	0
Psych	2	0%	2	0	0	0	0	0	2	0
Radiology	0	0%	0	0	0	0	0	0	0	0
Trauma	37	5%	13	24	0	1	0	2	24	10
Urology	41	5%	15	26	0	0	0	0	36	5
Vascular	31	4%	12	19	0	0	0	0	26	5
<b>Totals</b>	805		333	472	0	4	6	29	684	82

ASA (No of Cases)			Age Criteria (No of Cases)	
ASA	Total	Solo	Age Group	
1	489	281	<6 mths	4
2	212	175	6mths-3yrs	6
3	79	13	3-7yrs	29
4	23	2	7-80yrs	684
5	2	1	>80yrs	82

Hours of Work (No of Cases)		Priority (No of Cases)	
0800-1800	601	Scheduled	578
1800-0000	164	Urgent	188
0000-0800	40	Emergency	3

Diagram 1: This is an example of an anaesthetic logbook summary, demonstrating the variety of information that can be stored.

The current training programme, overseen by the RCoA, *'is a competency-based, supervised, continuously evaluated and tightly regulated programme, with the potential for tailoring to suit individual requirements and interests'*. The recommended minimum duration of training is seven years: two years of Basic Level training (CT1 and 2); two years of intermediate level training (ST 3 and 4); and three years of advanced level training (ST 5-7). The actual duration of training is not fixed to seven years, but will depend on the individual needs and the rate at which the competencies are achieved. The aim of such a programme is to produce anaesthetists of high quality.

## **Core (Basic) Level Training**

### **Overview**

Basic level training for anaesthetists consists of two years training including a minimum of 21 months in anaesthesia and three months in intensive care medicine. Progression depends on the appropriate competencies being achieved. The aims during this important period of an anaesthetist's career are: to acquire an overview of the multi-profession complex work environment; and to learn the basic principles of safe and effective anaesthesia, pain management and peri-operative resuscitation.

### **The first six months**

Anaesthetists spend the majority of their time in the theatre suite and it is important to familiarise yourself with its workings. The Operating Department Practitioners (ODPs) will teach as well as assist, and you will find yourself relying on their expertise in difficult situations.

Your patients' safety is your responsibility. This not only includes the obvious, such as ensuring the patient is asleep, but also safeguarding the patient by protecting their eyes, pressure points etc. You will learn the necessary skills and knowledge during your training, but when working in an unfamiliar environment ensure you know the location of the nearest defibrillator, emergency drugs and whom to contact in an emergency.

Many trainees new to anaesthesia find themselves frustrated during the first few weeks of work. Having been competent to work independently after qualification, you find yourself back at the beginning, in an unfamiliar environment, learning the basics under constant supervision. Knowing what is expected of you enables you to focus on what you need to achieve.

### **The initial assessment of clinical competency**

The first hurdle of training is the RCoA 'initial assessment of clinical competency'. This is at the end of the

introductory period and is a RCoA requirement for anaesthetic trainees. It must be passed before progressing to indirect clinical supervision and until this is completed you should have immediate supervision at all times. When the assessment takes place depends on any previous anaesthetic experience you may have, and the speed at which you progress. The RCoA envisages that most trainees would pass this assessment after three months, and certainly by six months of training.

The initial assessment of clinical competency contains six assessments, each of which must be completed twice:

- 1. Pre-operative assessment of patients**
- 2. General anaesthesia (GA) for ASA\* 1 or 2 patients without intubation**
- 3. GA for ASA 1 or 2 patients with tracheal intubation**
- 4. Rapid sequence induction**
- 5. Cardiopulmonary resuscitation**
- 6. Clinical judgement, attitudes and behaviours**

\* *The ASA (American Society of Anesthesiologists) grade 1 or 2 patients are those who are fit and healthy, or have mild systemic disease.*

After completion of this initial

assessment of clinical competency, the trainee may undertake uncomplicated general anaesthesia and simple peripheral nerve blocks under guidance of a consultant with indirect supervision. The trainee may commence solo lists at this time during normal working hours, but only with the presence of a trainer working in the same theatre suite.

### **Workplace assessments and appraisals**

Anaesthetic training is competency-based, although it currently runs according to a time-based plan. Trainees undergo summative assessments throughout the anaesthetic training programme. These are designed to assess whether you have reached the specified standards in the training programme, to quantify experience, and to estimate the individual trainee's eligibility to progress to further stages of training. The RCoA has designed common tools and documentation that should be used for workplace based assessment. For 'novices' in anaesthesia the 'initial assessment of competency' takes precedence over the assessments listed below. The tools used are:

- Multi-Source Feedback (MSF)
- Mini-Clinical Assessment Evaluation Exercise (MiniCEX)
- Direct Observation of Procedural Skills (DOPS)
- Case Based Discussion (CBD)

These forms can be downloaded from the link: <http://rcoa.ac.uk/index.asp?PageID=982>





**Foundation doctor** (two years)

*(Or after another specialty e.g. general medicine)*



**Core training in anaesthetics:**

**Years 1 and 2**

**(OR two-year Acute Care Common Stem plus CT2 in anaesthetics)**

*During which time: **Primary Fellowship examination***



**Competitive application to specialist training in anaesthetics:**

**Years 3 and 4**

*During which time: **Final Fellowship examination***



**Specialist training in anaesthetics:**

**Years 5 to 7**

*(Potentially including work abroad or a research fellowship)*

**Certificate of Completion of Training (CCT) awarded**



**Consultant post**

## Supervision of trainees

When working 'solo' it is key to know whom to contact, and exactly how and how long it will take them to reach you. More importantly, you should not begin anything you feel unhappy about. **If you find yourself wondering whether or not to contact someone senior, you almost certainly should.** It is often during normal working hours when such lines of communication become blurred, so get into the habit of finding out who is your point of contact before starting a list on your own.

