Welcome to the second edition of the Clinical Career journal.

“Extremely useful.” “A great platform to share advice amongst colleagues.” “Fills a void that has been present for a long time.” These were just some of the comments we received following the publication of our inaugural edition late last year. They clearly demonstrate that Clinical Career has struck a chord with its stated aim – to inform, educate, and assist in the development of trainees throughout the course of their career.

We have been delighted with the response to our call for journal participants and many contributions are featured in this edition. These include an overview of the Shape of Training Review, an examination of the pathway to leadership, the 2023 challenge to improve healthcare, and the merits of part-time working for doctors.

Additionally, our request for your overseas accomplishments has also been well answered with experiences in India, Cameroon, South Africa, and the Himalayas showcased.

Now more than ever, it is vitally important that trainees at all stages have access to independent advice of the highest quality. Advice that will help them make informed choices as they navigate their way through a volatile healthcare environment.

I hope you enjoy reading this edition and I welcome your feedback and suggestions.

Sara

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The fact that the NHS landscape has been changing will have escaped nobody. However, the implications of this changing landscape have far reaching consequences to the career paths of those currently in training and indeed for every service in the UK. It is imperative, therefore, that all doctors gain a top level grasp of the nature of changes that will occur at the provider end of the system so that they can make absolutely sure that they develop the knowledge, skills and insight necessary both to operate successfully in this new environment and also to ensure their attractiveness to new types of potential employer. I hope that this article will go some way to providing a starting point for just such a top level analysis.

The Big Commissioning Change
In December 2013, NHS England issued planning guidance for CCGs that had a fundamental change to approach contained within its pages. Until this point, commissioners had only been required to produce annual plans of their proposed activity, which would also have contained valuable information about how the pattern of care delivery, and consequently care providers, would be approached. However, from this point forward commissioners are required to produce a strategic plan that covers the next five years, with the next two years being specified down to operational detail.

This means that shortly we will be able to deduce far more clearly how the provider landscape is likely to change over the next few years in the face of huge austerity and an increased agenda for integration across the secondary, primary and social care arenas. It is absolutely essential that anyone intending to have the pick of jobs going forward takes the trouble to research and understand the true nature of healthcare provision and how it is changing over time. From the provider’s perspective, it will mean actively monitoring these strategic plans for commissioning at a local level to see just how the provider landscape is likely to change and how this may affect them. Touching again on the career implications, if I was applying for a job today I would want to know just how aware my employer was of this changing landscape, given that I would wish to join an employer who is likely to stay around by making sensible strategic choices.

High Level Changes
Wider use of primary care
With an ageing and rapidly increasing population, it is no surprise that NHS England wants to see the use of primary care beefed up. They describe this as increasing the use of primary care at scale. This strategic agenda is driven not only by an increasing population but by the changing nature of that population and its healthcare needs. With increased numbers of particularly aged patients, the system has to respond to differing access requirements. An elderly, frail patient who may also have dementia, cannot be expected to undertake frequent, often physically brutal, journeys simply for routine health care that can otherwise be delivered in a location much closer to them. Equally, these patients tend to carry an increase level of chronic disease, for which hospitals are recognised as a less than ideal location.

From a career perspective, this heralds
two distinct themes:

- growth of the primary care/GP infrastructure
- an increase in primary care located secondary care services

The latter theme is an important one to consider from a skills and working environments perspective. Whereas many of the secondary care services may well be delivered by current secondary care providers, such as hospitals, although obviously in the community, an increasing number will be delivered by new private providers or indeed NHS providers with a much more limited scope, often choosing to address a very specific type of patient with very specific needs. Going forward, there will be an increased need for doctors who are prepared to work in these limited scope environments, often independently of the team and sometimes out of existing GP practices in a more integrated manner. It is worth considering what might make you attractive to these types of employers that is different from a traditional local hospital job.

Services need to take a strategic look at their portfolio of care and determine what aspects of care are likely to be moved into community settings. To continue to expect to operate in the traditional hospital-based mode and enjoy the same level of funding, is to place the service at risk of obsolescence as community delivery models take hold. The strategically intelligence service should be considering how to adapt its delivery model to match up to this changing pattern and indeed whether it needs to partner with a community organisation, in a more integrated approach to care delivery.

The integration agenda

A consistent theme in the planning guidance is the increase in integration across patient pathways for the delivery of care to people with long-term conditions. This is also interesting at two distinct levels – the increasing disease burden in certain long-term conditions, especially those that are age-dependent, and having to work in an integrated or cross boundary manner. To support integration, NHS England is investing some 3.8 billion in a fund called the Better Care Fund, which is specifically to prime or support integration projects. I think this tells us that NHS England is definitely serious about integration.

Again you might want to consider just which types of long-term condition are likely to be subject to changes in care delivery as a result of integration. For instance, are you developing a special interest in an aspect of care that is currently delivered in hospital but which may well switch to a more community focused location as an integrated pathway approach is adopted? Equally, employers may well be seeking candidates whose experiences bridge the gap between primary and secondary care, or perhaps more accurately between secondary care delivered in the community and that which is delivered in hospitals. This type of approach is often based around the principles of case management, again a useful addition to a CV for someone wishing to work in this type of environment.

Currently clinical professionals within services find themselves with so much clinical load that the thought of networking and developing shared
services with other providers across a pathway seems an impossible task that there is no time for. However, given the other change agendas, to fail to consider how a more integrated approach may be appropriate to your patients, could find your service without a chair to sit on when the music stops. As is often so true and business, the future tends to belong to the early movers, with the laggard’s left standing with the DJ says enough.

The elective care agenda
NHS England is expecting a 20% productivity gain across the next five years, coupled to an improvement in outcome and a 20% reduction in the resources necessary to deliver that care. Whereas this will chill the bones of current care providers, it also means that the provider landscape will have to change, both within the existing providers and also with the introduction of new models of care. It is almost impossible for that level of productivity gain and resource drop to be achieved without adapting how we deliver elective care. Consequently, we are likely to see the introduction of new delivery models and an increased number of private providers that bring those into our system.

An example that interests the government is the Aravind Eye Care Centres in India, where a routine cataract operation is delivered at similar outcomes to the UK but for around $30, around 3% of the UK hospital-based tariff for such an operation. The centres work on the principle of lean efficiency in the operating model and highly capable surgeons who only do cataracts but in vast numbers. At this point, we tend to train ophthalmologists who expect to work in hospitals and whose career aspiration would include a variety of ophthalmic problems, rather than one specific type of surgery. However, cataract surgery is likely to increasingly move to high-volume treatment centres and so again the system will be asking for an increased number of surgeons who are prepared to work in this environment. To be attractive to these types of employers means increasing the amount of cataract surgery undertaken in training, whilst developing a heightened sensitivity to delivering surgery without complications, as this can not only ruin the high-volume finance model but also the reputation of the provider.

Existing providers would be well advised to think deeply about how they streamline elective work by complexity. Rather than say viewing care by the type of Department that does it, they might consider starting from the point of view of complexity or reliable repeatability. Procedures that can be done in volume reliably and safely, are likely to be far more subject to this agenda than procedures of a more complex nature. The Department that fails to think in this way may find care, and consequently funding, redistributed to new provider types that work on this lean efficient model.

This is just one example but there will be many and varied as this agenda takes hold. One advantage that the new consultant has over a more senior consultant is that of a lower wage. As this agenda is about productivity...
5 Really Important Questions

• Are you 100% confident that you fully understand current healthcare policy?
• Do you know the conditions and mechanism for competition entering your locality & the influence you have over this?
• Are you completely aware of everything that affects both tariff and your service funding?
• Do you fully understand the new choice agenda and just what information will be made available to patients (and how)?
• Are you fully conversant with the new commissioning agenda and how this will affect secondary/tertiary care?

If you answered 'no' to some or all of these questions, it does raise some concern that you and your service may be vulnerable in the emerging landscape, especially if you are trying to influence or set strategy with an incomplete picture.

What's becoming clear is that the difference between a thriving service and one that struggles and lurches often comes down to depth of understanding and interpretation (leading to confidence to act appropriately). It's a whole new jungle out there and if you don't understand it then you are at a disadvantage, in an environment that has stopped looking after its prisoners.

It's now 2013, The Health & Social Care Act is enacted, the Commissioning Guidance released, the payment systems changing. Maybe it’s time to really understand… View the Full Programme
and cost reduction, we might expect employers to seek out new consultants in preference, especially those with a track record of high quality, high volume surgery in a specific area.

**Concentration of specialised services**
Currently, there are 143 specialised services that are commissioned centrally by NHS England. The strategic guidance on commissioning specialised services states that the system should aspire to 15 to 30 centres of excellence for each specialised service, co-located all linked to Academic Health Science Networks. Currently, many district general hospital services also deliver some specialised services depending on the specific interests of the clinicians. Over time these types of services will be expected to relinquish these patients in favour of centralisation.

From the career perspective, if you aspire to working in specialised services it means that there is likely to be much greater competition for fewer posts and those posts will be centred on fewer locations than they currently are. In many respects, this reorganisation of care brings with it the greatest changes to career paths and specifically to career strategies. For the most part, trainees elect to pursue a primary care career or a hospital. When choosing the latter, their expectation is frequently to do complex interesting aspects of care in a highly respected centre. With care more concentrated, we are going to go through a period of time in which we have more trainees with this expectation than there are posts.

If your aspiration is to be a specialist in one of these 15 to 30 centres, it is imperative that you consider deeply what would make you stand out from the crowd that will become increasingly large. To expect to take a specialist position but with generalist experience is likely to result in disappointment. The jobs will most likely go to those people who have strategically managed their career to end up with a set of both clinical and nonclinical experiences that set them apart. What these might be will vary according to the nature of the specialised service and where in the country it sets. A great question to ask yourself is “if I was the Brompton, recruiting a specialist in a highly specialised area, just what would I be looking for that would make that candidate irresistible?” Armed with the answers to this very enabling question, you must then deliberately set out to gain the skills and experiences.

As we view the behaviour of clinical services, we note with interest the tendency to resist relinquishing specialised care to tertiary centres. Unless you stand a strong chance of being one of the 15 to 30 centres, it would be better to work out what your new role in the system is and then build a reputation for excellence in that new area, rather than try to hang on to smaller, albeit interesting, bits of work that are likely to be taken away from you at some point.

**General Conclusions**
I presented just a few of the strategic issues emerging from the new commissioning guidance. Rather than this explaining just what to do and how to think, I hope it provides a starting point to a very different mindset. That mindset is one of open-mindedness towards career path, in a system that will throw up many and varied career opportunities, many of which will represent a significant departure from the traditional view of just hospital or primary care. In any system, there will be exciting jobs and there will be more routine ones. Most aspire to exciting position with career progression in an employer that values their employees and remained stable in a system that isn’t. It is difficult to ignore that these jobs will be fewer and farther between. If you want one, rather than waiting until your CCT, only to find that your planned career choice is not nearly so common, it becomes essential to make understanding the system an important part of career development and as that understanding builds, to develop the tendency to adjust your skills development to be more aligned to these new providers and the requirements.

My parting words are a reminder that failing to plan is planning to fail. The world increasingly belongs to the proactive, who realise that you must design a career in alignment with the system that you will be working in. My experience is that all too many doctors are still basing their development on a system that is changing and that many would do well to at least consider how those changes might affect the traditional career path and the opportunities within.
Assertiveness without Aggression is probably the most comprehensive, practical programme available, designed to help consultants, other doctors and healthcare professionals adopt the right behaviour, communication and approaches to have the desired impact. The resulting effect is greater achievement, more self-control and a greater level of emotional self-mastery. All of this is achieved without ever trying to change the inner you whilst enhancing confidence, self-mastery, impact and interpersonal effectiveness.

Next Dates:
• 10th Apr 2014, Warwick
• 8th May 2014, London

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Deadline looms for Clinical Fellow Scheme applications

Doctors in training have until 14 February to apply to the Faculty of Medical Leadership and Management’s (FMLM) National Medical Director’s Clinical Fellow Scheme 2014-15.

Sponsored by NHS England’s National Medical Director Sir Bruce Keogh and overseen by FMLM, the Scheme is an opportunity for trainees to develop leadership and management skills by spending one year in a national healthcare organisation, working alongside influential leaders and key players in healthcare from within the NHS and the wider healthcare sector.

The Clinical Fellow Scheme is open to those doctors in training who will have completed their Foundation Programme by the time they take up their post as a Clinical Fellow on Monday 1 September 2014. As usual, the Scheme offers placements across the country, including a number in the north of England.

Shortlisted candidates will have the opportunity to meet current Clinical Fellows during an information evening in London on 4 March 2014 and interviews will be held in London on 12 and 13 March 2014.

More information on the Clinical Fellow Scheme is available on FMLM website at: www.fmlm.ac.uk

Modernising Scientific Careers: HEE publishes Scaling the Heights

Health Education England’s (HEE) Scaling the Heights document which will assist in the training and development of consultant clinical scientists has now been published.

The document, part of the Modernising Scientific Careers (MSC) programme, outlines how Higher Specialist Scientist Training (HSST) will deliver the consultant clinical scientists who will provide expert scientific leadership and innovation for the benefit of patients and health services.

Consultant clinical scientists have a crucial role to play in providing scientific clinical advice and care alongside medical consultants across the healthcare spectrum. They will also support innovation in all its aspects of science, technological and service developments.

The Scaling the Heights document the full spectrum of HSST, including:

- The underpinning academic doctoral programme
- The development of curricula with scientists, professional bodies and medical royal colleges
- The implementation of these programmes through the National School of Healthcare Science
- Certification, registration and the recognition of previous training, experience and through the Academy for Healthcare Science.

Professor Sue Hill, Chief Scientific Officer (CSO) for England, said: “The Modernising Scientific Careers (MSC) programme sets out for the first time a comprehensive training and career framework for the whole healthcare science workforce inclusive of the more than 50 different scientific professional specialisms.

“I commend this document to those who will be involved in delivering and managing HSST training. I wish to acknowledge and thank all of those individuals and organisations who have given so generously of their time and for their commitment in developing the HSST curricula and programmes.”
BMA Junior Doctors Conference 2014 – the chance to lead change

The British Medical Association’s (BMA) Junior Doctors Conference is a major opportunity for junior doctors to have their say on the major changes that are taking place within the medical profession.

Open to all junior doctors in England, Scotland, Northern Ireland and Wales, this year’s event will address a range of issues including the negotiation of new hospital doctor contracts and postgraduate medical education and training reforms.

Conference participants have the option to submit a motion which, if successful, will form part of the Junior Doctors Committee (JDC) policy next year.

The conference will take place at BMA House in London on Saturday 17 May and will be accompanied by an informal dinner that evening.

And for first-time conference goers who wish to learn more about the BMA and the work of the Junior Doctors Committee, an event is scheduled for Friday 16 May (also at BMA House).

In a joint statement, Conference Chair Dr Latifa Patel, and Junior Doctors Committee Co-Chairs Dr Kitty Mohan and Dr Andrew Collier, said: “The Junior Doctors Conference is a major event in the medico-political calendar where the priority work for the JDC over the following year is determined. Negotiations on pay and working hours are underway and sweeping reforms to training have been proposed.

“This year’s conference will include an expert panel and an open discussion on key issues affecting junior doctors. There has never been a better time to get involved and influence policy.”

Members and non-members of the BMA are invited to attend, with places allocated regionally on a first come, first served basis.

HEE and CEM pledge more places for trainees to ease emergency staff crisis

HEE and CEM plan 75 new training posts each year for next three years

Health Education England (HEE) and the College of Emergency Medicine (CEM) have pledged to create more trainee posts to tackle the growing staffing crisis in emergency medicine.

Currently, around 50% of trainee posts for emergency medicine are vacant due to the increased view that the subsequent post is unattractive and pressurised.

This view was recently expressed in a survey of consultants - 60% said their workload was unsustainable and 94% revealed that they regularly work late to maintain standards. The survey also found there is a perception that it is difficult for junior doctors to access emergency medicine training posts, leaving too many emergency departments understaffed.

In a joint statement released with the report, HEE chief executive Ian Cumming and CEM president Dr Clifford Mann said they have “inherited” a “shortage of consultants resulting from poor recruitment into middle grade training posts. We recognise the difficulties of work force development in emergency medicine.”

