GAT COMMITTEE'S RESPONSE TO THE SHAPE OF MEDICAL TRAINING REVIEW

FEBRUARY 2013

GAT AAGBI
GROUP OF ANAESTHETISTS IN TRAINING

1. Over the next 30 years, how do you think the way patients are cared for will change?

The Group of Anaesthetists in Training (GAT) are a committee which represents trainee anaesthetists, who themselves are members of the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Our answers are intended to reflect their views, either directly from surveying their views, or indirectly as a consensus of opinion from the GAT committee. The committee is made up of 12 nationally elected members and 5 co-opted members. We represent the views of 3400 trainee anaesthetists within the U.K.

Improved healthcare has led to increased life expectancy. As a consequence, chronic disease is more prevalent and the challenges of looking after these patients will be greater. Safely caring for patients with multiple co-morbidities, including obesity, will require a highly specialised group of anaesthetists, trained to the highest level, that are motivated to provide the best care.

2. What will this mean for the kinds of doctors that will be needed in primary care? In secondary care? In other kinds of care?

The role of the GP as primary care provider will continue, but with greater integration of secondary care services in the community. Anaesthetists have traditionally been hospital based but will have to have the flexibility to provide services where they are needed, for example chronic pain clinics.

In secondary care, the ability of doctors to care for patients at the extremes of age will improve and anaesthetists will need to provide safe anaesthesia for very high-risk patients. The training programme for all specialties should evolve to reflect the highest standards of knowledge, academia, clinical skills and communication with patients. Revalidation will provide a framework by which doctors are able to demonstrate continued excellence in these areas.

The balance between training and service provision remains a challenge and training opportunities need to be maximised. The Temple report ‘Time for Training’ says that training can be achieved within the 48 hour week but we need to rethink ways in which training occurs and ways of working. This issue is probably not as acute as it is in some specialties. This is perhaps because a relatively high proportion of daytime work is consultant delivered. Moving towards a consultant delivered out of hours service would help to improve this further.

3. What do you think will be the specific role of general practitioners (GPs) in all of this?

GPs should continue to be the gatekeepers to secondary care.

4. If the balance between general practitioners, generalists and specialists will be different in the future, how should doctors' training (including GP training) change to meet these needs?

There may need to be an increase in the number of GPs and general medical physicians working within the community in order to reduce the number of patients requiring hospital admission. The introduction of consultant specialist posts with split hospital and community job plans would help to facilitate this. However, a huge expansion in support services and resources within the community (eg physiotherapists, OT, respite care facilities, community clinics) would be required, as would a large shift in the expectations of patients and their relatives. Hopefully doctors in training are not being focused on in isolation.

Specific to anaesthesia, this is a hospital specialty and training should continue to focus on providing anaesthesia within hospitals. If the role of consultant medical physicians changes to incorporate community care, then there will need to be more medical physicians. There is no evidence that there will be less surgery or intensive care facilities required in the future and therefore these changes should not impact on the numbers within anaesthesia.

If a more general training period were to be introduced, we would support the ongoing opportunity for trainees to move directly into anaesthesia training if this was their preference.

5. How can the need for clinical academics and researchers best be accommodated within such changes?

The consideration of increased numbers of academic foundation posts for those interested in pursuing these career avenues at an early stage.

6. How would a more flexible approach to postgraduate training look in relation to:

a. Doctors in training as employees?

Training was more flexible prior to Modernising Medical Careers (MMC), allowing trainees to move more freely between specialties. However, if the aim of increased flexibility were to facilitate moving trainees against their wishes into specialties that they have not chosen, this would not meet the approval of trainees. We (the GAT committee), along with the RCoA trainee committee, carried out a recent survey regarding workforce planning. Anaesthetics trainees were asked whether they would consider changing specialty to meet national service reconfiguration demands for more GPs. Of 1583 trainees who responded, 82 % strongly disagreed with this as a viable option (Joint GAT and RCoA workforce planning survey, 2012).

b. The service and workforce planning?

Moving anaesthesia trainees away from their current role in providing anaesthesia would not improve theatre efficiency or theatre service delivery. It would also have a negative impact on training delivery and skill acquisition, where currently anaesthesia as a specialty far exceeds the national average for these training performance indicators (GMC national training survey, 2011). Currently trainees in anaesthesia are already covering ICU outside of their training requirements.

c. The outcome of training – the kinds and functions of doctors?