You are encouraged to seek advice and/or assistance as early as possible whenever you are concerned about patient management. **Patient safety must never be compromised.**

## Grades of clinical supervision

Clinical supervision of daytime and out of hours' duties for anaesthesia falls into two categories: *direct* and *indirect*:

**Direct supervision** This means working directly with a senior supervisor who is actually present or can be within seconds. This proximity maintains patient safety but allows a degree of independence in order to develop confidence.

**Indirect supervision** Indirect supervision falls into two categories, *local* and *distant*:

- *Local supervision* – this means that the supervisor *is on the same geographical site*, is immediately available for advice and is able to be present within 10 minutes of being called.

- *Distant supervision* – this means the supervisor is available rapidly for advice but is off the hospital site and/or separated from the trainee by over 10 minutes.

## Named consultant

The RCoA document **Guidelines for the Provision of Anaesthetic Services (1999)** states that '*all services provided in the National Health Service are under the supervision of a consultant. This applies to all anaesthetic services. Where trainee or non-consultant career grade anaesthetists are providing clinical services this principle must be applied.*' Anaesthetic departments now need to ensure that named supervising consultants are available to all non-consultant anaesthetists. When a trainee is doing a list or a case without a consultant, he or she should check that a supervising consultant:

- Has been allocated by the department
- Is aware that he or she is supervising a non-consultant
- Is able to assist personally with the case within an agreed time frame
- Has discussed the anaesthetic management plan with the non-consultant if appropriate
- Has agreed the level and extent of supervision

Trainees should record the following on the anaesthetic record:

- The name of the supervising consultant
- The level of supervision as defined above

- Whether the case was discussed with the supervising consultant and, if so, the anaesthetic management plan agreed.

Ultimately, the trainee giving the anaesthetic is responsible for his or her own actions. As a qualified medical practitioner, you are professionally accountable in your own right.

**In summary, it is imperative that you:**

- **Know when to ask for help**
- **Know whom to ask for help**
- **Do not act beyond the level of your own competence**

Many departments operate a **starred consultant** scheme. A consultant working within the same theatre suite during elective sessions is nominated to be the focal point for trainees or Staff and Associate Specialist (SAS) grades with queries/problems. This consultant is often paired up with a senior trainee so that they're able to leave their theatre in times of need. In some hospitals the starred consultant will wish to speak

with a trainee before they start a solo case or list. In others the consultant may be floating, for example not attached to an actual list.

Speak to any trainee and they will recount a story of being 'forced' to take on something they felt was outside their comfort zone / above their level of competence. A common example is the transfer of a critically ill patient to another hospital. While we all have to do things for the first time at some point during our training, we should always be able to say no if we feel that it is in the patient's best interests. If you find yourself in such a situation don't hesitate to voice your concerns. If you are working with a senior trainee, tell them, otherwise inform the consultant on duty. If you still feel unhappy then you may have to contact your mentor, College Tutor, the Head of Department, or simply another consultant with whom you get on well. If you feel you require further help both the BMA and AAGBI provide such services, as well as other groups.

Please see Chapter 15 for further details of how to find help.

### **Running a list on your own**

'Going solo' seems sudden and can be quite daunting but it is actually reached gradually. Initially you will work with a senior colleague supervising you directly in the anaesthetic room and theatre. This 'one on one' supervision will slowly be removed such that you will provide maintenance of anaesthesia



unsupervised, then extubation and then induction. This will progress to supervision from the coffee room and you will begin managing single cases unsupervised until you are assigned your own theatre list. Here you will anaesthetise several patients unsupervised and begin to learn the art of 'running a list'. When this day happens there will be a supervising consultant available in the theatre complex and you should make them aware that this is your first your solo list. The next step, and perhaps the biggest one of all, is to progress from the presence of fellow colleagues in the theatre suite who are available for immediate help and support to anaesthetising with no other anaesthetists around, i.e. a night on call.

The list that you most often get to run is the emergency or trauma list. This can be a challenging experience as it involves patient assessment, optimisation of co-morbidities, planning peri-operative care including post-operative pain management. With three months experience in anaesthesia you will **NOT** be expected to know everything or deal with every case, but to recognise when to ask for advice and assistance.

### **The rest of the first six months...**

Emphasis is placed on the role of the anaesthetist in the peri-operative care of the surgical patient. Thus, a guided introduction to pre-operative assessment and post-operative care is just as important as the practice of anaesthesia.

The following basic units should be covered within this six month period:

- Care of the patient
- Anaesthetic equipment
- Basic techniques in general anaesthesia
- Basic techniques in local anaesthesia
- Anaesthetic pharmacology

### **Training for the next 18 months**

The following areas of basic training should be covered in this period:

- Obstetric anaesthesia, analgesia and resuscitation
- Pain management/ control/ treatment
- The upper airway and its problems
- Peri-operative care of the patient for major surgery
- Anaesthesia for day case surgery
- Paediatric anaesthesia
- Anaesthesia in the elderly
- Anaesthesia for patients with specific medical problems
- Intensive care medicine (ICM)

Trainees who have completed a full-time basic level training post in ICM can count up to three months of this training towards their basic level training in anaesthesia. Trainees who enter the Anaesthesia CCT programme via Acute Care Common Stem (ACCS) training may also have acquired some intermediate level ICM competences in that programme.