As emergency departments continue to face increasing pressure, staff shortages are being partly blamed for falling standards of care as well as lengthy admission times. Both organisations hope the new changes will encourage more doctors to train in emergency medicine and, ultimately, ease the pressure in A&E.

“Much has already been done,” said Cumming and Dr Mann, “and we have made considerable progress but we know more hard work will be required to develop and implement sustainable solutions.”
Trust to receive PROMPT Birthing Simulator

A product which has been proven to reduce childbirth injury – a PROMPT Birthing Simulator – is to be installed at Northumbria Healthcare NHS Foundation Trust following an anonymous donation.

The simulator has been proven to reduce injury during childbirth and is an integral part of the PROMPT multi-professional obstetrics emergency course.

Recent studies have revealed that the number of successful deliveries within the training environment nearly doubled from 42.9% to 83.3% when medical professionals had been trained using the PROMPT Birthing Simulator.

Dr Shonag Mackenzie, consultant and lead obstetrician and obstetric trainer at Northumbria Healthcare NHS Foundation Trust, said: “We are delighted to receive an additional PROMPT Birthing Simulator and would like to thank the person who very generously donated it to us.

“We have used this excellent equipment since it became available and are committed to continuously improving training for our midwives, obstetricians and all professionals who work on the delivery suite.

“The additional simulator will be a great asset and will help enable us to deliver training on several sites and continue to ensure that every woman and child we care for receives the highest standards of treatment."

The PROMPT Birthing Simulator (produced by the UK’s leading medical skills training product manufacturer, Limbs & Things) was developed in conjunction with the midwives and obstetricians from Southmead Hospital, Bristol and the Gloucestershire Royal Hospital. The model was designed to improve the management of shoulder dystocia through hands-on practice, and as a result has become an integral part of multi-professional training in many maternity units across the globe. The product provides a realistic platform for medical staff to acquire the delicate skills required for shoulder dystocia management; and allows healthcare professionals to build their confidence and skills to ultimately improve patient care as a result of facilitating a training experience close to the real thing.

Kate Fox Evans, Head of Marketing at Limbs & Things said: “The studies using our PROMPT Birthing Simulator have verified the positive impact medical simulation can have on patient outcomes. We are committed to improving patient safety, through excellent product training and are currently working closely with Baby Lifeline - a unique national charity supporting the care of pregnant women and new born babies. As well as providing the Prompt Birthing Simulator for the recent Baby Lifeline charity auction, we are supporting their 2014 Birth 2 training initiative via the provision of our Keele & Staffs Episiotomy Trainers to deliver improved episiotomy repair for mothers post-birth.”
Major increase in NHS staff benefiting from health and wellbeing programmes

A major Royal College of Physicians (RCP) audit has shown that the NHS has significantly increased support for the health and wellbeing of its staff.

The RCP report - Implementing NICE public health guidance for the workplace – states that 115 trusts are supporting their 562,723 staff with health and wellbeing plans.

This is a significant increase on 2010 figures of 70 trusts and 275,421 staff members.

The audit also shows significant increases in dedicated policies that cover specific health areas, and stability in all others. The key areas are:

- Obesity plans have more than doubled, from 13 per cent in 2010 to 28 per cent
- Physical activity plans have increased from 24 to 44 per cent
- Mental wellbeing has increased from 48 to 57 per cent
- Smoking is stable at 75 per cent
- Long-term sickness absence continues to be 100 per cent

Dean Royles, Chief Executive of NHS Employers, said: “The NHS has maintained an important and responsible focus on the wellbeing of its workforce, amid all the other challenges faced by staff and managers.

“Of greatest importance are those schemes that provide early interventions, support networks and different ways for staff to take responsibility for their wellbeing and report any concerns in confidence.

“As with so many things in the NHS, it’s clear that a culture of confidence and openness is essential and that everyone has a part to play in developing this. People who are given the confidence to speak up about their worries and stresses are more likely to highlight issues that could affect their performance or patient care, and we need this to happen.”

BMA’s electives guide offers top tips

Medical students planning their electives can now turn to a new BMA resource to help guide them through the process.

The latest electives guide (which is available on the BMA website) includes a downloadable checklist and a multimedia presentation giving students top tips.

The guide contains seven questions students should ask themselves:

- Whether to stay in the UK or go abroad
- Proposed budget
- If there are visa restrictions
- If English is spoken
- The time of year
- The kind of experience sought
- Whether the student has a specialty already in mind

The guide advises arranging an elective early and suggests making first contact 12 to 18 months beforehand.

The guide also strongly suggests the use of a ‘plan B’ should things not go to plan initially.

Joint Deputy Chair of the BMA Medical Students Committee Samantha Dolan said: “Medical electives are a great chance to broaden your medical education and they offer the opportunity to travel overseas, experience different cultures and see conditions rarely found in the UK.

“But many students underestimate the work involved — this updated guide helps you get the best out of your elective and provides a valuable timeline and checklist of what to consider.”
An international team of scientists has created a bionic hand which allows the amputee to feel lifelike sensations from their fingers. Dennis Aabo, from Denmark, who lost his left hand in a firework accident, received the hand following surgery in Italy. “It is the first time that an amputee has had real-time touch sensation from a prosthetic device” said Prof Silvestro Micera from the Ecole Pode Lausanne and Scuola Superiore Sant’Anna, Pisa. Mr Aabo has called the hand “amazing.”

Bionic hand allows amputee to feel once again

Professor Derek Gallen of the Wales Deanery has been elected President of the Academy of Medical Educators (AoME) - the professional and standard-setting body for clinical teachers.

As Postgraduate Dean for the Wales Deanery (Cardiff’s School of Postgraduate Medical and Dental Education) he has developed many innovative training schemes for junior doctors in academic medicine and leadership and has been a key supporter of the Academy of Medical Educators.

Professor Gallen said: “Tomorrow’s doctors need a solid foundation of knowledge, skills and professional attitudes on which they can base a lifetime of practice in a high-pressured and rapidly changing environment. As President, I will work to ensure that trainers and teachers of medical students and doctors are given the time, support and encouragement to develop professional excellence in this important area of clinical education.”

Professor Gallen’s work as National Director of the UK Foundation Programme and as Chair of COPMED, the UK Council of Postgraduate Medical Deans, has had a major impact on raising the profile and standards of medical education across the UK.

Gallen elected AoME President
PRESENTATION EXCELLENCE
FOR CLINICAL PROFESSIONALS

Effective presentation skills form one of the core backbone elements of a successful career in healthcare. Faced with a diverse range of scenarios, from teaching staff to interview presentations right through to a presentation of an international multi-centre trial or Trust board meeting, it is surprising that few have ever received any formal training in this vital area. This programme takes a single, intensive day approach to dealing with the core elements of effectiveness in presenting with poise and impact.

Next Date:
• 6th Mar 2014, Manchester

www.growmedical.co.uk
In recent years, there have been significant developments in UK postgraduate medical education and training based on recommendations from a number of reports<sup>1,2</sup> in the wake of Modernising Medical Careers. A common theme highlighted in these reports is the need for further reform in postgraduate medical training if we are to ever meet the evolving healthcare needs of our rapidly changing society demographics and the likelihood of greater expectations of healthcare among our population now and in the future. However, these previous reports have been slow to adapt to patient and service needs. Fundamentally the system needs to recognise and adapt to these principles accordingly through a non-disruptive transition phase to ensure sustainability and to avoid multiple redesigns of the system.

The Shape of Training<sup>3</sup> report led by Professor David Greenaway, the Vice-Chancellor of the University of Nottingham is an independent review of the current structure of postgraduate medical education and training across the UK. The purpose of the review was to make sure we continue to train effective doctors who are fit to practise in the UK, provide high quality and safe care and meet the needs of patients and service now and in the future. The report offers a framework to reshape the delivery of training doctors and maintain continuity of care with changes to the current system.

Several recommendations from the report are:
- Full registration should move to the point of graduation from medical school
- Broad based training to achieve Certificate of Specialty Training (CST)
- Develop credentialed programmes for some specialty and all subspecialty training post CST
- Training providers should be approved and quality assured by the GMC to provide high quality training and supervision

Some of the recommendations are laudable, and if implemented would lead to radical changes in the skills and experience of all doctors and how services are delivered to our patients. Other recommendations should be treated with caution and do raise many questions.

In the case of full GMC registration at the point of graduation, legislative changes will be required to achieve this. Universities will need to acknowledge and make the necessary provisions to undergraduate training and education to produce doctors with the skills and confidence to undertake the clinical judgments expected at the early stages of their career. The proposed change may allow for more doctors from the
European Union (EU) to apply for the UK Foundation Programme, thereby increasing competition for foundation posts. On the contrary UK medical graduates would be able to apply for posts within the EU with a fully registered UK qualification. There is also an opportunity to lift the cap on overseas medical student numbers as once qualified they could return to their country of origin again with a fully registered qualification without having to complete the first year of foundation training which they are bound by within the current system.

Following completion of the two year Foundation Programme, which should remain unchanged doctors will spend 4-6 years in broad based specialty training gaining experience and competencies in their chosen field. Existing specialties will be grouped together to form patient care themes for example: Women’s Health, Mental Health. Tensions do exist between generalists and specialists and although more generalists are needed to provide safe and effective care at the frontline, does not mean we need fewer specialists. With the pace of change in medical science and technology, specialists are essential to the delivery of the highest quality evidence based patient care. Evidence shows that patient outcomes improve with specialist care therefore advanced skills in specialties must continue to hold their place amongst the post-generic training.

In reducing the length of specialty training to 4-6 years, it is questioned whether there would be sufficient time to train. The procedure-based specialties in particular may be further impacted. These specialties need time to acquire the necessary technical, professional and knowledge based skills to become independent. Given that some of these trainees currently report difficulties to train within the time allocated in the current system (some state due to the introduction of the European Working Time Directive 2009), further clarity is required regarding the nature of training and competencies that would be achieved by their CST. Would this create expert diagnosticians in general care with limited operative ability?

Individual placements throughout broad based training will be longer than the current four-month rotations to provide better integration within the team, continuity of care and improved learning opportunities and training. During broad based specialty training, opportunities to spend a year working in a related specialty or undertaking leadership and management or medical education work will be available. Leadership and quality improvement are essential attributes for doctors in training. An alternative pathway for trainees undertaking dedicated time for research to attain a higher qualification must be supported and flexible within the system. The recommended increased flexibility should also enable doctors to gain competencies in one broad area and
transfer those competencies between specialties easily. Assessment of training should be reviewed to dispel the impression of paper-based exercises and form counting.

A CST is awarded for those that reach the end of broad based specialty training to verify that the doctor is fully trained and has obtained the competencies and knowledge to practice independently without supervision. This replaces the Certificate of Completion of Training and emphasises that education and training are never complete. The proposal to introduce credentialing post CST to acquire specialist competencies in specific areas of clinical practice provides a way to adapt skills to the prevailing needs of the population. However with certification of generalist capability at CST and further specialisation via credentialing do we run the risk in developing a sub-consultant grade? Further levels of complexity are introduced to the credentialing programme for larger specialties like general medicine that is an umbrella for many complex specialities.

Many problems remain unresolved and need to be address to avoid rapid radical changes to the system, which may inevitably fail. To accept the recommendations in Greenaway’s report the profession needs to embrace a culture of change. Training must be quality assured and the report recommends that training should be “limited to places that provide high quality training and supervision”. Local and national organisations must take responsibility to ensure dedicated training time is provided for trainees and trainers. Service delivery must also provide meaningful learning and training experiences. The report fails to mention in detail many pertinent issues for example the use of postgraduate membership exams, pre-existing curricula and how assessment methods would fit within this model. Producing broad based doctors who are equipped for hospital and community care must be aligned to the structures within the NHS healthcare system. Expectations of career ambitions need to be managed and conveyed at the start of ones career pathway to help with workforce planning and students entering medical school should be made aware of the roles and requirements the profession expects, with a focus on population needs.

On the basis of this proposed framework, careful planning is required before its implementation. Previous changes have had negative consequences, due to rapid implementation. Further analysis of the implications of change need to be reviewed followed by a phase in approach. This will allow the stability of the overall system to be maintained whilst reforms are being made. Current doctors in the system should not be disadvantaged during the implementation of change. A UK-wide delivery group will be formed to oversee the implementation of the reports recommendations with support from the royal colleges, employers and regulators.

The motivations of this review are laudable however, the recommendations lack detail. We should therefore use this opportunity to influence the finer details of the model including curricula, development of broad based training and credentialed programmes because as we all know too well, one size does not fit all!

References:

Dr Sonia Panchal
National Medical Director’s Clinical Fellow, Health Education England & Academy of Medical Royal Colleges

Author Profile
In March 2013, the organisations responsible for medical education and training in the UK launched a review of how doctors were trained, following their qualification from medical school. This has now been published, and makes a number of recommendations which could radically change how doctors train in the UK.

What are the changes?
New doctors should be given ‘full registration’ at graduation. At present, new doctors (FY1s) are first given ‘provisional registration’ to practice medicine. This imposes some limits on their practice. Trainees should now be given full registration when they graduate, but they will be expected to show they are able to work at this level.

Specialty training should be much broader. Existing specialties should be grouped into broad care ‘themes’ with common curricula: for example, Obstetrics & Gynaecology and Community Sexual & Reproductive Health could be grouped into ‘Women’s Health’. Trainees will then train within these broad ‘themes’.

Specialty training should be more flexible. Trainees should be able to transfer freely between specialties within a ‘theme’, without having to start their training again from the beginning.

Specialty training will generally be shorter, but not ‘completed’. The current ‘Certificate of Completion of Training’ (CCT) will be replaced with a ‘Certificate of Specialty Training’ (CST). Doctors should be trained to the same level of ability, in a broader area, but their training should be shorter. Afterwards, they should be able to complete more training in other areas, through ‘credentials’.

What’s it got to do with me?
Future specialty trainees will be expected to spend most of their time working in broad areas (e.g., general internal medicine). Trainees who want to work in more specialised areas (e.g., interventional cardiology) may need to complete additional credentials. They may also be expected to work across different specialties within their theme.

Future foundation trainees will also work in broader areas and settings. New doctors (FY1s) may be expected to have additional knowledge and skills, given their full registration. They should be able to apply for broader specialty training programmes, however, giving more time to decide on career plans.
Future medical students will have placements in broader areas and settings. Given that new doctors will gain full registration at graduation, medical students may also be expected to have additional knowledge and skills before they qualify.

Potential controversies...
Will all new doctors get a job? The British Medical Association (BMA) have said that moving full registration to the point of graduation may allow more doctors from the European Union to apply for the foundation programme in the UK. This could lead to more competition for jobs.

Is broader training viable in all specialities? The Royal College of Surgeons (RCS) have said that it may be difficult for trainees working in particular broad areas to gain the specialised skills and experience they need. This could lead to much longer surgical training.

The rise of a sub-consultant grade? The BMA are also worried that replacing the current CCT, and requiring additional credentials to work in specialised areas, will lead to the development of a ‘sub-consultant’. This could lead to more barriers to career progression.

What happens next?
The Shape of Training Review has set out a series of steps which should now take place. Most major changes are not expected to take place for 2-5 years, however. It remains unclear too, of course, whether the recommendations will be followed at all...

By Dr Sonia Panchal and Dr Steven Alderson on behalf of the National Medical Director’s Clinical Fellows 2013-14
EDITOR’S RESPONSE

Sonia raises some highly pertinent and controversial issues e.g. the re-emergence of fears around a sub-consultant grade, which open a very specific debate.

The training review clearly attempts to consider how training needs to change in light of how the overall healthcare system is changing and as a consequence identifies changes that might be aligned with the emerging system but unpalatable to those within it. It presents us all (clinicians, educators, trainees, deaneries, providers etc) with Hobson’s choice:

• Is it better to have education aligned with the realities of the new system, even if it heralds professional role changes that we don’t like, or
• Is it better to have an educational approach that we all believe in, as doctors, but which may not be aligned with the system, creating workforce issues

The third option – palatable and aligned appears to be highly elusive, as the review makes perfectly clear. That doesn’t mean we should not aspire to it.