There have been several changes to postgraduate medical training over the past ten years, with frequent changes to the curriculum and types of assessments required for their Annual Review of Competency Progression (ARCP). There is a risk of the NHS losing qualified doctors if further major changes threaten current training opportunities and the jobs that are available on completion of training. As an example, we asked trainee anaesthetists and anaesthetists within 5 years of obtaining their CCT what they would do if a graded career structure for consultant anaesthetists were introduced. Of the 1796 individuals who answered this question, 80% stated that they would consider leaving the NHS if this were to happen (Joint GAT and RCoA workforce planning survey, 2012).

d. The current postgraduate medical education and training structure itself (including clinical academic structures)?

We strongly feel that anaesthesia needs to remain as a clinical specialty. Anaesthetics trainees have unique skills that cannot be cross-covered by trainees in other specialties. Regarding current training, anaesthetics trainees are the third most satisfied postgraduate medical specialty (after General Practice and Pathology trainees), with above average satisfaction scores when asked to rate their current training (GMC national training survey, 2012).

7. How should the way doctors train and work change in order to meet their patients' needs over the next 30 years?

As mentioned in question 4, there may need to be an increase in the care provided in the community and this may require more consultant physicians and GPs to enable the provision of this care. Within anaesthesia, with a move to some services to tertiary level centres, there needs to be improved integration within regions to facilitate training and revalidation of anaesthetists with specialist interests. It is likely that 24 hour consultant anaesthetist delivered care, particularly in intensive care and obstetrics, will be required.

8. Are there ways that we can clarify for patients the different roles and responsibilities of doctors at different points in their training and career and does this matter?

Postgraduate training has already been complicated by different nomenclature for different levels of training. House officer, senior house officer, registrar and consultant are terms still being used by other healthcare providers to refer to levels of medical training. Perhaps these terms would be understood more easily by patients than the current terminology.

9. How should the rise of multi professional teams to provide care affect the way doctors are trained?

Within anaesthesia, Physician's Assistants in Anaesthesia (PA(A)s) are present in very small numbers compared to anaesthetic trainees. A recent review by the AAGBI (2011) found that there were 100 PA(A)s practicing in the UK. In 2011 there were at least 4160 anaesthetic trainees practicing (GMC 2011 national training survey). The above AAGBI review group concluded that if the PA(A)s were to continue they required a national body to ensure that national standards were maintained. Current recommendations published by the AAGBI and RCoA require that PA(A)s are directly supervised by a consultant anaesthetist during induction and emergence from anaesthesia and that the overseeing consultant is within 2 minutes of the theatre they are working in at all times and able to attend them immediately. This criteria is far more rigid than that for anaesthetic trainees with the exception of novice anaesthetists (first 3 months of anaesthesia training). With the very small numbers, no regulatory body and rigid recommendations in place (due to patient safety concerns), it is difficult to see a large role for PA(A)s in the future of anaesthesia provision.

High quality care may be able to be provided more broadly by multi professional teams in some other areas within hospitals and in the community. This will partly depend on the expertise of individual staff and the infrastructure in place to support them. If there evidence exists that less doctors are required, then a reduction in the numbers of medical students would be more cost effective than altering doctors' roles or their training. When anaesthetics trainees were asked about reducing the national number medical student intake as a way to reduce the oversupply of CCT holders, 80% either agreed or strongly agreed that this was a viable solution (Joint GAT and RCoA workforce planning survey, 2012).

10. Are the doctors coming out of training now able to step into consultant level jobs as we currently understand them?

Overall we feel that they are. However for some anaesthesia sub-specialties, trainees may need further experience. This is partly due to the recent changes to the Royal College of Anaesthetists' (RCoA) curriculum, which has introduced spiral learning and allows trainees less flexibility within training in order to ensure that trainees have obtained all of their necessary competencies to achieve their CCT.

11. Is the current length and end point of training right?

Anaesthesia training is longer than in many other countries, including the United States, Australia and New Zealand. In addition to being longer, the standard of training currently provided within the UK is high quality and produces anaesthetists with the knowledge, skills and attitudes required of consultant anaesthetists.