During this 18 month period trainees will widen their experience to obtain the RCoA Basic Level Training Certificate and become eligible to

move to intermediate level training in anaesthesia, ST3.

By the end of basic level training, trainees should be able to:

- Undertake the anaesthetic care of most routine cases
- Assist in the anaesthetic care for more complex surgery
- Provide anaesthetic care for routine obstetric practice
- Organise, with the surgical team, an emergency list; identify potential problems and seek appropriate help
- Understand the principles underlying the care of patients in intensive care and high dependency units
- Understand the principles of pain management
- Participate in audit
- Pass an assessment of knowledge and certain skills by examination

### **e-Learning**

The 'Integrated Anaesthesia Learning Portal' or e-LA is a recently developed web-based educational resource produced by the RCoA in partnership with e-Learning for Healthcare (e-LfH). It is available, for free, to all UK anaesthetists practicing in the NHS, and aims to deliver key knowledge and concepts from the anaesthetic curriculum helping trainees to prepare for the FRCA examination.

e-LA comprises:

- **e-Learning Sessions** – Knowledge and scenario-based sessions covering the first two years of the

anaesthetic curriculum. Each session takes around 20-30 minutes to complete.

- **e-Library** – Access to thousands of full-text journal articles which have been cross-referenced and mapped to the anaesthetic curriculum.
- **e-CPD** – Articles and associated MCQs to support general and core topic based continuing professional development for trainees and trainers.
- **e-Assessment** – Formative assessments with feedback that will test the user's understanding of the knowledge based session and introduce students to the standard expected at the FRCA exam.

### **Simulation medicine**

Simulation training is increasingly being used in medicine and its use is supported by recent publications from the Department of Health. *'The RCoA encourages the use of simulators for relevant aspects of postgraduate training in anaesthesia especially for events of high importance but infrequent occurrence (as exemplified by anaphylaxis), for situations where there might be a high risk to patients, for team building and working under pressure. Simulators are also used as assessment tools in the Primary FRCA Examination.'*

Anaesthetic departments are utilising simulators to varying degrees and many are currently developing this service. Now that simulation is a feature of the primary FRCA it is well worth familiarising yourself with this method. If your department does not

offer simulator training there are many courses run at the larger simulation centres across the country.

### **Basic Level Training Certificate (BLTC)**

All trainees progressing to ST3 (Intermediate Level Training), including those moving from Fixed Term Specialty Training Appointments, are required to have the Basic Level Training Certificate before they can start their intermediate level training. The BLTC confirms completion of basic level competency-based training in anaesthesia and ICM, of which the second year must be in the UK. The certificate should be signed off by at least two designated consultants, one of whom must be the College Tutor. There are ten workplace assessments to get signed up. These are outlined in **'The CCT in Anaesthesia II: Competency Based Basic Level (CT years 1 and 2) Training and Assessment'** available at [www.rcoa.ac.uk](http://www.rcoa.ac.uk). Along with passing the Primary exam (Chapter 10), these will be the core aims of any educational planning. Besides these formal assessments, you should also have regular appraisals to discuss matters informally. You must maintain formal records of both appraisals and assessments.

### **Appraisal and assessment**

*'The RCoA regards the regular appraisal, assessment and review of trainees as an integral part of the postgraduate educational process. It is also a non-negotiable requirement for all doctors employed by the NHS and for revalidation with the GMC.'* The three parts of the process are:

### **1. Appraisal**

Appraisal of trainees is intended:

- To provide constructive dialogue that will identify, anticipate and lead to action on the strengths and weaknesses in a trainee's performance
- To review educational targets
- To review the results of any assessments or examinations
- To provide provisional feedback and support towards progress
- To meet the NHS requirement for the annual appraisal of all employees
- To facilitate the production of a personal development plan
- To provide evidence for GMC revalidation

### **2. Assessment**

The purpose of assessment is to:

*Determine fitness for professional practice.* This means more than the performance of clinical skills, no matter how complex. Very importantly it carries an in-built commitment to standards, and the attitudes which will maintain those standards throughout professional life.

*Provide evidence of competence in a trainee.* This is to confirm the possession of the appropriate knowledge, skills and attitudes required to undertake safe clinical practice at a level commensurate with their level of training.

*Provide evidence of confidence and competence in a consultant.* This

is to confirm the possession of the confidence, knowledge, skills and attitudes necessary for independent professional practice.

### **3. Annual Review of Competence Progression (ARCP)**

The three key elements supporting trainees through the training curriculum are brought together each year in the ARCP. They are:

- Appraisals
- Assessments
- Planning of trainee's development

Information taken from the RCoA publications *'The CCT in Anaesthetics and Guidance for Trainers and Trainees'*.

### **Intensive care medicine**

Intensive care medicine (ICM) is an integral part of training in anaesthesia, with all trainees having to complete three months during Basic Level Training and a further six months during Intermediate Training. However, some trainees may be interested in dual accreditation, achieving a CCT in both anaesthesia and ICM. Anyone interested in ICM should contact the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) Educational Supervisor in their hospital, or failing that the IBTICM Regional Adviser, as soon as they can. To obtain further information, go to [www.ibticm.org](http://www.ibticm.org).