By way of an example, a clear system change is that of moving care out of hospitals into the community, often into providers with a limited scope or breadth of responsibilities. This adjustment to the delivery model is completely consistent with Michael Porter’s principles of value-based medicine, promoting a ‘specialist’ focus on very specific value components of care, around which the new system is attempting to organise.

If we consider what this means for doctors, it is likely that we will have an increased need for doctors with a relatively ‘junior’ broad capability and yet a limited scope of specialist capability. If we train lots of ‘traditional’ specialists, we run the risk of massively mismatching three key elements of effective workforce planning:

• Aspiration of the trained workforce – to be a specialist
• Nature of the work to be done – limited scope
• Workforce numbers – lots of people who there aren’t the right jobs for

However, the flipside is, as Sonia eloquently states, the effective introduction of a sub-consultant grade, ironically akin to a Specialty Doctor – not trained in depth for everything but highly capable in specific aspects of care.

I am not sure there is a right answer but I do think this is something we need to debate more. Consequently, I propose to invite comments in this issue and let’s see where that takes us.

Sara Watkin
Editor-in-Chief

REQUEST FOR COMMENTS & PERSPECTIVES

Please let us know where you sit on the following debate and why…

• Is it better to have education aligned with the realities of the new system, even if it heralds professional role changes that we don’t like, or
• Is it better to have an educational approach that we all believe in, as doctors, but which may not be aligned with the system, creating workforce issues

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As a Special Health Authority and one of the UK’s key education and training leadership organisations, Health Education England (HEE) is well-placed to comment on how healthcare services in the UK can best adapt to massive environmental, technological and demographical changes and remain at the forefront of providing good quality patient care. Since its inception in 2012, HEE has pledged to ensure that the workforce has the right skills, behaviours and training by supporting providers and clinicians to take greater responsibility for planning and commissioning education and training.

HEE’s Director of National Programmes, Patrick Mitchell, is a passionate advocate of the training and leadership agenda, as he explains to Clinical Career...

Clinical Career: What’s your vision for medical education in the UK and what is the role or purpose of Health Education England within that?

Patrick Mitchell (PM): Health Education England (HEE) needs to ensure that it has the right number of doctors for the clinical workload, in particular picking up key issues such as the move from secondary to primary care. Alongside major reports, including the Shape of Training Review, we need to ensure that we improve the ways that our doctors are trained. We can achieve this by paying particularly attention to our Better Training Better Care (BTBC) programme and continue the work that we are doing to ensure that the recruitment and selection processes are fair and equitable and that we attract the highest calibre of candidates to the posts we have on offer.

Clinical Career: Clearly the structure is evolving but what are the major changes that we will see over the next five years or so?

PM: Essentially we need to look at what types of doctors we will require for the 21st century, how they work with other members of the clinical workforce and the new roles that emerge including advanced clinical practitioners, and consider the use of physician assistants and the wider role that paramedics might play in the management of patient care. We are aware of the development of clinical
leadership, especially in relation to the roles that doctors will play in managing organisations and managing change. We are also aware that of the leadership role that educators and trainers play in their organisations. HEE in particular are very keen to recognise the role of the trainer and the importance of this role in ensuring that health organisations have an appropriate learning environment. We also recognise those organisations that embrace education and training have been shown to be more likely to be patient safe organisations.

Clinical Career: In which areas is your work going well and not so well?
PM: We recognise there are some major challenges including getting organisations to look at their clinical workforce as a whole rather than looking at professional silos. We also recognise the major challenges in attracting candidates to General Practice and some of the acute specialties such Emergency Medicine.

Clinical Career: What differences will trainees feel as these challenges are met?
PM: We need to educate individuals entering into medical training about the variety of careers they can have whilst practicing medicine. It is imperative that we highlight those who have been surprised moving into these fields by presenting case studies of good practice. For example, a lot of people that move into General Practice don’t start out in their careers thinking they would become a GP. However, statistics show that their level of satisfaction is as high as those who wanted to be a GP in the first place.

Clinical Career: How and how closely do you liaise with or collaborate with NHS England?
PM: HEE works closely with NHS England. For example, we are leading the workforce element for the Emergency Medicine Taskforce, which is run by NHS England. Our CEO, Professor Ian Cumming, and members of our executive team, have regular meetings with NHS England. And at LETB level, there are early signs that NHS England have recognised that they need to work with local area teams.

Clinical Career: How does the organisation of Health Education England mirror or align with the changing secondary care infrastructure?
PM: We recognise that there are some areas where we need to grow including Emergency Medicine and workforces (such as the community workforce) that support and stop patients getting admitted to hospital in the first place. We are also aware that we need to work with the ambulance service on the development of their education. Essentially, we would like all paramedics to be trained to degree level so that they can do a lot more in the field to stop people being admitted to hospital and to support people out in Primary Care settings.

Clinical Career: High quality training obviously benefits from a stable clinical infrastructure. How do you see education of trainees being affected by instability and Trust failure in our system?
PM: HEE will be joining the Chief Inspector of Hospitals during visits to ensure education and learning is given the right priority within the inspections programme. Quality Surveillance Committees - Post Graduate deans are ensuring where there are poor training experiences, that organisations are given time to change and turn this around. However, if there have been no significant improvements or changes, trainees will be withdrawn, allowing us not to have any poor training programmes. Currently, HEE is investing in the development of Technology Enhanced
Learning (TEL). In the years to come, trainees will receive ‘blended’ learning opportunities which will allow them to receive a mixture of e-learning and simulation training as well as physical clinical practise. TEL is proving to be very popular in various areas of the country. HEE are currently working with the Royal College of Physicians to build a simulation script for the whole of the core medical programme. This will mean that core medical trainees will have the facilities to use simulation training as part of the core medical programme.

Clinical Career: Given that we have a rough plan that further centralises complex work i.e. relocates it from DGHs to major acute centres, how will that affect the location of training numbers and rotations?
PM: General Hospitals have important opportunities for doctors in training and these will be as important as the very specialist teaching centres.

Clinical Career: Given the growth in community and long term condition management, do you see trainees spending more time in community rotations, of which there are very few at the moment?
PM: Though our BTBC Programme we have been looking at the foundation training programme. We are going to mandate all foundation trainees to do one community based placement by 2015. We will be asking our LETBs to work with their local organisations to identify areas where clinical care can be provided in the community and where trainee opportunities will exist.

Clinical Career: With this diversification in our structure, how should trainees think about their career plans and paths that differ from the historical approach?
PM: The Shape of Training Review is likely to challenge trainees to think more broadly about the type of medicine they will be practising in the future. We will be asking trainees to think differently about their careers and the opportunities that they can have. Historically, consultants have stayed in one organisation during the duration of their career and not moved. However, it is now much more likely that there will be more movement as people move to different areas of medicine to further their careers. We also believe that trainees need to see themselves as more than just a doctor. They need to see themselves as leaders, educators and managers. A key example of this is that one of our key stakeholders, The Faculty of Medical Management and Leadership, has over 2000 members and they have only been up and running for two years. This demonstrates that trainees are recognising that their medical career isn’t just about managing patients but has a much wider portfolio.

Clinical Career: Do you think we will see greater polarisation in the development of medical trainees e.g. into highly specialist doctors + generalist doctors + doctors less specialist limited scope qualifications?
PM: We don’t think the quality of trainees and their qualifications will dilute. However, we do recognise that we need to move away from specialist requirements except for where it is needed. This will allow trainees to have a broader way of thinking.

Clinical Career: Do you have any further words of wisdom for the trainee of today?
PM: We would say make sure you consider all of the options open to you as the opportunities for a career in medicine are great and wide ranging. Think about how you can work with other professions to bring about change rather than around what doctors can do. As HEE gets more established we will try even harder to publicise the excellent examples of good practice where education and training takes place across the specialties. We will also work to distribute these across our various channels to make sure those good examples are spread and adopted so that others take advantage of what our case studies have shown. We would also ask trainees to take advantage of the opportunities for multi-professional training.

www.hee.nhs.uk
Alongside leadership, innovation is a word that you might well hear in every other sentence offered by senior NHS staff. NHS England is acutely aware that it will not be able to sustain the level of service required on the current healthcare settlement unless our system undergoes significant innovation in delivery models and the use of technology. Ongoing financial austerity, coupled to a rapidly increasing and ageing population are placing pressures on the system that it just cannot keep up with. The gauntlet is firmly thrown down – we either innovate or risk the loss of what we currently call the NHS. Consequently, we thought that it was a good idea to run a feature on innovation, although we suspect that innovation will be a topic that runs and runs in many successive issues of Clinical Career.
The first 2023 Challenge competition, which calls on junior doctors to put forward their ideas for improving healthcare, has been won by two trainee doctors from Milton Keynes Hospital NHS Foundation Trust. The winners, Dr Rhiannon Furr and Dr Angus Goodson, who are both trainee paediatricians, were presented with the 2023 Challenge Award at the Said Business School in Oxford. Their winning healthcare improvement idea to improve drug delivery to child patients impressed a panel of top judges including Caroline Chipperfield, Director of Thames Valley and Wessex Leadership Academy, and Steve Fairman, Director of Business Improvement and Research at NHS England.

The first runner-up was Dr Asli Kalin (Oxford University Hospitals NHS Trust) with her idea for an App to help induct and support junior doctors with the multitude of hospital processes and information, and Samuel Folkard (medical undergraduate at Oxford University Medical School) secured third place with his idea for a novel surgical device which could prevent unnecessary admissions to hospital.

Having been selected from 57 entries, the finalists were invited to make one final, face-to-face pitch during which they were quizzed on the finer detail of their cutting-edge ideas. They also stood in the spotlight for 90 seconds, pitching to an audience of around 100 of their peers and mentors during a prestigious ceremony.

Their ideas will now undergo a final assessment and funding may be allocated from a Health Education Thames Valley innovation fund, alongside a funded support package for the junior doctors leading the implementation, for the benefit of patients across the Thames Valley.

Judge Professor Richard Bohmer, Visiting International Fellow, The King's Fund and Professor of Management Practice at Harvard Business School, said: “We chose the winners due to...”
the strength of their ideas and the scope for implementation. The ideas presented were all rooted in day-to-day experience of delivering care in the NHS.

“Furthermore, we were impressed by the combination of confidence, passion and yet also humility displayed. These are the core traits needed to make a great entrepreneur and to take an idea forward into an implemented innovation.”

First proposed by members of the Trainee Advisory Committee (TAC), an association for doctors in training across the Thames Valley region, the 2023 Challenge gives junior doctors an opportunity to create positive ideas to further improve the NHS. The NHS Thames Valley and Wessex Leadership Academy developed the idea, working with trainees and a number of key partners to deliver the competition for the first time.

Winners Dr Angus Goodson and Dr Rhiannon Furr said: “It’s unbelievable to have been a finalist, but to win is just incredible. We’ve had great support from colleagues back in Milton Keynes Hospital to whom I am very grateful.

“We cannot recommend the 2023 Challenge highly enough, it’s been a terrific experience and we’ve all learnt so much. But this is just the beginning – we now have to go on to deliver our idea into practice.”

Caroline Chipperfield, Director of the Thames Valley and Wessex Leadership Academy, which put the 2023 Challenge into practice, said: “We have been delighted with the response to the 2023 Challenge which was positive not only in terms of the number and quality of entries, but encouraging in the way the amount of talent amongst our next generation of innovators has been highlighted.

“All six of our finalists will now receive a support package to help them continue to develop their ideas into practice and we will follow them closely. I cannot wait to see how we can grow this competition next year and for the next decade.”
Innovation falls into two broad categories: incremental and revolutionary. The first proceeds gradually, step by step, developing and improving from within. The second tends to be more abrupt, breaking new ground, bringing novel techniques and knowledge from outside established practice.

The history of healthcare repeatedly shows us how, whereas incremental innovation brings value by doing better, revolutionary innovation brings value by doing differently. We can also see again and again how the spread of such advances has been hampered by reluctance – and even downright refusal – to accept a paradigm shift.

In the 1840s, Hungarian physician Ignaz Philipp Semmelweis noted a marked disparity between the puerperal fever mortality rates at Vienna General Hospital’s two obstetric clinics. It was common knowledge that the clinics admitted on alternate days, and some women reportedly begged on their knees not to be treated at the less reliable of the two.

The first clinic was staffed by doctors and their students, the second by midwives. But comparative skills and experience were not relevant. The explanation instead lay in the fact that autopsies were also conducted at the first clinic but not at the second.

Semmelweis decided a solution of chlorinated lime would address the problem and ordered all doctors and students to wash their hands before examinations. The mortality rate fell
from 18% in May 1847 to less than 3% the following month.

Yet the clear evidence of this breakthrough was not enough to earn universal recognition from the medical establishment. Many shared the reaction of the celebrated American obstetrician Charles D. Meigs, who wrote in 1848: “Those of you who are contagionists will say that he carried the poison from house to house. Did he carry it on his hands? But a gentleman’s hands are clean.”

In 1980 the treatment of gastric ulcers and gastritis was the subject of a vast body of medical literature. The major causes were thought to be stress and spicy food. Today most of these books are redundant: the recommended treatment for more than 90% of duodenal ulcers and up to 80% of gastric ulcers is a simple course of antibiotics.

Two Australian doctors, Robin Warren and Barry Marshall, had suspected a link between ulcers and the bacterium Helicobacter pylori. Their initial research was met with extreme scepticism. Established medical opinion began to soften only after Marshall infected himself and effected a cure through antibiotics. In 2005 Warren and Marshall were awarded the Nobel Prize for Medicine.

Incremental and revolutionary change frequently coexist. An examination of the history of breast cancer treatment provides a good illustration.

In 1811 the novelist Madame d’Arblay (née Frances Burney) underwent surgery. Her account makes grim reading. Whatever sedative she may have been given was ineffective. “I began a scream that lasted uninterruptedly during the whole time of the incision – and I almost marvel that it rings not in my ears still, so excruciating was the agony. The evil was so profound, the case so delicate... that the operation, including the treatment and the dressing, lasted 20 minutes – a time for sufferings so acute that was hardly supportable.” (Incidentally, the fact that Madame d’Arblay survived for another 28 years leaves two distinct possibilities: either the procedure was wholly successful or it had been utterly unnecessary.)

Today a mastectomy might last for two or three hours. Twenty minutes seems obscenely swift. But speed was of the essence in the days before anaesthetic – which explains why James Syme, the surgeon who carried out the first leg amputation at the hip, was able to proclaim in a letter written in 1823: “It is true that the patient cannot be considered out of danger, though I certainly have little fear... I did the operation in about a minute.”

Innovations in anaesthesia – first nitrous oxide and then ether and chloroform – fundamentally changed surgical procedures, while the arrival of antiseptics drastically reduced postoperative mortality. Yet once again these advances prompted
opposition (although not, it must be said, from James Syme). Some thought pain a useful indicator that should not be disguised; others raised ethical concerns about operating on insensible patients; also, as we have seen, the suggestion that gentlemen might have dirty hands was simply insulting.

Subsequently, with surgeons able to cut farther and deeper, removing skin, muscle and even bone, radical mastectomy became the orthodox treatment. The pain might have been reduced, but the disfigurement was possibly even worse than in Madame d’Arblay’s day – which meant women were less likely to present for early treatment.

Developments in a completely different field – physics – eventually led to the use of radium in the treatment of tumours. First introduced in the 1920s, this genuinely disruptive innovation, despite representing a more conservative approach, was also greeted with hostility and was not widely acknowledged for another 20 years.

What we see in all of these examples is that innovation is sometimes met with resistance, even in the face of manifest evidence of significant benefits. This happens to some extent with most innovation but especially so when change is radical. And at the heart of this tension is the malign yet all too familiar effect of a combative culture of winners and losers.

Innovation does not always just add to existing practice: it often challenges, sometimes destroys and occasionally replaces it entirely. For this to happen it is essential to nurture what the great American polymath Carl Sagan described as an “exquisite balance”: “If you are only sceptical then no new ideas make it through to you. If you are open to the point of gullibility and have not an ounce of sceptical sense in you then you cannot distinguish the useful ideas from the worthless ones.”