12. If training is made more general, how should the meaning of the CCT change and what are the implications for doctors' subsequent CPD?

If training is to be made more general, the qualifications awarded on completion of this training need to be clarified from the outset. Other than financial gains (i.e. time taken to train and cost of appointing CCT holders as consultants) it is difficult to identify either training or patient benefits to trainees achieving anything other than a CCT as it currently stands.

Perhaps an adjustment to the numbers of trainees, with more GP training slots and more national training numbers (NTNs) within specialties which can cross cover hospital and community care are needed, not necessarily the addition of a new training system overall. Within anaesthesia and ICM a more generalised training structure would not shorten training very much as sub-specialisation only occurs in the final year of training or post CCT and many anaesthetists are 'generalists' anyway without sub-specialist training.

13. How do we make sure doctors in training get the right breadth and quality of learning experiences and time to reflect on these experiences?

The new RCoA curriculum ensures that anaesthetics trainees only obtain their CCT when they have completed the appropriate levels of training within the different anaesthetics sub-specialities, in addition to Intensive Care and Pain specialties. Training includes reflective practice and is competency based. It is therefore the responsibility of the trainee and trainers to only allow progression when these competencies have been achieved.

Again, some other hospital specialties may benefit from a more competency based approach to ensure that trainees feel appropriately equipped as a result of their training.

14. What needs to be done to improve the transitions as doctors move between the different stages of their training and then into independent practice?

Trainees in anaesthesia receive a high level of direct consultant supervision and therefore the transition to different stages can easily be facilitated by more or less direct supervision by consultants when on training lists or when providing emergency cover. Trainees rated the level of supervision that they received above average when compared to other specialties and scored significantly higher than other trainees when asked whether they knew who was responsible for supervising them at any one time (GMC national training survey, 2011).

More direct supervision from senior trainees and consultants in other specialties, such as is already provided within anaesthesia, may help to improve the transitions that may occur within these specialties.

15. Have we currently got the right balance between trainees delivering service and having opportunities to learn through experience?

The European Working Time Regulation has altered the balance between on-call commitments and daytime elective list experience. In order to be compliant with the 48-hour week, trainees spend proportionately more time on call and therefore less time doing daytime elective lists than previously.

On-call work, although service provision, can still be viewed as a training opportunity, with direct or indirect supervision provided by consultants or senior trainees. The work provided within working hours is for most trainees (except senior trainees) directly supervised by a consultant within the theatre suite or intensive care unit.

16. Are there other ways trainees can work and train within the service? Should the service be dependent on delivery by trainees at all?

Their role within management could be explored and developed, perhaps with more management competencies within the curriculum. This would equip trainees better with the management skills required in the current and future NHS.

A consultant led service would provide a greater proportion of patients with expert anaesthesia care and expert care throughout other specialties. It would also allow a greater number of trainees to be directly supervised, particularly in currently less supervised specialties. Although patient care would most likely improve, there would be large cost implications to this service structure.

17. What is good in the current system and should not be lost in any changes?

Anaesthesia should remain as a separate specialty delivering high quality training, with appropriate supervision and protected training lists.

18. Are there other changes needed to the organisation of medical education and training to make sure it remains fit for purpose in 30 years time that we have not touched on so far in this written call for evidence?

From the 2010 NHS Staff Survey in England (CQC) when doctors in training were compared to other NHS employees they were less likely to feel that there was good communication between themselves and management, less likely to understand where their role fitted in and that they were able to contribute to service improvement. An increased role of doctors within the management of the NHS would teach doctors about strategy and other business expertise to enable both trainee doctors and consultants to be competent managers, which would in turn improve service delivery and patient care.

Any other comments? Some of the problems that this review appears to wish to address do not exist within anaesthesia or ICM to the extent that they exist in some other specialties, particularly medicine. Having recently restructured training it would not be worthwhile to undertake further changes to attempt to address a problem, which arguably does not exist.

About You
Finally, we would appreciate you providing the following information about yourself to help us analyse the consultation responses.

Your details

Organisation: Group of Anaesthetists in Training (GAT) Committee

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Would you like to be contacted about the Shape of Training review in the future?
Yes