Attention must be drawn to the fact that trainees must complete at least 21 months of training in anaesthesia before they are eligible to move to an

Intermediate Training post. On some rotations, it is possible to end up doing three months of ICM during a year at one hospital, and arrive at the next hospital to find that you are down to do another three months of ICM. If you find yourself in this situation, we advise you to take the matter up with your College Tutor or Regional Adviser as soon as possible.

Trainees wishing to obtain dual accreditation (e.g. advanced level ICM or intermediate level training) need six months of acute medicine experience (of which three months may be emergency medicine). This complementary medical experience is usually acquired at CT1/2 level and the easiest route to acquire this is via the ACCS programme.

### **Intensive care logbook**

The Intercollegiate Board for Training in Intensive Care Medicine has stipulated that all anaesthetic trainees should keep a record of cases under their care in the ICU. This should include cases that the trainee has admitted, or had a substantial input into, and also all procedures.



## Workplace based assessment in ICM

IBTICM have made recommendations for the quantity of workplace based assessments for the ICM component of the anaesthesia training programme.

The following is currently suggested as the minimum number of assessments required to achieve the basic level of training (a three month period during the first two years of training):

- Multi Source Feedback x 1
- Direct Mini-Clinical Assessment Evaluation Exercise x 2
- Direct Observation of Procedural Skills x 3
- Case based Discussion x 1

For further information see: RCoA 'The CCT in Anaesthesia Part II Appendix C, section 7'.



## Acute Care Common Stem training

The Acute Care Common Stem (ACCS) training programme has emerged as part of the overhaul of postgraduate medical training that is 'Modernising Medical Careers'.

The ACCS training programme is two years long and designed to follow on from the Foundation Training programme. The rotation consists of six months of acute General Internal Medicine, six months of Emergency Medicine, six months of Intensive Care Medicine and six months of Anaesthesia.

The aim of the ACCS programme is to 'produce trainees able to identify and manage the acutely unwell patient, in particular by providing training in complementary specialties in a structured programme of training'. The introduction of the programme should improve the acute clinical skills in trainees going onto any one of these specialities.

Since the splitting of training programmes, trainees are now considered as Core Trainees (CT) and must apply again in their chosen specialty to become a specialty trainee (ST). Completion of the ACCS rotation allows entry to CT2 in Anaesthesia and ST3 in Emergency Medicine and Acute Medicine. Another benefit of the programme is that it allows trainees

to gain the complementary specialty experience required for a dual ICM CCT, which is otherwise difficult within the current training scheme.

As with anaesthetics, ACCS is a competency-based training programme, but with different objectives for each specialty. The RCoA gives further detail of the training programme in '**The Acute Care Common Stem Core Training: A manual for trainees and trainers**', available on their website [www.rcoa.ac.uk](http://www.rcoa.ac.uk). And there is a new website for ACCS trainees: [www.accsuk.org.uk](http://www.accsuk.org.uk).

## The ARCP (Annual Review of Competence Progression)

The ARCP replaces the previous RITA (Record of In Training Assessment) process and has been introduced in line with changes to training via MMC. It is an annual assessment process for all trainees which is based on the more explicit use of evidence to inform the annual assessment of progress.

In general, appraisal processes are based around the GMC's document 'Good Medical Practice' (Good Medical Practice, General Medical Council 2006), which describes the principles of good medical practice, and the standards of competence, care and

conduct expected of doctors in all aspects of their professional work.

These are:

- **Good clinical care**
- **Maintaining good medical practice**
- **Teaching, training, appraisal and assessment**
- **Relationships with patients**
- **Working with colleagues**
- **Probity**
- **Health**

The first heading of Good Medical Practice - good clinical care - is specialty specific and for the majority of trainees, the information provided will be their College logbook and assessment documents. The other headings of GMP are common to all doctors and the information required is detailed in this document.

## The Primary FRCA examination

The Fellowship of the Royal College of Anaesthetists (FRCA) is a hurdle to overcome and there are ongoing changes to the examination structure. These will be finalised and introduced progressively over the next few years.

The FRCA is divided into 2 parts, 'The Primary' and 'The Final'. Formal

assessments of knowledge must be passed before a trainee can progress from Basic to Intermediate training and from Intermediate to Higher training. These assessments form the Primary and Final FRCA examinations or prospectively approved equivalent qualification.

Passing the primary part of the exam is a requirement for progression to a ST3 post and intermediate level training.

The Primary exam is designed to assess:

- The candidate's understanding of the fundamentals of clinical anaesthetic practice including equipment and resuscitation.
- The candidate's knowledge of the fundamental principles of anatomy, physiology, pharmacology, physics, clinical measurement and statistics as is appropriate for the discipline of anaesthesia.
- Whether the candidate's skills and attitudes are appropriate to the level of training.

A full syllabus and exam timetable is available on the RCoA website ([www.rcoa.ac.uk](http://www.rcoa.ac.uk)). People tackle the exam in different ways but it is important not to underestimate the amount of work and commitment required. Attending one of the many primary courses helps with preparation. Which of the many courses to attend comes down to personal choice and financial constraints. Do not forget to use the e-learning package provided by the RCoA and other websites, e.g. [www.anaesthesiauk.com](http://www.anaesthesiauk.com).