The sphere of healthcare has been encouraged to learn from the world of business. Again this has not been universally welcomed; but an understanding of the processes of innovation, including the concept of creative destruction, would be useful in an arena where profit and loss are counted in more than mere cash.

Paul Kirkham is a researcher in the field of entrepreneurial creativity with Nottingham University Business School and co-deviser of the Ingenuity problem-solving process taught to students at its University of Nottingham Institute for Enterprise and Innovation (UNIEI).
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With some astonishing advances in technology over the past decade, the use of simulation as a significant part of surgical training has now become an accepted practice. As with many areas of medicine, neurosurgery involves complex procedures with little margin for error and so the benefits honing planning, diagnostic and surgical skills on a simulator or within a simulated environment are patently obvious. However, the key factor is ensuring that the experience is as close to reality as possible.

This is the challenge that faced Richard Ashpole FRCS when developing his innovative new neurological simulator known as Rowena. As a consultant neurosurgeon at the Queens Medical Centre (QMC) in Nottingham, including seven years as training programme director, Richard is a passionate advocate of high quality training as crucial to maintaining a quality health service within the UK - and across the world. Demonstrating his commitment to training neurosurgeons of the future, he developed the Rowena model (Realistic Operative Workstation for Educating Neurosurgical Apprentices) specifically to teach important surgical techniques.

The background
During his career as a consultant, Richard has developed specific interests in cervical spine surgery, particularly the insertion of artificial cervical discs (arthroplasties), and the management of hydrocephalus in adults. Combined with a longstanding interest in the design and development of new neurological instruments and technology, branching out into the development of inventions himself seemed a logical pathway.

Prior to the creation of Rowena, Richard's inventions have included a set of surgical instruments to assemble ventriculoperitoneal shunts with a non-touch technique, patented and developed during his registrar training, as well as a set of instruments to enable the more accurate and safer placement of the Discocerv artificial cervical disc, combined with a plastic spinal model to demonstrate their correct use. It was during the development of this spinal model that Richard first collaborated with Calibre Models in Wales; a specialised small
scale plastic modelling company who helped Richard’s concept of a craniotomy simulator to become reality.

Richard explains the idea behind Rowena: “With the changes in junior doctors’ hours and other aspects of medical training, the exposure to operative neurosurgery (like all other surgical specialities) has decreased, with neurosurgical registrars spending significantly less time in theatre, whilst the necessity of turning out a fully trained and appropriately experienced consultant at the end of training remains. Trying to square this circle is tricky, hence the idea of a simulator.”

Rowena in development
Almost a year in development, Rowena consists of a moulded plastic base with internal skull anatomy on which is fixed a replaceable upper cranium with scalp, bone and dural layers. Inside the skull is a realistic plastic brain. Richard explains how his idea for Rowena was realised: “In many ways, neurosurgery lends itself particularly well to the application of simulation as a significant part of the speciality, especially in the early years of training when procedures generally involve getting into the skull and closing it up again afterwards.

“It was this fact that first spawned the idea of making a plastic head with the neurosurgically important bits, i.e. the top or calvarium, made in various layers to mimic the layers of tissue that a surgeon has to get through in order to gain access to the brain itself. Unfortunately, this ‘tissue’ would inevitably be destroyed during any simulated surgery. However, in practice, it is only the top piece of the skull that is drilled/cut/sawn and so the creation of a model composed of a high quality permanent base unit with a replaceable and inexpensive ‘top’ seemed like the ideal solution.

“Inevitably, it took some time to get the design right, involving several ‘off the shelf’ trials with a partial head that the model makers had lying around spare, as well as experimenting with various hemispheres of layered plastic to see which ones behaved most like skull and scalp. Once we were happy with the basic structure, we were then able to add a basic plastic ‘brain’ inside and to create a crude working model.

“The next stage involved mimicking the overlying scalp and the underlying dura (the tough membrane that covers the brain beneath the skull). To achieve this, we tried any number of combinations of different plastics in varying strengths, thicknesses and degrees of adherence, in conjunction with similar trials and error in order to get the plastic ‘skull’ to cut, drill and saw in the same manner as a real one. The internal architecture of the skull was modelled from a real skull which enabled us to get all the appropriate anatomical landmarks so crucial for simulating operative surgery.

“Having established the basic viability of the idea, the next step was the creation of a full custom made head and neck. For authenticity and accuracy, it was essential that the model be as close to a real skull as possible, both internally and externally, so it seemed logical to base the design on a real person.

“We approached my 14 year old daughter Rowena who was happy to act as the model for the fascinating and painstaking process of creating the master moulds. In a session lasting almost two hours, the human Rowena had her hair hidden under a plastic cap to smooth it down, after which her entire head was gradually covered with layer upon layer of moulding material. This set over the course of a few minutes, allowing the next layer to be
applied. Two small straws were popped in her nostrils to allow her to breathe - a great feat of patience if ever there was one. At the end of the process, the plastic mould was carefully cut open at the back and peeled forwards. This mould was subsequently used to make the initial Rowena heads.

Rowena in practice
The completed plastic Rowena consists of a permanent head base with internal skull architecture, on which is fixed a top or calvarium, consisting of skull, scalp and dura. This piece is easily located with a lug and a screw for security. Intended to be replaced once it has been drilled and sawn to destruction by trainees, it has been designed as a relatively inexpensive consumable. The scalp can be used with Raney clips to turn different flaps as well as standard burr holes and ICP monitoring devices, whilst the underlying dura with its vascular markings can be hitched up and opened in various ways to expose the soft plastic deformable brain (complete with ‘lesions’) beneath. Bone flaps can be replaced and fixed with sutures or a variety of plates and screws. The model is compatible with both CT and MRI scanning, enabling use of the head with computerised image guidance systems, further expanding the range of procedures that it can be used to mimic, as well as helping to plan surgical approaches.

For closure, the dura is sutured, the bone flap replaced and fixed with any proprietary fixation system and the scalp stapled. Fractures can be reproduced with a hammer and fragments can be elevated and fixed.

“One of the most useful features is that Rowena can be held using a standard neurosurgical three point headrest (where the skull is rigidly held by three small pins under tension). This keeps the skull absolutely still during delicate procedures,” explains Richard. “Putting a head into the headrest without mishap is another basic skill that trainees need to learn. This can be very easily reproduced before they actually get to the nitty gritty of opening the scalp and skull.”

Putting Rowena to the test
The first real use of Rowena was at the inaugural simulator course at QMC in autumn 2013 which included four neurosurgical trainees from the regional neurosurgery unit with differing levels of experience. The course involved trying out a multitude of basic techniques from head positioning through to using different types of power tools and cranial fixation and repair techniques.

“One of the most useful features is that Rowena can be held using a standard neurosurgical three point headrest (where the skull is rigidly held by three small pins under tension). This keeps the skull absolutely still during delicate procedures,” explains Richard. “Putting a head into the headrest without mishap is another basic skill that trainees need to learn. This can be very easily reproduced before they actually get to the nitty gritty of opening the scalp and skull.”

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Richard Ashpole
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Profile
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University Leadership & Management Qualifications Feature

• Have you undertaken a programme?
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In the next edition, we will be running a feature on trainees pursuing formal qualifications such as Health Management Masters, MBAs and formal certification in all forms. We want to understand more about the value, the relevance, how they performed and whether you would do it again. We are keen to discover what you did with the learning too.

If you would be prepared to contribute, please can you contact me, Sara Watkin (Editor-in-Chief) on sara@clinicalcareer.co.uk and we can arrange a mini-interview with either myself or my colleague, Fraser Tennant.
Whereas the requirement that innovation in health care delivery is both expected and accepted by the profession at large, I can't help but wonder whether the profession has truly grasped the nature of that innovation and what it will mean for existing service providers. Commissioning has been changed to support the introduction of new innovations, in particular the introduction of what are described as new business models. The expectation of NHS England is that these new business models will most likely disrupt the existing provider network by offering entirely new ways of delivering care that have the potential to leave the existing providers obsolete if they do not adopt them. This short article focuses on just this sort of innovation, disruptive innovation, and how it might affect services and individuals going forward.

Just what is a disruptive innovation? The clue, of course, is firmly in the name. A disruptive innovation is a type of innovation that tends to change the very nature of a market or just how something is done. In the technology field, recent decades have brought a whole host of disruptive innovations, many of which leave the existing players in panic mode as the new technology takes over from there established way of doing things. Disruptive innovation is best understood by looking at a series of examples.

Examples of disruptive innovation
- the PC disrupted mainframe computing as the standard method of processing data, resulting in the demise of almost every large mainframe computing company
- digital camera technology disrupted film technology as the main method for capturing and storing images, very sadly resulting in the collapse of Kodak
- MP3 technology has resulted in significant disruption of the music industry, which strongly resisted this new approach brought firmly onto the horizon by Apple

In healthcare, we also have emerging technologies that seek to disrupt the traditional way of doing things. The following represent good examples of disruptive innovations that are likely to change health care delivery significantly within our working lifetimes:
- Telehealth will enhance our ability to care for patients without subjecting them to cycle of outpatient visits simply
to monitor their progress (or not)
- Genome sequencing has the potential to disrupt traditional methods of diagnosis by identifying patients or potential patients in advance of symptomatic development

**Disrupt or be disrupted**
You can’t help notice that in each of the examples above, the existing players tended to be displaced by those companies promoting the new technology. Indeed, it is worth considering the well-known phenomena that disruptive innovations very rarely emerge from existing players i.e. almost always come from a new market entrants. This suggests that there is something about the R&D process of an existing organisation that fails to develop or embrace new ways of doing things over and above innovating to enhance the existing way of doing things. This should be a clear red flag to organisations in technology areas at risk of disruption.

The truth is that organisations need to learn to disrupt rather than be disrupted and yet our psychological reaction to potential disruptive innovations is defensive and at odds with our likelihood of seizing them or adopting them. An excellent example of this in healthcare is the emergence of treatment centres for delivering high volume, comparatively simple elective care. The system embraces this disruptive business model because it has the potential to radically transform the financial footprint for certain procedures. However, the profession tends to adopt the position that treatment centres are bad for healthcare because the results won’t be as good, moving routine care into treatment centres will undermine the existing departments and by shifting volume procedures into non-training organisations we will struggle to train the surgeons of the future. Whereas each of these arguments has some merit, all of them represent the typical pattern of reaction to something that we see is threatening. Consequently, it is no surprise that the vast majority of treatment centres are owned and operated by commercial organisations rather than the NHS.

**Why do we fall into this trap?**
If this tendency to resist disruptive innovations until such times as they take over is well recognised just how come we don’t recognise this trap early and consequently adopt a different approach? The answer lies in the very nature of disruptive innovation and how it comes into being. Let’s utilise digital camera technology as an example. When the first digital cameras appeared on the market you would have to conclude that the technology was not very good, especially compared to today and particularly compared to the existing way of doing things i.e. film. Consequently in an organisation like Kodak that had built much success on investing in film technology, it was easy to
see digital technology as a fad that would pass and not displace film technology which produced a superior image. So, we commonly discount disruptive technologies when they first appear.

However, that is not the only part of the trap. We also fail to recognise that alongside a new technology or business model, there is a change to the desired or expected job to be done. Kodak misjudged that because film technology produced a superior image they would be secure. What they were failing to recognise was that the job to be done with an image was changing and that image quality was rapidly becoming a secondary consideration to an emerging primary requirement that images could be shared e.g. on Facebook. What tends to happen is that if the disruptive technology fulfils a need that the existing technology doesn’t there even though it starts out in life a bit rough round the edges, it attracts investment and development and becomes much better. Consequently, digital images today outstripped film technology for quality whilst also being of a form that is easy to share. Digital wins.

System innovation in healthcare
Currently we have a system that we cannot afford due to poor financial health in our economy alongside rapidly growing demand through an increasing and ageing population. Consequently if we simply tried to deliver healthcare in the way we have done so essentially since 1948, we cannot hope to support this in the face of this increasing demand. Quite simply, the system must reinvent itself to be able to deliver more and different types of care in a form that is financially sustainable going forward.

Commissioning has been changed to facilitate any provider, new or existing, to come forward and suggest a better way of treating a particular group of patients. In the past it was extremely difficult to get established as a new provider, even if what you are offering was ground-breaking. Today, Any Qualified Provider and the localisation of commissioning provide a mechanism for all sorts of organisations to bring forward their ideas and have them supported into the system, if they hold merit. However, presently you can’t help notice that many of the new ways of doing things are brought in not by existing providers but by commercial organisations. It seems that system innovation in healthcare is following the expected disruptive innovation pathway. This should ring alarm bells loud and clear with an existing providers.

An opportunity to be seized
Given that the system is demanding...
new, sustainable ways of delivering health care, all providers have immense opportunity to innovate and then use that innovation as a means of expansion and consequently longer term stability for themselves. However, this requires both a change in practice and a shift in mindset.

The change in practice centres around the innovation process. If you job plan people to within an inch of their lives and then puts them under immense and continuous pressure to churn day-to-day work, there is precious little mental or physical timespace in which to innovate. Unless you create the conditions that enhance the likelihood of innovations emerging, it is highly unlikely that they will spontaneously appear in our current overworked environments. This means that almost by default, new innovations are more likely to be discovered by organisations not constrained by this overwhelming delivery requirement.

The change to mindset means learning to think with a commercial orientation. Frequently, and NHS service finding a new way of doing something results in that service doing it only to themselves within their traditional existing geographical boundary and consequently cannibalising their own financial stability. A commercial mindset would seize the opportunity to establish the new way of doing things not just within their own traditional patch across other people’s patches as a competitive move, in effect disrupting the organisations still trying to deliver care in the traditional manner. As you can see, success goes to those capable both of coming up with an innovation and utilising it to best advantage from a commercial perspective.

Doctors as innovators
It is easy to see doctors as a rigorous followers of clinical and scientific evidence i.e. conformist rather than innovating. However the history of medicine and health service is one of innovation, in almost every aspect of care. I tend to think that many of the new innovations are more likely to come not from our most experienced doctors but from more junior colleagues who have the traditional methods less ingrained at their core. This in no way means that senior colleagues do not have the ability to innovate, so much as highlighting that they must recognise the tendency to discount new ways until proven and develop a healthy view of challenge towards traditional methods.

I would encourage all to learn far more about innovation, methods of discovery and most importantly commercialisation of new innovations both to seize the opportunity laid out before us and also to ensure that we are not victim to new innovations. As with almost anything in life, a new innovation starts out as a seed in the mind but true success comes from acting on that seed and cultivating it into something of value. Good luck with your search.
Okay, so you’re just into clinical roles and already someone is asking you to consider your future career and what you can do today to enhance your chances. Isn’t it a bit early? The answer is a firm no and what many doctors discover is the closer you get to actually applying for career posts, the more difficult it is to ensure that you have exactly the right CV at the right time. Consequently, it is imperative to get started on career enhancing experiences as early as possible. This short article is designed to highlight just a few things that we encourage FY doctors to consider as early as possible.

Although it seems that every last individual is talking about the importance of leadership development, in our experience most doctors leave attending the leadership course until they are within sight of their CCT. Given the likelihood of increased competition for the best posts, leadership course has become simply a must have to get shortlisted but in no way does it provide any differentiation between one candidate and the next. So, I would not only encourage you to engage in leadership development as early as possible but also then use the insight gained to plan a series of leadership experience building activities that demonstrate a true commitment to leadership evidenced by stepping up at an early stage. Such an activity might be leading an improvement project or investigating how a pathway of care could be altered to enhance patient experience. Either of these would be within the grasp of an FY doctor.

My second piece of advice concerns the importance of developing deep system insight, invaluable both to future employers and yourself in considering just how jobs and career paths may change going forward (try reading The Big Article). From our interview skills work, we know that employers are particularly looking for people who understand how healthcare provision is likely to change over the coming years and consequently our services need to adapt. As you start to get into this topic area you will realise that our health system is a highly complex and constantly evolving beast, where that complexity is hugely difficult to grasp if you are doing it from scratch in the run-up to applying for posts. Consequently, I strongly advise you to become a system detective from an early stage and make it a passion to understand why the system is changing, how the system is changing and the implications of those changes to the service providers within. At the risk of being slightly self-promotional, a good starting point is to attend our low-cost Insights programme, which will provide you with a solid basis of understanding in commissioning, competition, choice, finance and quality in the new system.

My third piece of advice is to seek out the article on how best to approach rotations from a career perspective, written by my partner, Dr Sara Watkin. In this article she recommends approaching each rotation as an opportunity to develop just one thing that enhances your CV for the career that you aspire to. The majority of FY doctors focus almost all the efforts on
clinical skills development, missing the opportunity of adding significant nonclinical experiences over time. The principal at play is the same one about taking out a pension policy. The true benefit is earned by starting early and investing consistently, leaving you in the latter years with the far simpler task of now adapting your latter experiences to suit the very post but you aspire to.

My final piece of advice concerns the actual process of planning. Having already made the point that the career of tomorrow may look very different than traditional career paths today, it therefore becomes vital to ensure that your planning process carefully considers just how employment will change over time. We are likely to see a big mismatch between available candidates and the posts they desire. This will work both positively and negatively, with some job types having an abundance of candidates and consequently huge competition, whilst other, likely to be new, jobs having an absence of candidates who are perfectly suited.

I encourage you to take a three-step approach to early career planning:

• firstly, decide on the type of post you think is for you e.g. hospital specialist in a particular specialty
• secondly, consider whether the specialist area of care will even be delivered in a hospital or if it is likely to remain so, just how the nature of work may change over time
• thirdly, ask yourself whether your choice is simply a reflection of traditional career paths and whether you have appropriately considered new or emerging career paths when you made that initial choice

Armed with the output of this thought process, you can now sit down and work out what the employer might be looking for in terms of both clinical and nonclinical skills and experiences at the time you are seeking a substantive post. For instance, will that type of post come with the requirement for this and this knowledge and skills, alongside clinical skills? If the answer is yes, why not plan in an MSc or MBA in Healthcare Management as part of your career strategy to ensure that you are perfect for the type of post you will ultimately want. It is abundantly clear that you cannot decide to do an MBA in your final year before CCT, if this is the point at which you have discovered it might just be the perfect CV item to get you your dream job.

I have hardly touched on the myriad of options available to FY doctors wishing to stack the deck in their career favour. Over the coming editions we will build on this important aspect of career strategy, with more examples and specific advice. However, at this point I simply wanted to get the mental juices flowing in the direction of being highly proactive about your long-term career at the front-end as you enter clinical posts. Whether by design or by accident, the successful in life tend to be those that have set themselves up to be just that. So I hope that this article will have been the inspiration or stimulus to start planning today for an enormously successful career tomorrow.
Let me ask you a provocative question. If you are presented with two candidates for surgical post, both of which had similar CVs in terms of nonclinical department, projects led, audit, publications and the usual array of career enhancing activities, which one would you choose and how? Now let’s change just one parameter. Let’s say one of those surgeons has vastly more surgical experience than the other. Would that make a difference?

The reason this is provocative is that there has been an increasing debate about how trainees can gain sufficient surgical theatre time, as well as participate in all other aspects of a post, since the available hours have been cut so dramatically by the European Working Time Directive. Gaining the right surgical experience is made even more problematic by the rarity of some surgical procedures and indeed by the shift of others into high-volume low cost treatment centres who typically do not offer training posts. Consequently, we are seeing an increase in the use of overseas appointments as a way of obtaining a huge volume of surgical experience in a comparatively short space of time.

This reminds me of a conversation I had with an overseas surgeon working in the trauma field who had expressly opted to work in downtown Baltimore so that he could gain significant experience of the emergency treatment of gunshot wounds. Whereas we might believe from the news that every town in the US has gunmen on every corner, in truth you could go years without having to treat gunshot wound... unless you moved to Baltimore. I am not suggesting that all trauma trainees should plan on a stint in this frankly quite attractive US city and if your goal was to work in a trauma centre that would value the skills associated with treating gunshot wounds, then a rotation in Baltimore would provide you with more experience in a year and you could reasonably expect to get in a lifetime elsewhere in the US. I can’t help but think that what we are starting to see today is a career strategy very much aligned with the small anecdote.“

Choosing to work overseas for...
the specific purpose of gaining experience that you simply could not get in the UK is becoming a much more viable option than previously. As all health systems, including emerging health systems, improve and move towards a relative standardisation of healthcare delivery, surgical experience gained in overseas territories can be highly relevant to UK trained doctors. Of course, it is not simply a case of packing the bags disappearing three weeks and returning with 50 cases under your belt. There are important planning considerations to make sure that you do indeed end up with the cases you seek, as well as issues like indemnity that need to be clear before you embark on operations. That aside, and overseas stint has become more and more viable as a method of either gaining superior surgical experience or indeed filling gaps where you simply have not managed to obtain sufficient surgical experience of a particular procedure already.

We are delighted to feature two articles in our Overseas Section focusing on foreign elective terms undertaken to augment surgical experience. The environment is chosen are very different for each and of course the right choice of environment is critical for the experience to become a CV enhancing activity. However, as a career strategy it is one that has increasing merit in the job market that is not only changing but also becoming increasingly competitive.

Dr Sara Watkin
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Author Profile

NEXT EDITION

Enhancing Private Practice Success
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In the next edition, make sure you check out our article on the sorts of things you can start doing now to ensure that you have a successful entrance into private practice by accelerating the acquisition of private work. It’s easy to think that this is something for later but we think differently and you’ll see why in the article.
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5 Really Important Questions

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• Do you know the conditions and mechanism for competition entering your locality & the influence you have over this?
• Are you completely aware of everything that affects both tariff and your service funding?
• Do you fully understand the new choice agenda and just what information will be made available to patients (and how)?
• Are you fully conversant with the new commissioning agenda and how this will affect secondary/tertiary care?

If you answered ‘no’ to some or all of these questions, it does raise some concern that you and your service may be vulnerable in the emerging landscape, especially if you are trying to influence or set strategy with an incomplete picture.

What’s becoming clear is that the difference between a thriving service and one that struggles and lurches often comes down to depth of understanding and interpretation (leading to confidence to act appropriately). It’s a whole new jungle out there and if you don’t understand it then you are at a disadvantage, in an environment that has stopped looking after its prisoners.

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“Thousands of people would kill for your job!” - said the Registrar to the SHO who was struggling to control the tears of helplessness, disempowerment and disillusionment.

The moisture overflowed the little available space in my eyes and a huge tear slowly crawled down my cheek. Its bitter-salty taste was surprisingly refreshing. I wiped away this uninvited reflection of the state of my inner world and stared at the stains of mascara on my fingertips. Was it just me who was not finding the fulfilment in “the job of my dreams”? I was so numb and confused that I could not find the words to say. The bleep went off reminding me to put my “commitment to Medicine” hat back on and to stop embarrassing myself in the middle of the ward.

I had always known I wanted to be a doctor. As early as four or five, I had a pretend hospital in my room where I was curing my dolls and teddies of various ailments. Everyone around me was joyful that this pretty little ‘helper’ was getting good grades at school.

The path to a career in Medicine was not only an obvious choice; it was the only thing I ever considered. After all I always ‘knew’ I wanted to be a doctor.

At University, I used to be fascinated whenever I heard of some medical student who was unsure they had made the right choice. I experienced shock whenever I heard of some doctor who left Medicine. “What?! Why would anyone do something crazy like that?” I pitied them for missing out on what seemed like the journey of a lifetime.
As doctors, we all have our highs and lows. My patients taught me many lessons about myself and the world around me. I felt grateful for the opportunity to meet amazing mentors, to go to fantastic conferences and events, and to make a small difference in other peoples’ lives. I was one of many who would arrive on the ward to prepare the patients’ list well before the ward round would start. Drawing boxes next to the hundreds of tasks each day and then ticking them off when a task was complete had a meaning and a purpose. More often than not I would choose to tick off extra boxes on my list of jobs instead of a ten minute “natural” break. I would then fail to admit on the Hours Monitoring Exercise that I had not had any breaks. You just play the game that everyone else is playing. I would turn up to work ill because my conscientiousness would not let me call in sick. I would stay late in the evening sorting out endless paperwork in the full knowing that if caught, I would be labelled “disorganised”. I told the guy who I liked very much that I had to take care of my career and did not have time for a relationship. A comforting thought “It’ll get better” made it all seem worthwhile.

Over time I also learnt that thinking outside the box within the NHS is discouraged. So I kept silent, only ever venting my frustrations in The Mess with other junior doctors. The years went by and I was still ticking off boxes on the list of jobs instead of taking “natural breaks”. It started to feel less natural. Frequent relocations for job rotations made me feel like a rolling stone. I would look around every day and would see many disillusioned, frustrated and burnt-out doctors who functioned on autopilot.

“Is this all my life will ever be?” Whenever this thought popped into my head, I would feel guilty. I felt like I was betraying my patients, my colleagues, and even the society that invested in my medical training. I had always been “a high achiever” who had passed all professional exams with flying colours... My multisource feedback forms were complimentary. I made it through all medical interviews first time round. A future as an NHS Consultant was only three years away and yet I was longing to experience real meaning and purpose in my life.

Like a thief in the night, I would sheepishly type “alternative careers for doctors” into Google. It felt like a crime. I could not share it with anyone. What was wrong with me? What happened to the joy I had the day I passed my finals? What happened to my creativity, my enthusiasm, my passion? Was I the only one?

I had ticked off all the goals in my professional life yet it felt like there was more to life than ticking boxes. There was more to life than staying in the box. I was a Registrar in a highly sought-after specialty, but it was not feeding my soul. In my hands was a fantastic CV listing all the achievements that got me the dream job, but no one to hug my empty soul in my empty flat. An A-star doctor got no stars for prioritising her career above other relationships in her life. The nagging feeling that something fundamental was missing in my life was getting painful. I lived through these doubts alone in the fear that the medical profession would judge me as a failure. It seemed ironic to hear my junior colleagues express their envy over my “dream job”. The story I had heard a few years previously about a senior registrar who left Medicine somehow no longer felt all that outrageous. Thousands of people probably would kill for my job yet I was not ready to die over it.

After many months of soul-searching and reflecting, I had my epiphany moment. One Friday evening I stayed behind after a clinic to do
my paperwork. I walked into the Registrar's office to collect my bag. What I saw was my wake-up call. My senior colleague still in her theatre scrubs sat crossed-legged on a chair staring into a computer screen. She was surrounded by multiple patients' notes and numerous papers. She was doing an audit. Her partner was on the phone and I could work out from their conversation that he really missed her. It was 8pm on a Friday evening. She kept telling him she had to do the audit but would try to come back home soon. In that brief moment I had what seemed like a never-ending string of flash backs to all the relationships fractured by my frantic career pursuit. Eight o’clock on a Friday evening. It was not going to get better. That insight into my future within the NHS gave me the answer. I had to break free.

Did I ever really know that I wanted to be a doctor? I may never know how much the “helper” label in my childhood combined with my A-star grades determined the path that I chose. Over the years helping colleagues and friends with personal and professional development gave me great fulfilment. Even more than the “doctor” label I was proud to be the “go-to” person whenever someone needed help with preparation for interviews, exams, public speaking or career management. My heart smiled every time I supported someone with their job application or gave them feedback about their research article or CV. My soul sang when a school student I mentored through the Social Mobility Foundation secured a place to read Medicine at Cambridge. I spent years beating myself up about feeling more emotionally connected to personal development and psychology than I was to reading the BMJ, performing surgery or doing clinics and ward rounds. I know now that it is neither good, nor bad that prescribing essential medication or administering CPR did not give me as much personal and emotional gratification as did attending personal development seminars and reading books on psychology.

So it turned out that bringing out the best in people and helping them realise their potential was my calling all along. The frequent tears of helplessness, disempowerment and disillusion were merely drawing my attention to the fact that I was not aligned with my values and beliefs.

Michael Pastore said: “It is better to follow the Voice inside and be at war with the whole world than to follow the ways of the world and be at war with your deepest self.” It took some courage to listen to the voice inside and to decide to start all over again and this time to create a life of joy, meaning and purpose. Once the decision was made, I started noticing that my health began to improve and a sense of peace and harmony followed. I could finally breathe. I felt reborn. There must be a way – I thought - to help others get their lives back and to get them to experience empowerment, contentment and joy while doing the jobs of their dreams.

Serendipity played its part and I am now doing exactly that for a living. I am lucky to know that there are unlimited ways and opportunities to live a truly fulfilling life. I am lucky to be creating the life just the way I
want it and to experience boundless energy in the process.

It is wonderful if Medicine is your true calling and gives you joy and fulfilment more often than not. Congratulations if you look forward to getting out of bed in the mornings to do what inspires you! Congratulations if you are happy with your work-life balance and feel in control of your life! There are many doctors out there who are less fortunate and Medicine is just a job, a status, a reliable source of income or a way to prove something to relatives, friends or even society. Be honest with yourself. What would you do if you knew you could not fail? What would you do if health and money was not an issue and you had a thousand years to live from now? Does it come as a surprise to you that at the recent BMJ Careers Fair, the workshops on the topics of Career Change and Work-Life Balance were sold out?

Before I am judged for taking up someone’s place at Medical School, a 16 year old “helper” who wanted to make a difference in other people’s lives simply did not know any better way to do so than to become a doctor. Before the critics say “you just wanted an easy life”, I have to confess it was far from easy to leap into the unknown, out of my lonely but safe box. Doing it all alone poses unique challenges I had never encountered while working in the NHS. Not having a Plan B means I have to make Plan A work. It is a steep learning curve which often feels like an impossible task. Finally being able to really take care of myself, to breathe, to live in the city of my choice, to create, and to rebuild meaningful relationships are the things that keep me going.

For me, success is about being true to oneself. It is not what you do but how you do it. If you don’t feel passionate about what you do, ask yourself why you are doing it. As I started sharing my journey with some medics I trust, it transpired that there are many doctors out there who wish they could do something that would make their hearts smile. Someone told me her passion was baking and her dream is to open up a bakery. Another doctor told me she would love to help women look beautiful and would set up a Beauty Spa if she knew she could not fail. A third doctor would love to teach dancing professionally. They say “I just don’t want my job to be my life”, but stepping out of the box is scary. They are not pursuing their dreams because they do not see a possibility that their passions could pay off. Heraclitus would say to them: “Those who are awake have one world in common. Those who are asleep live each in a different world.”

What gets you out of bed in the morning? Are you living so fully and presently in every moment that you always feel alive and energized by the gift of life? If not - what’s stopping you? Do you love the life you live, or are you merely making a living? Whatever the answers, how honest (really) are you with yourself?

Steve Jobs’ words were the light when I needed it the most: “Your time is limited, so don’t waste it living someone else’s life. Don’t be trapped by dogma - which is living with the results of other people’s thinking. Don’t let the noise of other’s opinions drown out your own inner voice. And most important, have the courage to follow your heart and intuition. They somehow already know what you truly want to become. Everything else is secondary.”

Until recently, Evgenia followed a straightforward medical training path: from Cambridge Medical School through Foundation Years and Core Medical Training to a National Training Number in Dermatology. Throughout her medical career, Evgenia gradually came to be aware that clinical practice was not feeding her soul. She found greatest fulfilment in mentoring and helping colleagues to grow and develop professionally. Evgenia stepped outside her comfort zone to follow her heart and pursue what gives her a deep sense of purpose in life. She now helps doctors realise their full potential and do more of what makes them truly happy.

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Author Profile
“YOU HAVE TO LOVE YOUR PATIENTS AND YOU HAVE TO LOVE WHAT YOU DO”

Top UK plastic surgeon Rozina Ali reveals the inspirations behind her passion for the healthcare environment

ROZINA ALI is one of the UK’s top consultant surgeons specialising in plastic and reconstructive surgery. Strong-willed and determined, her journey to becoming a top plastic surgeon has been a steady one—a remarkable rise for one originally drawn from working-class stock in Liverpool. Testament to her high level of professional integrity, Rozina was recently the recipient of a Professional of the Year award nomination at the Pakistan Achievement Awards UK & Europe 2013. Alongside such recognition from her professional peers, Rozina is also much sought after for appearances on television and was most recently seen dispensing her expert advice on Channel 4’s How Not to Get Old consumer guide to the anti-ageing industry.

What made you take the road to becoming a consultant plastic surgeon?