Also use the GAT website for links: [www.aagbi.org/gat.htm](http://www.aagbi.org/gat.htm).

There are 3 parts to the primary examination:

1. Multiple Choice Questions (MCQ)
2. Objective Structured Clinical Examination (OSCE)
3. Structured Oral Examination (SOE)

### **The MCQ**

Eligibility to sit the MCQ component of the Primary FRCA is achieved upon obtaining a RCoA approved training post in anaesthesia or ACCS. All trainees must be registered by the RCoA.

The MCQ consists of a three hour multiple choice question paper of 90 questions, each with five stems. Negative marking has recently been abandoned and so marks will no longer be deducted for incorrect answers.

The pass mark is approximately 80%. The Primary MCQ exam may be attempted a maximum of five times and a pass in the MCQ will be valid for two years; if the Primary has not been completed by this stage it must be repeated.

### **OSCE**

The Objective Structured Clinical Examination (OSCE) consists of up to 18 stations of which 16 count towards the result. The OSCE lasts approximately one hour 50 minutes and covers all aspects of anaesthesia, including resuscitation, technical skills, anatomy,

history-taking, physical examination, communication skills, anaesthetic equipment, monitoring equipment, measuring equipment, anaesthetic hazards and the interpretation of X-rays. One or more stations may incorporate the use of an anaesthetic simulator.

The pass mark for each question depends on its difficulty and the level of knowledge expected of a 'borderline' candidate. The pass mark for the exam is the sum of all the individual 16 pass marks and will vary depending on the combination of questions used.

### **SOE**

From September 2009 there will be a single Structured Oral Examination (SOE) or viva examination, which will be conducted as two separate sessions. One SOE tests physiology and pharmacology and the other clinical anaesthesia, physics and clinical measurement.

At the first attempt the OSCE and SOE must be taken at the same sitting. If you pass one but fail the other component then you can re-take just the failed component. As with the MCQ, a pass in either will be valid for two years.

From September 2009 closed marking (1, 1+, 2, 2+) has been removed and now each section of the exam must be passed in order to gain the Primary FRCA.

## **Bibliography for the Primary FRCA**

### **General:**

#### **Anaesthesia and Intensive Care A-Z**

Yentis SM, Hirsch NP, Smith GB

*An excellent first anaesthetic book. A summary of just about everything you will come across and much more detailed than it sounds.*

#### **Fundamentals of Anaesthesia**

Pinnock C, Lin T, Smith T

*This useful basic textbook follows the primary syllabus.*

#### **Oxford Handbook of Anaesthesia**

Allman K, Wilson I

*Doesn't teach you the basics, but great for looking up specific cases prior to a list.*

#### **Drugs in Anaesthesia & Intensive Care**

Sassada M, Smith S

*A pocket guide to all drugs you may come across, good for tricky MCQ answers, structuring of drug information for a viva question and as a reference book*

### **Primary specific:**

#### **Basic Physics and Measurement in Anaesthesia**

Kenny G, Davis P

*Previously Parbrook, the 'classic' physics textbook.*

#### **Respiratory Physiology: The Essentials**

West JB

*Again, a 'classic' primary textbook.*

## Pharmacology for Anaesthesia and Intensive Care

Peck T, Hill S

*Excellent pharmacology textbook for FRCA exam revision.*

## Essentials of Anaesthetic Equipment

Al-Shaikh B, Stacey S

*Excellent for the OSCE.*

## Guide to the FRCA Examination - The Primary

The Royal College of Anaesthetists

*Contains sample questions, some of which still appear.*

## QBase MCQs for the Primary FRCA series 1, 4, 7

Hammond E, McIndoe A

## Anatomy for Anaesthetists

Ellis H

A number of books are also available based on the Primary FRCA OSCE and SOE examinations.

## Getting an ST3 post in anaesthetics

### Progressing to intermediate level training:

Before a trainee can progress to intermediate level training (ST3-4) they must have:

- a) obtained the Basic Level Training Certificate (BLTC)
- b) demonstrated reasonable attitudes and behaviour
- c) passed the Primary FRCA or an exempting examination

The actual duration of an individual's training will be determined by the rate at which they achieve the necessary competences. The principles of the UK CCT training programme are that it:

- is competency based
- is planned
- is evaluated
- has clear objectives
- is supervised
- is delivered by appropriately appointed trainers
- allows time for study
- accommodates the specific career needs of individuals

There are certain generic professional skills, essential to the training of all specialists that should be covered.

These include:

- Skills, attitude and behaviour
- Communication
- Presentation
- Audit
- Teaching
- Ethics and law
- Management

The Basic Level Training Certificate is the minimum requirement for an ST3 post and for those who must undergo further selection before entering Intermediate Training.

But, it does not help to answer the question...

### **“How do I get onto a Specialty Trainee rotation?”**

#### **So what else might be useful to help you to stand out during the selection process?**

Word-processing your application form, checking for spelling mistakes and having a clearly set out Curriculum Vitae (CV) is a rather obvious place to start. Update your CV at least every six months. Studying the Person Specifications for upcoming ST3 posts may enable you to tailor your CV for specific posts. Research and publications impress selectors and allow them to differentiate between candidates with similar qualifications. A letter in a peer-reviewed journal is probably the easiest way to start your publication portfolio. Scan the journals for topics which are of interest to you or your department, and ask an interested consultant to help you submit your first letter. Once you have joined the AAGBI, you will receive the Association's scientific journal *Anaesthesia* and the newsletter *Anaesthesia News* monthly. These are obvious publications to target first.

Publishing papers based on research is more difficult because of the time required to produce anything substantial. If you are lucky enough to persuade someone to allow you to contribute to a project that is already up and running, check whether they intend to include you as one of the authors.

You might consider presenting your paper orally at one of the many national or international scientific meetings. The AAGBI awards the Registrars' Prize for an original paper presented at the GAT Annual Scientific Meeting.

Audit projects, as well as being an essential part of training, are often a good way to impress, especially if published. This is more likely to be the case if you cover something 'topical', or currently controversial, and include an element of literature review and discussion. Completing the audit cycle is vital and impressive. Furthermore, the AAGBI awards a trainee poster prize (the Audit Prize) at the GAT Annual Scientific Meeting each year, which is audit-based. Always register your audit with your hospital audit department to prevent any unforeseen problems before you start.

There is more to publishing than just primary clinical research. Case reports are worth considering whenever you find yourself involved with a rare or unusual case. Articles on topics of interest can also, for example, be sent to *Anaesthesia News* or to the *RCoA Bulletin*. The AAGBI also awards the *Anaesthesia History Prize* jointly with the *History of Anaesthesia Society*; each year the winning essay is presented at the GAT Annual Scientific Meeting.

Many of those competing for posts will have completed courses such as *Advanced Life Support (ALS)*, *Advanced Trauma Life Support (ATLS)*, *European Paediatric Life Support (EPLS)* or

Advanced Paediatric Life Support (APLS), and you could consider becoming an instructor on such a course.

Unfortunately many such courses only allow you to become instructors if you are in ST 3 or above. You could offer your services to your hospital's Resuscitation Officers, as they are often looking for doctors to teach on in-house resuscitation courses.

Management skills, which can be as basic as organising a social event for the department, writing rotas and getting involved with teaching, also enhance any application.

Finally, there are other aspects to your career that may not seem relevant at first glance but are important in enabling you to stand out from other candidates. These include any positions of responsibility you may have undertaken within the department or outside of medicine, such as organising an event or involvement with charity work. In some regions having worked abroad in medicine also gains you points.



## Anaesthetic training in Scotland

Author: Dr Adam M Paul

Since political devolution in 1999, the Scottish Parliament has had control over the NHS in Scotland, and with this employment and training for the doctors within the NHS. However Anaesthesia retains a UK wide training programme, through the Royal College of Anaesthetists. Therefore a CCT in Inverness will be exactly the same as one in Plymouth, but there may be subtle differences in gaining a training post and in the working environments.

It is refreshing to see how hard and how successfully the RCoA and AAGBI have worked to keep training a UK wide process despite the increasing differences between home nation NHS systems. The AAGBI has a Scottish Standing Committee, which specifically looks at Scottish anaesthesia issues and contains at least one trainee representative.

Across Scotland there are four schools of anaesthesia: South-East Scotland (based in Edinburgh, incorporating Lothian, Fife and Borders); East of Scotland (based in Dundee, incorporating Tayside and Perthshire); North-East Scotland (based in Aberdeen and Inverness, also coordinates the new Highlands and Islands); and West of Scotland (based in Glasgow, incorporating Greater Glasgow and Clyde, Ayrshire and Arran,

Dumfries and Galloway, Forth Valley and Lanarkshire).

Overall these schools fall under the governance of NHS Education for Scotland (NES - <http://www.nes.scot.nhs.uk/>) which was set up in 2002 to allow a coordinated national approach to medical education - this is what Medical Education: England (MEE) has been based on. NES is responsible for the implementation of MMC Scotland (<http://www.mmc.scot.nhs.uk/>). Within NES there are 7 specialty boards, of which one is Emergency Medicine and Anaesthesia.

Overall, the application process is like elsewhere in the UK, ever evolving, and candidates must keep up to date using the above websites. There is no bar to applying to Scotland as well as other areas in the UK. Moreover, candidates can still freely move across borders between different NHS systems because the training has been kept UK wide.

## Anaesthetic training in Northern Ireland

*Authors: Dr Paul Johnston, Dr Clive Stanley*

Currently in Northern Ireland postgraduate medical training is managed by the Northern Ireland Medical and Dental Training Agency (NIMDTA).

Local recruitment to anaesthesia for the 2009 process will take the form of core training in anaesthesia alone. This may change for the 2010 process and beyond. Information pertaining to a change in this process within Northern Ireland will be advertised via the NIMDTA web site. The switch to core training in 2008 followed three successful years of run through training, as a pilot in 2005 / 2006 and subsequently as part of the national scheme in 2007.

Core training will consist of a two year period (CT1, CT2) of initial, basic level training, which must be successfully completed (including the Primary FRCA exam) before a candidate is eligible to apply competitively for a position at ST3 level. Following successful entry to ST3 there will be a five year training programme, incorporating intermediate and higher level training, culminating in the completion of training and the award of a CCT document. A small number of anaesthetic posts per year are allocated to allow ACCS emergency medicine trainees access to anaesthesia and intensive care medicine, a

requirement of their training scheme. ACCS trainees themselves, however, are no longer recruited into the anaesthesia training scheme. Currently there are no FTSTA anaesthesia posts in Northern Ireland.