Rozina Ali (RA): When I was a child I decided that I was going to be not just a doctor, but a surgeon….I think the most important thing is that nobody said no, you can’t. I was raised and schooled in Liverpool and it was generally accepted by all around me that I was going to be a surgeon. So off I went to St Thomas Hospital medical school wanting to be a surgeon and, again found nothing but encouragement. There were no doom and gloom merchants saying ‘well, women can’t be surgeons you know.’ I was Scouse, working class, female ‘of colour’ and from a minority cultural and religious background yet I had the same spirit, drive and ambition as every other surgeon this country
produces. I had originally wanted to be a general surgeon but a wonderful mentor in Sidcup called John Payne decided I had a good pair of hands and should consider becoming a plastic surgeon. I had my first experience of Plastic surgery at Billericay hospital and was entirely seduced! So in short, I became a plastic surgeon because Surgery was my calling from an early age and because those I most respected and trusted – my family, my medical school, my tutors, my mentors, encouraged it.

What kind of work do you undertake at Norfolk and Norwich University Hospital (NNUH)?
RA: I’m a reconstructive microsurgeon and the majority of what I do is breast reconstruction, usually performing DIEP flaps (where you use someone’s tummy to reconstruct a breast). I’m also involved in reconstructions after major gynaecological and colorectal cancer surgery. The other thing I am involved in is lower limb reconstruction following trauma and road accidents. My job is to move tissue from one area to another, effectively bringing a fresh blood supply and healthy tissue to massively injured areas. Without this, the underlying structures e.g. bones have no chance of healing. What I appreciate most about my work is that I work in teams with my colleagues from other specialties (orthopaedic surgeons, colorectal surgeons, gynaecologists). Together, we do some really significant surgery and we do it well.

Which of these surgical procedures provides the greatest challenge?
RA: The most difficult, without a doubt, is breast reconstruction. That’s because it’s really difficult to anticipate how the patient is going to feel about it. The art of managing expectations is probably what gives patients the most long-term satisfaction and it is vital to build a relationship of trust and realistic expectations with every patient.

For example, if you have someone relatively young with a high likelihood of breast cancer due to genetic predisposition and they are recommended the removal of both breasts....then it is obviously going to be very difficult to substitute for the loss. Some of the most challenging yet fulfilling aspects of my surgical career are undoubtedly
the trauma patients. There's a huge range of possible traumas and accidents and more often than not, less than ideal or sufficient tissues to move. Other limbs or structures may be very badly damaged so you can't use them; or you can't violate certain areas because they are required for rehabilitation e.g. the upper limb because they're going to need it to use crutches, so lots of planning and discussion go into such surgical scenarios.

It's immensely satisfying, because those patients are going to be benefitting from the results of your surgery for the rest of their lives. They are also often young, fit patients with really high expectations. I just relish that. I think surgery is always pushed forward by functional and lifestyle demands that patients make of you. Personally I encourage it and think it's marvellous!

Patients are now much more knowledgeable as to their own care. Is this a good thing?
RA: It's a very good thing that patients are more knowledgeable. There is a tendency in some patient groups to not take any responsibility for themselves. I'm still astounded if someone cannot answer the question as to what procedure they had, when they had it and even why they had it. So I think personal responsibility is essential and I welcome patients coming in with lots of information and I will often ask them about what they know already so that we can discuss it. I encourage and welcome as much knowledge as possible and I am more than happy to address it. I'm proud of the quality of healthcare we provide at NNUH across all surgical specialties.

The Government's NHS reforms programme is radically changing the UK's healthcare landscape with massive financial savings being required over the next few years. How has this affected you and the environment in which you work?
RA: I would say we are trying to carry on 'business as usual'. It's still a one-to-one, doctor patient relationship. As a doctor, you have to protect and serve and listen to your patient. You may however have to tell them what's available or suitable, and then tell them of what limited procedures you can offer in your Trust. What all these changes have meant is a huge level of anxiety where we're always anticipating or fearing the next political or financial move that is going to have an impact on clinical care. As a specialty, plastic surgery has been hit hard and I have much sympathy for patients who come in requesting quality-of-life enhancing procedures like breast reduction or correction of breast asymmetry. Such procedures have more than just psychological benefits; they have huge physical and social benefits. There are studies to show that breast reduction has the same impact as a major joint replacement... however these days it's rare to secure funding to do those cases. I can think of maybe two or three patients in the past four years I've been granted funding to operate on, for the rest, you can only give them your understanding, your best advice and wish them well. There's no doubt these clinical decisions are hard but it's the inevitable fallout of a tight financial climate. It is also the taxpayers' money and we have to respect that, I just think the boundaries and criteria should be more transparent to the public and consistent across the country.

How important are training and development opportunities to you?
RA: Training, practicing, personal development are very much an ingrained part of any surgeon's nature. We're all about personal responsibility, all about learning, all about achieving and being completely self-motivated and self-driven.

A recent course I attended was called Time Management and Personal Effectiveness. I was interested in the 'personal effectiveness' component i.e. it's not enough just to be efficient and to getting things done smoothly or quickly. I want to perform meaningful tasks, measure meaningful outcomes and lead a fulfilling professional life. At that particular time I was managing a full time NHS career, coping with
Clinical Career

a fast-expanding private practice, honing my communication and business skills and navigating the convoluted, somewhat opaque world of the media, all at the same time.

There was a hard truth to the course leader saying ‘STOP, revise what you can personally do - The course was useful, while it reiterated you could only fit 120 litres into a 120l suitcase...I learned the secret was to have more suitcases! So now, I play to my particular strengths – surgical skills, creative ideas, communication etc but have learned to have a team of like-minded, trustworthy professionals around me who are skilled and experienced in their own fields. Turns out, there’s an art to delegating so that people that are really good at what they do, are left alone to do what they do best! I’m lucky that such good people choose to work with me. I have only succeeded because I work in a team. I have learnt that although you may work faster on your own, you go further as a team. So time management and personal effectiveness taught me that really worthwhile tasks take effort, planning and teamwork.

What does Rozina Ali offer that other plastic surgeons do not?

RA: I try to listen until I understand and then I would hope to work with my patient to get the desired outcome. I’m open, I’m honest, and I will work very hard and very long for my patient. All too often I get involved in cases which other surgeons deem inoperable or won’t take on, but I figure that since I spent 12 months in Taiwan (the world-acknowledged international centre of microsurgery excellence), that’s at least the equivalent of a decade of micro-surgery experience.

In my world, even anxiety, disease, reconstruction can in fact be made into a worthwhile experience. You’re wondering if somebody can really go through an experience of having a diagnosis they don’t want, surgery they’d hope never to have to undergo and then the arduous road of reconstruction? I assure you they can. I have plenty of patients who are very sorry to be discharged because the whole experience has been life-affirming and meaningful. My intention is to make even an otherwise unpalatable surgical experience into as enjoyable and inspirational a journey as possible for my patients, by acting as a trusted guide. That’s what I endeavour to do. It may be too strong a word, but it’s true, you have to love your patients and you have to love what you do and if you really dedicated to something, I think you’ll start heading in that direction.
With consultant posts becoming increasingly difficult to obtain, how do you ensure you absolutely stand out from the crowd when it comes to your turn to apply for the job of your dreams? This is especially relevant when training has become so standardised and everyone has been on a leadership course (which you must, or don’t expect to be shortlisted). I’d like to offer an idea or two.

To truly answer this question it is important to consider several factors:

- How might the job requirements change depending on the type of post you want?
  - For example are your aspirations for a major teaching hospital or a DGH
  - Do you want to do be an academic or a clinical consultant

- How have the requirements that future consultant colleagues value in applicants changed over recent years (and how might they change going forward)?
  - Job descriptions today have consistent themes:
    - For an NHS post
      - Proactive individuals who follow things through
      - Individuals motivated towards service redesign and delivery of care in different ways and settings i.e. prepared to work and think differently
      - Individuals motivated towards delivering quality improvement
      - Individuals with specific specialist skills for the post
    - For a University post
      - Proactive people who are going to deliver high impact papers and secure significant research funding

- How will the job description and hence essential and desirable criteria evolve over time?
  - For many, the jobs of the future will fall under two main banners being: broader based, delivering care close to home and in different settings or highly specialised, delivered in 15-30 major teaching hospitals across the UK. Each will require new skills and qualities

Good interviewers recognise that your past is also the best predictor of your future behaviour. In other words those individuals who have done some or all of these things are much more likely to do them again in the future. The individual who says they will do these things at interview but who has never done them previously is far less likely to deliver in these areas and therefore represents a greater risk to an appointing Trust or service. A track record counts.

This clearly makes it essential to try and obtain along the way, some of the experiences necessary to deliver the specific role you want in the future. It still amazes me how many individuals apply for a post with a specific interest and yet on their CV/application form they have made no attempt to demonstrate that they have developed the skills and experiences required.
in that area. Ironically, the CV is the easy bit. Trying to demonstrate that you are proactive, have lead quality improvements and small redesign projects is almost impossible if you have never done so!

So, how can you ensure that you do these things as a junior doctor? It is very easy to use each clinical job solely as an opportunity to learn more clinical knowledge. However, side by side to this, I strongly suggest you need to be using each post in your rotation as an opportunity to develop other skills that help demonstrate these new skills and qualities wanted by Trusts today.

I would encourage you to see every post as an opportunity to add ‘just one more thing’ that makes you a stronger candidate in the future. In the same way as most of us would hopefully plan in advance what we want to achieve from a clinical perspective, we need to start planning what we need to achieve to help demonstrate the broader skills and qualities required of new consultants today. Sometimes this is possible to do fully within the confines of a post but to be truly effective goals need to be set well before the first day on the job, before time flies and you realise starting now will not deliver the achievements you desire in the time available.

Your choice of goals is made easier if you have a clear vision of the type of job you would ultimately like to achieve and the expectations of what will be expected from a successful applicant. What is stopping you reviewing a few job descriptions on NHS jobs now to get a clear feel for present requirements for the types of post you would like to apply for in the future? Ask yourself; “If this is the type of person they want, how would they judge that from their experiences?”

Once you have a clear vision of the type of job you would like, you can begin to develop some high level goals. For example, if your vision is to be head of service at the Brompton, your high level goals might include a high impact academic record, specialist clinical skills and evidence of leading quality improvement projects and service redesign. Once you are clear of your high level goals, these can be broken down into smaller steps or objectives to be delivered within the context of a single post (e.g. an audit demonstrating actions taken to improve quality of care or a small but completed quality improvement project) or goals which can run parallel to your clinical work e.g. undertaking an MSc or MEd.

Your choice of specific goal for any particular job will also depend on feedback you had at the midterm & exit appraisal in your present job and enhanced knowledge of the job you are entering, developed by ideally meeting your educational supervisor in advance of that job and perhaps also through soliciting ideas from juniors presently in the post.

The type of career enhancing item will vary depending on your present level of training but at an SHO-level could include:

- A good quality audit especially where it has the ability to change practice
- Publication of a case review which demonstrates that you are a proactive person
- Evidence of teaching and presenting
- Evidence of being proactive e.g. being the SHO who sits on various groups or committees
- Evidence of audit demonstrating actions taken

At a registrar-level the types of goals will become more specific:

**Example 1**

1st 6 months - going on a leadership course and undertaking quality improvement training
2nd 6 months - leading a small quality improvement training
improvement project or joining a Chief Executive’s shadowing programme (if the Trust has one)
Year 2 - working as part of a team undertaking more specific service redesign.

Example 2
1st 6 months - doing a train-the-trainer and teaching course
2nd 6 months - Enrolling on an MEd course and being responsible for the SHO teaching programme
Year 2 - redesigning an SHO teaching programme and delivering several aspects of the training yourself

Failure to think and behave in this way leads to a phenomena not uncommonly seen; a doctor 6 months away from CCT with no publications, no high quality audit, no examples of leadership or quality improvement and really nothing on their CV to demonstrate proactivity or drive to be a consultant today. By this stage it is too late without specifically delaying applying for posts and, be under no illusion, these are the doctors currently applying time and time again but not getting the posts they desire. The earlier you start the easier it is to develop the qualities and skills necessary to be an all-round, great consultant today. So, don’t forget:

• Start with a vision
• Research what is needed to deliver that vision
• Develop some high level goals
• In each post aim to achieve some smaller goals or actions which will help you on your way to your high level goals
• Plan these goals early and in advance
• Keep reviewing the vision and plan

The latter point is an important one. The NHS is changing and will change increasingly rapidly in the future. Ensure your plan remains the right one for your longer term aspirations. However, if I were to leave you with one embedded thought it is this; for every rotation ask yourself the simple question “what’s the one thing I can gain experience of here that makes me more attractive for the post I eventually want”.

Dr Sara Watkin
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Author Profile
OVERSEAS FEATURE

For a medical trainee, the chance to work overseas is an amazing opportunity to gain experience that will add immeasurably to their medical development as well as providing an impressive and distinctive entry on their CV.

In our Overseas Focus section we like to focus on the practical and organisational issues that face trainees when they make the decision to take up an elective or contract in a foreign land and the personal and cultural benefits that this provides.

Sharing these experiences for the benefit of others is something we are very keen on and in this edition of Clinical Career we showcase the inspirational stories of four individuals who undertook training in India, Cameroon, South Africa, and the Himalayas.

As you will discover over the following pages, each benefited enormously from their experience, and each wished to share them with others who may be considering a move overseas...
In June 2013, I spent three weeks in the Rupin Valley, Himachal Pradesh, Northern India, courtesy of the health charity Himalayan Health Exchange (HHE). I had been to Ladakh in Kashmir with HHE in 2006 during my medical school elective, and had been looking for an opportunity to return.

My motive for going (on both occasions) was entirely selfish: I wanted the opportunity to trek in a beautiful and remote mountain region and have direct and meaningful contact with the people who live in this environment. Having completed MRCPsych and started a higher training post, it was time to treat myself. I was able to secure 10 days of study leave (although no funding!) and took the rest as annual leave for this trip. I applied for study leave through the usual channels, and justified it through stating how the clinical aspects of the trip would link to the curriculum. Then it was a case of emailing HHE and paying up to book my place on the trip. Apart from booking flights and getting a visa, HHE organised everything, which was great.

What we did

The trip consisted of 5 doctors, one dentist, porters, interpreters and lots of medical students. The numbers are simply based on who applies to come. We would spend a day or two at a village, before moving on to the next one in the valley. At each Village we would set up army tents as clinic rooms and a pharmacy. Villagers would crowd into the tents, so confidentiality for patients was non-existent. Although when privacy and confidentiality was required, we could manage it, but it required a team approach to shepherd other villagers away. So it was only done if absolutely necessary. Patients were triaged and sent to a tent and seen by the medical students (most of whom were American and mostly first or second year). Students would then present their findings and proposed plan to a doctor (one to each tent) who
would guide, teach and prescribe. If necessary, a patient would be referred to the nearest hospital (sometimes over a day’s travel).

**Challenges faced**

HHE have been aware for many years that the quality of interpreters is poor. The interpreters would frequently answer questions on a patient’s behalf, especially if it was something sensitive, and clearly ask questions that we were not asking. This especially became frustrating if clinic was getting busy, the tent was crowded and people were impatiently waiting. We had to hone clinical examination skills rapidly to compliment the small history we were able to obtain. One interpreter was excellent though, but planned on leaving the organisation soon. It will always be hard to find interpreters who can speak tribal languages, drive jeeps on dangerous roads and be prepared to lift and carry heavy equipment up and down hills and set up camp sites.

With these trips, many unpredictable scenarios are guaranteed. I remember one doctor washing maggots out of the wound of someone’s mule. More harrowing though was when we made camp by the side of a river. Those of us who set our tents up on the beach found our tents to be over-run by (mostly pregnant) spiders. It wasn’t much fun clearing them out with just the light of my head torch and a
cup. The next morning, we moved our tents further up the hill, which solved the problem, but my rucksack (which I had left in the porch) was still weeping spiders for days. It was just as well that we moved our tent up the hill, as the worst rains in decades came the next day. The river burst its banks, and much of our campsite was flooded. The floods were on the international news and there were many fatalities in the region. The floods destroyed parts of the road, and it was touch and go whether or not we would get out in time to catch our flights home. Thankfully the rains stopped and JCBs came to fix the road out. One more day of rain and I don’t think we would have made our flight.

Benefits from the trip
Apart from feasting on the unbelievably good food that the cooks could produce, it is always going to be beneficial to see how other people live in the world. It is good to remind yourself how much we have, and how we have easy access to so much. Dealing with adversity in the Himalayas, both clinically and with our environment, has made me feel calmer in my own environment, whether at work or at home. I can sit more comfortably with uncertainty, and have a calmer approach to thinking through situations which are deteriorating. I often find myself thinking back to my time in the Himalayas, saying to myself: “well this isn’t as bad as then”? Also, by spending time abroad, I mixed with people of different cultures, which only fosters a greater respect and understanding of people, which is invaluable working in medicine, in multi-cultural UK.

Things I would do differently if I had my time again
Thankfully, as a once-upon-a-time scout, I went prepared for most eventualities; although I’m sure 90% of the people on the trip would have wished they had more suitable waterproof clothing. Mountains, in particular the weather there, is unpredictable. As a psychiatrist, I noticed some mental illness, which everyone else seemed to miss. This was everything from somatisation of psychosocial difficulties, which was common, to the cognitive impairment of schizophrenia (a mental state examination revealed clear first rank symptoms in one patient). Therefore, I wish I had made enquiries with the organisers of the trip as to what psychotropic medication would be taken, and what medication and services were available out there. I should have made some inquiries into cultural understanding of mental illness in the area too (although luckily we had a professor of anthropology with us who had made this his particular area of expertise). Given this
lack of preparation, I was essentially unable to help, other than to offer an explanation to patients as to what might be the cause of some of their experiences. And in case you were wondering, we had 10 risperidone tablets, and some weird PRN “anxiety-be-gone” tablets that contained alprazolam and escitalopram!

Dr Adam B. Joiner
Psychiatry Registrar (STS), Early Intervention Service, Lancashire Care NHS Foundation Trust
At 16 I wanted to be an air hostess. I wanted to travel the world, elegantly solve my passengers’ problems and chat to happy families in foreign languages. This fantasy was quickly shattered when my career counsellor told me I was 2 inches too short to meet the minimum height requirement for an air hostess. Ten years later I was a paediatric registrar and strangely enough it suited me. The ever changing rotations satisfied my restless nature. Speaking to people of all ages from parents to toddlers to teenagers felt like I spoke many different languages in any given day, and though my elegance may have been debatable, the job was all about problem solving. I thought it was enough for me, until I saw an advert on the Royal College of Paediatrics and Child Health (RCPCH) website for an opportunity to work abroad, and it tickled my curiosity.

The Royal College of Paediatrics and Child health (RCPCH) works together with Volunteer Services Overseas (VSO) to develop placements for UK based paediatric trainees to go out to hospitals in developing countries. These placements are typically 1-2 years but shorter placements of 6 months are available. Since these placements are developed and approved by the Royal College it easier to get deanery approval for time out of programme than for a placement from an unaffiliated program. The RCPCH also appoints educational supervisors for all fellows, which gives you the option to carry competencies obtained during the placement towards your training.

The application process was very straightforward. After contacting the RCPCH to express my interest in January, I had a brief telephone interview and assessment day at the VSO offices in London where they explore whether your personality suits VSO outlook and strategy. Once accepted, I started pre-country training which consisted of online activities and two residential weekends. The RCPCH Committee matched us candidates to the most suitable placement and by April I was told that I would be going to Cameroon.

I arrived in Cameroon in September and was given the task of improving services for children with chronic diseases at a regional referral hospital. This involved the services for children with HIV,
Sickle Cell Disease, Epilepsy and Diabetes. Each illness presented a different set of challenges. Children with HIV struggled with social stigma which resulted in huge losses to follow up and poor compliance with treatment. Those with diabetes had a reasonably good service with a specialist nurse and free insulin courtesy of the World Diabetes Foundation. In light of this, patients with sickle cell disease and their families, felt ignored and demanded subsidised pain relief, access to more information, specialist services and more research. Children with epilepsy were largely invisible, as many communities viewed it as a spiritual rather than medical disease and often sought treatment from traditional healers.

Before getting stuck in, I was encouraged to spend some time exploring what it’s like being a child in North West Cameroon. I spent some time with urban and rural families gaining insight into the roles of family members, how decisions are made in a household, limitations of infrastructure and their impact on health seeking behaviours. This was immensely useful in enabling me to empathise with families during consultations.

The paediatric department consisted of four doctors, one consultant paediatrician, myself and two junior doctors (F1-2 equivalent). Everyday we saw “walk-ins” with the usual acute infections and rashes in a general paediatric outpatient clinic. On alternate days we did inpatient ward rounds on the paediatric wards and neonatal unit. The neonatal unit had no ventilators, one oxygen cylinder with capacity to supply up to three babies with wafting oxygen and six makeshift incubators; but the neonatal nurses were amazing and worked tirelessly to keep sick babies alive.

During my 12 months there I developed an epilepsy handbook so patients with had handheld records detailing their seizure types, what to do during a seizure and their treatment regime. I held some community education sessions with a local NGO to reduce the mystery surrounding seizures and we encouraged people to come to hospital. On Saturdays I did a radio program with a sickle cell activist, discussing health
issues and living with sickle cell disease. The hospital’s HIV team was exceptional, and we worked together to explore the reasons behind the loss to follow up and improve things for our patients.

On one day a week I worked with the VSO health team, which consisted of health care professionals from Cameroon, Canada, Uganda and UK. We worked together to deliver community health programs such as HIV awareness schemes, encouraging men to take their wives to antenatal care and training of rural health care workers in isolated areas.

It was exciting living in a foreign country. VSO made sure we always felt safe, and they provided us with a monthly allowance. The hospital had received previous volunteers in the past and so had anticipated many of my difficulties, making it really easy for me to settle in. We often had power cuts, water shortages and the internet was extremely slow, but my biggest source of woe was the absence of cheese. Otherwise the fruits were divine and the local food really tasty. I was invited to several different cultural celebrations from weddings to funerals, giving me a glimpse of many traditional dances, foods and rituals. Cameroon is unique in having all types of landscapes from the Sahara desert in the North, to beaches in the South with lush green mountains in the middle, including the highest mountain in West Africa. So there were plenty of opportunities for the adventurous types.

I was forced to rely heavily on my clinical skills because of limited access to investigations. For investigations that were available, I had to carefully consider their cost, accuracy and benefit of the test before convincing parents to pay for the tests. Even though I was in an English speaking region my communication skills were challenged daily and I got to build on my A-level French.

I worked with doctors who had not been paid for several years because of the lengthy procedures involved in getting the Ministry of Health to authorise their salaries. Despite this, they turned up at the hospital and worked without complaint. Often they had to take up extra jobs and consider alternative sources of incomes to survive until their salary was approved. I really admired their commitment to their careers and felt ashamed at the many complaints I made as a registrar back in the UK. Many
of these doctors taught me about managing tropical disease, HIV care and creative alternatives to the limitations of working in a resource limited setting. Memorable cases include managing an unconscious child with DKA with no syringe driver for continuous insulin, and the palliative care of a ten year old with a brain tumour.

I also learned a lot about teaching and service improvement. The language barrier, differences of experiences and different agendas led us to keep our training sessions interactive and group led. There were often unexpected tangents and changes and I had to be flexible and creative. The lack of electricity in many of the rural communities we visited quickly weaned me off power point and I learned lots of new ways to facilitate learning.

In developing community projects with VSO I learned how to write a business proposal, recruit staff, monitor and evaluate a project’s impact and sustainability. It opened my eyes to career options outside of hospital medicine, and helped me appreciate the challenges of public health work. I am hoping that this experience will help me be a better doctor, teacher and help me stand out as I apply for consultant jobs.

I would volunteer with VSO again. The experience is incredibly enriching and VSO and The RCPCH go out of their way to place you appropriately and keep you safe. In this season where many junior doctors are identical in training schemes with identical competencies and portfolios, I am grateful to have had the chance to follow my own path, and develop in new areas of learning. VSO has fellowship schemes with the Royal College of General Practitioners (RCGP), the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Paediatrics and Child health (RCPCH), I encourage at least look into the schemes, there might be something for you.
Augmenting Surgical Experience Utilising Overseas Placements

In our Career Strategy section, we highlighted an increasingly common approach to gaining a high volume of surgical experience by utilising foreign placements or electives. And so in our Overseas section, we are delighted to include two articles featuring the experiences of two trainees who undertook such an approach, each with a very specific reason.

We hope that by sharing their experiences, you will not only be inspired to consider this innovative career strategy but also to enter into any adventure with your eyes firmly open.

Call for comment
We would love to hear of other experiences of working abroad, particularly with very specific reasons associated with gaining training experience that you feel the UK was not meeting. We would be keen to build a reference section of articles on these types of overseas placement, so that trainees considering gaining experience abroad can read through the real-life experiences and what people had to do to ensure that they got not only the right experience and achieved it in a UK relevant fashion and without risk to themselves or their professional position.

Please contact Dr Sara Watkin on sara@clinicalcareer.co.uk
Cataract is known to be responsible for 50 to 80% of bilateral blindness in India. Although greater numbers of cataract surgeries has led to a decrease in prevalence, projected increases in India’s 60+ population is likely to mean a greater number of those at risk of cataract. During the summer of 2013, Neuro-Ophthalmologist Srilakshmi Sharma undertook an elective with a cataract surgery unit at the Sankara Eye Hospital in Pammal, Chennai, an experience she describes as “tremendous.”

Clinical Career: Why did you make the decision to undertake surgical training in India?
Srilakshmi Sharma (SS): Firstly, you can get experience in a very particular cataract surgery technique which is invaluable in helping you deal with some complicated cases, and it’s also useful if you want to do any kind of relief work in this field in the future. You don’t get that training or experience in western countries because we’re reliant on an ultra-sound assisted technique. But the small incision cataract surgery technique that I learned in India is extremely useful training. That’s number one. Number two is India’s home. Number three, it was good to do free work.

Clinical Career: How would you compare the unit you worked in to a similar service in the UK?
SS: Basically, they have a fee paying service and a non-fee paying service. I was working in the non-fee paying service. Only consultants work in the fee-paying service because patients come in and get their cataracts done by the lead surgeon and the slightly more junior surgeon operates the theatre which is purely for non-fee paying patients. It’s totally different from the UK in that the technique used is far quicker. They can take a cataract out in under five minutes and then do the cataracts back to back. It’s a very high volume cataract surgery, far higher than in the UK. The surgeons are exceptionally skilled and their outcome rates are very good. Another key difference is that staffers go out and collect these patients from the rural areas and then bring them back to the hospital if they’re willing and want to have their cataracts operated on for free. So there’s none of the hotel service that patients are offered here in the UK and there’s not much time for tremendous niceties. There’s not an onus on personal care at all; patients are in for one night.

Clinical Career: How many procedures did you carry out per day?
SS: They could have something like 100 a day. So that would be four surgeons, including trainees, seeing a hundred cataracts. That’s about 2 to 2.5 times the volume of a standard cataract surgeon in the UK. And procedures are

“IN INDIA IT’S PURELY ABOUT GAINING SKILLS AND NOT ABOUT TENDING YOUR EGO”
A Neuro-Ophthalmologist’s experience in South Asia

Srilakshmi Sharma

AUGMENTING SURGICAL EXPERIENCE UTILISING OVERSEAS PLACEMENTS

OVERSEAS FOCUS
carried out under a local anaesthetic as they are in the UK.

Clinical Career: How do complication rates compare?
SS: The complication rates for surgeons working under these sort of circumstances are no different to that of the UK. For trainees, it’s probably higher, because there isn’t always that intensity of supervision. My experience was that you’re probably not rescued quite as quickly as you would be in the UK. But with experienced surgeons, it’s really no different.

Clinical Career: What was the experience like from a work and a personal perspective?
SS: The working environment is definitely more intense, particularly if you’re in private practice. If you work in private care, rather than in this kind of social care set up, you don’t really see home until eight or nine at night. It’s much more intense but in India a lot of things are more intense. Education is more intense because the competition is so very high. And it’s no different in the work environment because it’s purely capitalist. If you can’t pay for it, you don’t get it. In India, the pressure to compete and make money in the private sector is enormous and the population is also enormous. So with social enterprises like this one and its network of hospitals, the number of patients coming through your door will be enormous. So that’s one of the biggest differences in my work life, the intensity of the workload. Personally, as an Indian citizen, the differences are not at all impressive to me because I’m used to India, but the differences for someone coming in from the West, who hasn’t had previous exposure, would be much more obvious. Another difference is in the quality of the equipment used for non-fee paying patients; they just weren’t as good quality as clearly there was a financial pressure.

Clinical Career: Do you have any thoughts as to how the UK can deliver care differently?
SS: From a surgical point of view, you can certainly deal with a greater volume of patients by employing some of the methods that I saw in India. For instance, you can have theatres running simultaneously, with surgeons moving between cases instead of sitting down and waiting an hour for the patient to make it up to the operating suite. So efficiency could maybe increase in the UK, especially within hospitals. That’s probably a principle to take away. However, there are cultural differences which would make it difficult for the NHS to accommodate some of the differences to make for better care. I can’t really suggest many more strategies that aren’t employed anyway. As far as the care is concerned, there’s not a tremendous amount of difference at all. In India, they have the equipment, they have all the medications that we do, and there’s actually not a whole lot of difference except when it comes to rarer conditions which require the most expensive treatments. In this they fall short, but in the major hospitals, it would be a different story.

Clinical Career: What are the long-term benefits of having done the training in India?
SS: I know that things can be done...
differently and are done differently in different places. When you may feel that you're challenged or limited, there is a sense that there is another way to achieve what you want to achieve. I really enjoy exploring new horizons and that's kind of the main take home lesson for me, aside from the surgical skills I gained. Those are the main things. There is also a lack of blame when something goes wrong. There's not a tremendous shame about making a surgical error. You can actually speak very freely about them and talk amongst each other to describe what went wrong and to gain opinions from different people. I've heard a lot in the UK about needing 'surgeon's hands' but in India there's a much greater openness about people's surgical ability. My exposure there, talking to the surgeons every single day, the philosophy was very different. You simply apply yourself and you can learn. There's no such thing as surgeon's hands. I was actually very reassured by the attitude that if you apply yourself with enough diligence, you will certainly gain a skill, and surgery is a skill like any other. There's no real reason to be intimidated by surgery. There's a tremendous fear of doing something wrong in the UK but there isn't that fear in India. There's a greater transparency and a greater acknowledgement that mistakes occur and you can actually be open about it and gain some confidence from your colleagues. I've never found that to be the case in the UK. In India it's purely about gaining skills and not about tending your ego.
With such competition for higher level surgical training posts and the difficulty in gaining sufficient clinical experience with the introduction of the European Working time Directive it can be difficult to gain sufficient exposure needed to progress to higher training. Many suggestions have been made to improve the efficacy of training during these restricted hours such as dedicated theatre training lists and outpatient clinics to maximise trainees time. With this in mind, and only two years to gain enough clinical and academic experience before applying for ST3 registrar posts, I decided to seek surgical exposure elsewhere and take an out of programme year to work overseas.

Surgical trainees spend time abroad for various reasons. I wanted an increase in operative exposure in an area of high trauma and with English being my first and only language, South Africa was my destination of choice. Ngwelezana Hospital in KwaZulu-Natal got glowing reports from various UK based surgical trainees and having applied for a medical officer post there I was granted 12 months of approved out of programme experience between CT1 and CT2. Having passed my MRCS and gained 2 years surgical experience as a trainee I wanted to use the knowledge and clinical experience I had gained abroad in a different setting and culture.

Ngwelezana is a 500 bed government run tertiary referral hospital covering a population of over 2 million patients in north eastern South Africa. It treats around 8000 patients a month with limited facilities and staff numbers. The orthopaedic department I worked in for 12 months had 2 full time consultants, 1 part time consultant and anywhere between 5 to 10 medical officers depending on fluctuating staff numbers including 2 other UK based surgical trainees. There were 5 theatres (2 with image intensifiers and radiolucent tables) shared between orthopaedic, general, dental and eye surgery. Other facilities included a 9 bed emergency resuscitation unit, ITU, CT and MRI scanner.