Of note, following a recent review of recruitment to specialty training by the Health Minister in Northern Ireland, is that the total number of anaesthetic training posts is expected to fall slightly over the coming years. This has been proposed as an attempt at workforce planning to match training places to the expected need for senior and consultant level medical staff. However, as with EWTD, preparedness is not yet fully achieved and reductions in training numbers seem less likely.

The Northern Ireland Deanery is in the process of seeking legal advice concerning its responsibility towards junior doctors whom it acts to employ. It is in the process of affirming its position as a recruitment agency in order to devolve responsibility for terms and conditions of employment to individual Trusts which will hold junior doctor contracts.

## Professionalism and accountability

Author: Sarah Whitehouse, MPS

Professionalism in the medical world means constantly adapting to the changing needs of society. How do you know what is professional? What are the standards, who should set them, and how are these standards judged?

Professionalism as a trainee anaesthetist is about knowing your limits, being appropriate and working to reduce risk.

The GMC, as the standard bearer for professionalism, bases good medical practice on good clinical care, good relationships with patients, working with colleagues, teaching and training, probity and health.

The GMC's Good Medical Practice (2006) states that patients must be able to trust doctors with their lives and health, and doctors must show respect for human life, making the care of patients their first concern. Anaesthetists and all other healthcare professionals should protect and promote the health of patients and the public, while providing a good standard of practice and care.

Professional responsibilities go beyond a mere contract of employment. The Royal College of Anaesthetists sees maintaining standards as a core element of professionalism. Raising the standard (2006) focuses on audit as part of clinical governance, looking at ways to improve patient care.

Professionalism is shown through well-developed communication skills. The RCoA places emphasis on establishing the confidence of the patient, promoting meaningful dialogue, and communicating any risks in a way that a patient can understand.

Being professional means treating all patients equally and with empathy; even so-called difficult or 'heart-sink' patients. Labelling a patient can cause offence to the patient, blind your clinical judgment, and cause you to underestimate the severity of physical symptoms, perhaps bringing your fitness to practise into question.

Since 1858, the GMC has promoted high standards of medical education, dealing firmly with healthcare professionals whose fitness to practise is in doubt. In 2007, the GMC spent £49.1 million on fitness to practise, and between April 2006 and February 2007, there were 389 fitness to practise cases.

Professionalism is not about never making mistakes, but it is about dealing with adverse events promptly and correctly – handling any impact on patient care, giving a full and frank account of the facts, apologising where appropriate, and conducting a critical incident or significant event review to reduce recurrence.

Being professional is about being prepared if things do go wrong and having the right indemnity support when facing challenging medico-legal situations.

For more information on professionalism and good medical practice, or for professional indemnity advice, visit [www.mps.org.uk](http://www.mps.org.uk), or contact MPS on 0845 605 4000.

## Whom to ask for help?

Sometimes things in life don't go to plan and are much more difficult than anticipated. There are always a number of options and whilst it can seem that you are the only person having a particular issue with your training; we can assure you that you will not be alone. It is important not to bottle things up, and it is never seen as a weakness, but more as a sign of maturity to seek help when it is required.

Often having a chance to speak to your fellow colleagues in a social environment can reassure you that you are on track and others are having the same concerns as yourself. If you feel however that you require more help there are a number of people you can turn to.

Many departments now offer a mentoring programme, where you are paired up with either a senior trainee or consultant. Mentors tend to fulfil a more pastoral role than your educational supervisor and may be your first point of contact. If you have not been given a mentor you can request one.

Others to consider within your place of work include your Educational Supervisor, College Tutor, the Head of Department, Programme Director or simply another consultant with whom you get on well. You may prefer to speak to a non-anaesthetist and there is normally a nominated consultant as a point of contact for junior doctors, or you could consider the Head of Medical Education.

Sometimes it's easier to speak to someone outside the work environment and many feel more comfortable in this situation. Your GP is a good starting point and can refer you on to a third party if you both agree.

Furthermore, your occupational health department may also be extremely helpful and they are worth approaching for not only physical problems.

If you feel you require further help the BMA and AAGBI both provide support services, as do other groups:

The **BMA Counselling Service** for doctors and their families provides instant access to a telephone counselling service that operates 24 hours a day, 365 days a year. It is there to help all doctors and their families with personal, emotional and work-related problems. The **BMA's Doctors for Doctors Unit** deals with a wide range of problems such as drug and alcohol problems, bullying at work, mental health issues, and doctors who have been referred to the GMC/NCAA.

### **BMA Counselling Service**

**Tel: 08459 200 169**

**BMA Doctors for Doctors Unit:**  
**[www.bma.org.uk/doctorsfordoctors](http://www.bma.org.uk/doctorsfordoctors)**  
**or tel: 020 7383 6739.** This service provides 24 hour support and a number of these advisors are anaesthetists. Please note that although the service is 24 hour, an anaesthetist may not be available at all times.

The **AAGBI** recognises the importance of supporting members' welfare. Contact is welcomed from members with regard to any welfare issue. If for any reason this does not address your problem, call the AAGBI during office hours on 020 7631 1650 or email [wellbeing@aagbi.org](mailto:wellbeing@aagbi.org) and you will be put in contact with an appropriate advisor.

Members who need to discuss more

practical aspects of their career management or employment or who have problems of a less urgent nature should email [wellbeing@aagbi.org](mailto:wellbeing@aagbi.org) or call the AAGBI Secretariat who will direct your call to members of Executive or the Welfare Committee as appropriate.

The AAGBI Welfare Committee has recently produced a **Welfare Resource Pack**. This is available online at [http://www.aagbi.org/publications/guidelines/docs/welfare\\_resource\\_pack\\_2008.pdf](http://www.aagbi.org/publications/guidelines/docs/welfare_resource_pack_2008.pdf). Further details of help can be found in the GAT Handbook and on the Association of Anaesthetists website: <http://www.aagbi.org/memberswellbeing.htm>.

**Finally, remember you are not alone. Many anaesthetists will have felt the same at sometime or have been through similar experiences - you just need to ask for support.**



## Final checklist

We hope that the information contained within this guide proves useful for your future anaesthetic career.

So, remember to:

- Fill in the form and join the AAGBI
- Register with the Royal College of Anaesthetists
- Start a logbook today
- Start a portfolio
- Keep a list of all study leave used, internal and external. This should include clinical governance meetings, etc.
- Don't leave all your workplace assessments until the last minute!

## Appendices

### Abbreviations

AAGBI	Association of Anaesthetists of Great Britain & Ireland	ARCP	Annual Review of Competence Progression
ACCS	Acute Care Common Stem	ASA	American Society of Anesthesiologists
ALS	Advanced Life Support / Advanced Cardiac Life Support	ATI	Anaesthetists in Training in Ireland
APLS	Advanced Paediatric Life Support	ATLS	Advanced Trauma Life Support
		BMA	British Medical Association
		CCT	Certificate of Completion of Training
		CT	Core Trainee
		DoH	Department of Health
		EPLS	European Paediatric Life Support
		FRCA	Fellow of the Royal College of Anaesthetists
		GAT	Group of Anaesthetists in Training
		GMC	General Medical Council
		IBTICM	Intercollegiate Board for Training in Intensive Care Medicine
		ICM	Intensive Care Medicine
		LTFT	Less-Than-Full-Time Training

MMC	Modernising Medical Careers	SAS	Staff and Associate Specialists
ODP/ODA	Operating Department Practitioner: you will however notice that they are often referred to as Operating Department Assistant, which was the title used in previous years. There may also be anaesthetic trained nurses and Physicians' Assistants (Anaesthesia) - previously described as Anaesthetic Practitioners - within your department.	SpR	Specialist Registrar
		ST	Specialty Training / Trainee

### Useful Addresses

#### Group of Anaesthetists in Training (GAT)

The Association of Anaesthetists of Great Britain & Ireland  
 21 Portland Place, London W1B 1PY  
 tel: 020 7631 1650  
 fax: 020 7631 4352  
 email: [gat@aagbi.org](mailto:gat@aagbi.org)  
 website: [www.aagbi.org/gat.htm](http://www.aagbi.org/gat.htm)

#### The Association of Anaesthetists of Great Britain & Ireland (AAGBI)

21 Portland Place, London W1B 1PY  
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 fax: 020 7631 4352  
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 website: [www.aagbi.org](http://www.aagbi.org)

#### Royal College of Anaesthetists (RCoA)

35 Red Lion Square, London WC1R 4SG  
 tel: 020 7092 1500  
 fax: 020 7092 1730  
 email: [info@rcoa.ac.uk](mailto:info@rcoa.ac.uk)  
 website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)

### **RCoA Examinations Department**

tel: 020 7908 7312

fax: 020 7636 8280

email: exams@rcoa.ac.uk

### **The College of Anaesthetists, Royal College of Surgeons of Ireland (RCSI)**

22 Merrion Square North, Dublin 2,  
Ireland

tel: 353 1 661 4412

fax: 353 1 661 4374

email: info@coa.ie

website: www.anaesthesia.ie

### **The Intercollegiate Board for Training in Intensive Care Medicine (IBTICM)**

c/o The Royal College of Anaesthetists  
35 Red Lion Square, London WC1R  
4SG

tel: 020 7092 1556

fax: 020 7092 1730

Email: ibticm@rcoa.ac.uk

website: www.ibticm.org

### **The College of Anaesthetists, Royal College of Surgeons of Ireland (RCSI)**

22 Merrion Square North, Dublin 2,  
Ireland

tel: 353 1 661 4412

fax: 353 1 661 4374

email: info@coa.ie

website: www.anaesthesia.ie

### **Anaesthetists in Training in Ireland (ATI)**

PO Box 6526, Dublin 4

email: ati@coa.ie

Website: [http://www.anaesthesia.ie/sections/Default.asp?cms=training\\_ATI+Group&cmsid=59\\_83&id=83&secid=5](http://www.anaesthesia.ie/sections/Default.asp?cms=training_ATI+Group&cmsid=59_83&id=83&secid=5)

### **The Bernard Johnson advisors**

#### **LTFT Training**

c/o The Royal College of Anaesthetists  
Training Department  
35 Red Lion Square, London WC1R  
4SG

tel: 020 7092 1553

fax: 020 7092 1730

email: training@rcoa.ac.uk

website: www.rcoa.ac.uk

### **Essential Reading**

- The GAT Handbook – 9th edition. AAGBI, London, 2009
- The CCT in Anaesthesia I: General Principles: A manual for trainees and trainers. Edition 1: January 2007
- The CCT in Anaesthesia II: Competency Based Basic Level (ST Years 1 and 2) Training and Assessment. A manual for trainees and trainers. Edition 1: January 2007



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