As a medical officer (middle grade equivalent) your working week comprised of between 4 and 6 sessions operating, 4 sessions in outpatient clinics, one teaching ward round and day to day running of an assigned ward of 24 patients with an intern. One day a month you were also part of an outreach team to a peripheral hospital to oversee and operate on patients that
could be managed without image intensification in their theatre. One session a week was set aside for academic study and teaching as well as daily trauma meetings at 7.30am. On call commitments were shared between medical officers ranging from 1 in 5 to 1 in 10 days on call. On calls were 24 hour shifts often operating late into the night with a half day the following day.

Kwazulu-Natal is an area of high trauma. The reasons for this are multifactorial including a high incidence of domestic and non domestic violence, high alcohol abuse rates, poor road and vehicle maintenance with a high proportion of the population travelling on overcrowded public transport.

Because of this the vast majority of the workload is trauma and acute bone and joint sepsis. There is also an incredibly high rate of bone and joint sepsis due to the climate, living conditions, poor sanitation and high rate of HIV infection. Elective or ‘cold’ cases were fitted in when possible with procedures carried out for various pathologies such as Blounts, Rickets, Tumours and resistant club feet.

Management was complicated in a large percentage of patients due to late presentation. Many would visit the local ‘sangoma,’ or healer before presenting for conventional medical treatment as well as a delay in patients coming from referral hospitals due to transport and financial problems. Similar problems were encountered in follow up of patients and with the vast majority of patients only speaking Zulu and communication taken via an interpreter, histories had to be simple and concise.

Supervision and Support
Being at a junior level of surgical training it was important for me to have the support and supervision of seniors. There was always a consultant on call who would happily come and help day or night. The chief specialist or lead consultant (UK trained) had over 25 years of trauma experience with a specialist interest in paediatric orthopaedics. With limited theatre time, resources and staff however you were given a large amount of responsibility and expected to manage your own workload. On call commitments included continuing operating on emergency cases well into the night independently as well as supervising the wards and taking referrals from A and E.

Development
The learning curve was steep and the
Scope for learning about trauma was considerable. The high volume of trauma included a large number of polytrauma patients. Injuries rarely seen in the UK such as gun shot wounds and ‘panga,’ or machete chops were common place as well as road traffic accidents. A baptism of fire on my first on call saw a mini bus crash into a 4 x 4 jeep causing a mass incident with 18 patients admitted with long bone fractures including 6 open fractures all managed with out of hours staffing levels (9 doctors and 2 consultants).

With 4 to 6 operating sessions a week as well as on call commitments the opportunities for operating were fantastic with generally just 2 people in each theatre sharing the work load. In comparison to the usual one session a week of emergency theatre time in the UK it is no surprise my logbook was greatly enhanced in comparison. Even with the enthusiastic trainers I have had in this country the volume of work and reduced time in trauma theatre makes it very difficult to give trainees comparable exposure.

The opportunities were not only restricted to the operating theatre. With such an interesting range of pathologies clinics were full of fascinating patients and with this the opportunities for research were also fantastic. Recently the largest study of open fractures in HIV patients was published in the JBJS and further papers on the subject are to follow.

Lifestyle
With the high crime rates and press attention South Africa gets in recent times there was a certain level of apprehension in moving there. There is no doubt that security lives in the forefront of South-African’s minds. Mtunzini is a relatively quiet coastal town an hour north of Durban with a large percentage of doctors that worked at Ngwelezana living there. There was always something going on in the evening usually in the form of a brai (BBQ) and it gave us a fantastic base to travel and explore during weekends off. With many foreign doctors and South African doctors living away from there ‘home,’ base it was an extremely social year and I have formed many friends both home and abroad from many walks of life. At no point did I feel threatened and we were warmly welcomed from the moment we arrived.

Challenges and Rewards
Fortunately I was successful in my application to higher orthopaedic training on my return to the UK. Colleges however were divided in their recommendations of training abroad in 2006. Although they agreed surgical exposure could be beneficial the worries of entering back in to training in the UK was apparent especially with the implementation of MMC. There is no doubt I benefitted and developed hugely from my year out of programme both personally and professionally. My emergency operative experience has increased and there were fantastic opportunities to be involved in research.

Some deaneries have short term attachments in overseas units and I was very grateful for my deaneries support of my year abroad. If it became a more commonly agreed period of ‘out of programme,’ training I think many trainees could benefit hugely from there experiences during a year in which they have the security of a further year in training back in the UK and avoid the difficulties of applying for jobs whilst abroad. I would highly recommend such an experience and the need for foreign doctors in developing countries is vital in maintaining state health systems.
OVERSEAS FOCUS

If you have read the interview with Srilakshmi Sharma, you will have realised that not only is working overseas is a fantastic opportunity but also that we are keen to share real experiences for the benefit of others. We’d like to focus on both the practical, organisational issues facing trainees taking foreign electives or contracts, as well as the cultural, personal and learning experiences they gained.

CALL FOR YOUR STORIES & ADVICE

In each edition of Clinical Career, we would like to publish 2 to 3 short articles (maximum) of about 1000 words on your experience working overseas either as a junior doctor or a medical student, to inspire others to follow suit. We are particularly interested in:

- What made you decide to go overseas?
- How did you organise it?
- What challenges did you face?
- What did you actually do?
- What was it like living in a foreign country?
- What benefits has it given you?
- Anything you would do differently if you had your time again?

We cannot guarantee to publish all contributions but this is an opportunity to get perhaps your first (hopefully of many) publications which can be added to your CV and help you to stand out from the crowd when applying for that all elusive next post. Please send submissions, or if you just want to discuss further please email me, Sara Watkin (Editor-in-Chief) at sara@clinicalcareer.co.uk.
AWESOME AND AUDACIOUS: THE AUDI Q5

If I had over £35,000 I would happily buy the 2.0 TFSI quattro S line version of the Audi Q5.

You see, the styling of the Q5, with its coupe-like roof line and wrap-around tailgate, has been subtly refreshed. The design of the headlights has been changed, and the sparkling xenon units are now framed by new-look LED daytime running lights that form a continuous band surrounding more of the lens.

Inside, the Audi Q5 is pure understated refinement. The controls are trimmed in chrome, and the narrow panels of the centre console are finished in high-gloss black. The hi-tech central media component, MMI navigation plus, has very few buttons, so you don’t need a degree in Rocket Science to work out how to use it. Other touches such as heated seats, air conditioning and a multifunction steering wheel make the Q5 a dream to drive.

The car is as solidly made as an oak table and yet seems as light as a feather. There’s a reason for this: the bonnet and tailgate are crafted from aluminium, while the car’s structural elements integrate ultra-high-strength steels; they reduce weight and improve crash safety. The result is that the Q5 handles like an executive saloon and takes off like a bat out of hell when you dab the accelerator. Indeed, the performance totally matches the looks of this Germanic road warrior: top speed is 138mph and the 0-62mph sprint is done in a satisfying 7.1 seconds.

Another explanation for this awesome performance is the updated Q5’s TFSI petrol engine, which combines direct fuel injection, while the eight-speed tiptronic automatic powers the 2.0 TFSI Quattro up the cogs effortlessly. The chassis of the latest Audi Q5 also adds a great dollop of refinement and comfort, thanks to changes to the spring, shock absorber and anti-roll bar settings. The new power steering system gives you a better feel for the road too.

The Q5 driving experience is further enhanced when the optional Audi drive select system is specified. Audi drive select lets you vary the operating characteristics of the throttle pedal, the shift points of the automatic transmission, the degree of power steering assistance and the operation of the automatic air conditioning system via four modes, including an efficiency work-life balance zone.
mode. In addition, three optional components can also be controlled by the Audi drive select system if they are fitted. These include adaptive cruise control, damper control and dynamic steering. During higher speed cornering, it compensates for understeer and oversteer by intervening with slight steering pulses.

I'm not saying you'll ever get sick of driving the Q5, but when you've had enough of all that commuting to work and driving the kids to school malarkey, the Audi will thrill you off road. It may look a bit bling but it actually performs well on rugged terrain. Its maximum climbing angle is 31 degrees and its approach and departure angles are each 25 degrees. And you won't rip anything off the Q5's underbelly because the vehicle's ground clearance measures 20 cm.

This is truly a motor for everyone – but you'll have to have a decent bank balance, or a boss who's nice enough to put this on the company car list to drive one.

By Tim Barnes-Clay, Motoring Journalist

PROS 'N' CONS
- Looks √
- Performance √
- Build √
- Expensive X

FAST FACTS
- Max speed: 138 mph
- 0-62 mph: 7.1 secs
- Combined mpg: 35.8
- Engine: 1984cc 4 cylinder 16 valve petrol
- Max. power (bhp): 222 at 4500 rpm
- Max. torque (lb/ft): 258 at 1500 rpm
- CO2: 184 g/km
- Price: £35,350
With so much focus placed on topics such as how to answer questions posed an interview, how to deliver effective presentations etc I wanted to focus on a topic that is important but often under-addressed by candidates preparing for interviews. Regardless of what we may think about psychological factors in interviews, body language matters. You can deliver in almost all regards at an interview and have your selection subverted by mannerism that you are not even aware of. Equally, the effective use of body language techniques can substantially enhance a candidate’s chances of being offered the job.

Avoiding the unseen
Almost all of us have body language traits or mannerisms of some kind or other. Sometimes these are quite benign but others can cause problems. One of the biggest problems with these mannerisms is that often we are blind to them ourselves. I remember speaking to a trainee who each time I delivered an instruction that he hadn’t heard or understood fully reacted by scrunching his eyes and forehead (difficult to convey in text). Whereas I realised that this was his mannerism, physically, for indicating that he had not understood, it came across more as though he was disagreeing. You can plainly see that indicating you haven’t understood is relatively benign but the suggestion that you disagree can have further reaching consequences.

I strongly advocate devoting part of your interview practice to establishing whether or not you have any of these mannerisms. There are two ways of doing this, depending on how comfortable you are undertaking the exercise in company. By far away the gold standard method is to find a colleague and have them interview you but with the specific purpose of observing you and your body language. At the end of the interview they reflect back to you what elements of body language they particularly noticed and more importantly what the impact of those elements was on them. If you are unable to do this with a colleague, an alternative is to video yourself and then critique yourself afterwards. The limitation of this is that without an interviewer you may not exhibit quite the same body language as you would with one present.

Having established that you may will have a behavioural trait that is not entirely in your best interest, interview, you can now set about addressing it. In case you are worried I am not suggesting any deep psychotherapy and practice a series of simple steps is quite sufficient to keep it in check. Clearly being aware of it is the first and by far the most important of those steps. Once you have established that it exists the next step is to understand the circumstances in which it appears. Again this is best done by using a colleague to interview preferably on multiple occasions so that they can recognise the pattern of emergence. Once you are confident that you know when you exhibit this mannerism, you can now practice being interviewed whilst being conscious and watching for the conditions that trigger it. You will find in most cases that this is sufficient to stop it occurring. An enhancement to this is to specifically remind yourself of the likelihood of it occurring, immediately before you go
into an interview. If you are worried that by focusing on the interview you will lose awareness of the mannerism, you can always take a small object that you can keep in your hand, the presence of which acts as a subconscious reminder of the mannerism i.e. it is the reason you have the item in your hand.

Useful body language strategies

One of the most useful techniques that is easy to adopt is that of matching the behaviour of individuals on your interview panel. To be clear we are not talking about mimicking, which will not only not get you to job but also may land you with the tag of being distinctly weird. What I am talking about is the subtle adjustment of body position to better match that of the key people who may be interviewing you. The technique is also known as a mirroring. Allow me to explain further.

Let’s say that your new potential head of Department is sat opposite you with the arms gently folded. Matching would result in you gently folding your arms in a manner that just appears natural. This aligned body stance would result in far greater feelings of rapport between you and the department head. Implementation of this technique must be done in full consideration that you cannot appear to just be copying their moves. This track is most frequently fall into when people make obvious and immediate changes to their body position in response to someone altering theirs. The best way to avoid this is to carry on talking for a moment and then whilst talking slowly and gently adjusting your position. It is highly unlikely with the distraction of words to listen to that the person you are matching would notice what you are doing.

Assuming the interview is going well, you will start to notice over time that the person you have been matching starts to adjust their body position to match yours. This is a very good sign that you have strong psychological rapport with this individual. The primary difference is that they will not be remotely conscious that they are doing this. It is happening as a direct result of the rapport and is a behavioural reaction seated firmly in our origins as creatures, where matching behaviour was away of indicating that you were friendly towards and not dangerous towards another creature.

Further advice

The whole area of body language is one with a solid body of literature behind it but also a huge volume of complete rubbish written on the Internet. My advice is to keep it simple. There’s enough to think about in an interview without spending all of your mental energy on thinking about your body stance. However, becoming aware of adverse mannerisms is vital to improving your chances of success. Equally putting a little bit of effort into a simple technique like body matching represents a sensible investment of time with a good return on investment.

There are a number of decent videos on YouTube for those of you who wish to understand the body matching or mirroring technique further. A simple one can be found at: https://www.youtube.com/watch?v=rqhsWi4-hnA

If you want to discover a bit more about how to optimise your body language specifically for the interview scenario, try the following: https://www.youtube.com/watch?v=rqhsWi4-hnA

Dr Sara Watkin
Clinical Service Lead & Consultant Neonatologist, University College London Hospitals NHS Foundation Trust & Medical Director, Academyst LLP

Author Profile
THE GOLD STANDARD
FOR DOCTORS WANTING TO GET THE EDGE

CONSULTANT INTERVIEW COACHING

Coaching also includes...

Specialty-specific e-Learning Module
Designed to short cut your preparation and ensure you consider the issues of the day.

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Gain access to our huge resource base enabling you to prepare in short order and always be at the top of your game.

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Back Up Coaching
Let’s face it, life is never certain. If you falter 4 times after doing the programme, we’ll coach you for free until you get a job!

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The coaching itself is 2 hours in duration. It commences with a short practice interview to give insight into the areas requiring specific attention, provides direct feedback to help develop and hone key skills, includes exploration of the effects of internal wiring on interview outcome and the opportunity to explore issues specifically relevant to you. At the end of the session there is a further practice interview to help reinforce everything you have learned and to address any outstanding factors that could improve your chances of success.

Following the coaching session you can then access a vast amount of additional material to ensure you turn up on the day fully prepared and ahead of the pack.

About Sara

Sara is Consultant Neonatologist and Clinical Service Lead at University College London Hospitals NHS Foundation Trust, with over 14 years as a consultant and more than 8 years in senior service & network leadership roles. She has appointed (and rejected) many consultants in that time.

Sara is also author of the prestigious title The Consultant Interview, published by Oxford University Press and has a formal coaching training from the country’s leading coaching school, The Coaching Academy.

Besides her unbeatable credentials in interview insight and preparation, she is also a very active member of the leadership faculty of Academyst LLP and Editor-in-Chief of two journals; The Consultant and Quality, Governance & Experience. This depth and breadth of relevant experience is undoubtedly why she has such an enviable success rate.

Feedback

Dear Sara, Many thanks for your time last week for the coaching session! I am glad to say that they have offered me the job after the interview I had yesterday!

On reflection, the coaching session was absolutely fantastic and I only wish that it happened a lot more earlier in the course of my preparation.

Hi Sara, I just wanted to let you know I was successful at the interview for the Consultant job. Thank you for your expert coaching, it definitely gave me an edge. It was a unanimous decision and I actually almost enjoyed the interview at one point.

Definitely worth every penny. Gives you every chance you need to be successful at interview.
Doctors who work part-time have recently been the subject of a media storm, thanks to an outspoken and controversial article by a cancer surgeon in a national newspaper (1). In the opinion piece, entitled “why having so many women doctors is hurting the NHS”, he claimed that the feminisation of the workforce was having a detrimental effect on the NHS, as two female doctors would need to be trained for every man, thus potentially costing the taxpayer more money. Why? Because female doctors often intend to work part-time, and retire early. His comments prompted angry rebuttals from many individuals and bodies, including his own college (2, 3, 4, and 5). However, it highlighted just how many misconceptions remain over less than full time doctors, including trainees. This article seeks to address some of them.

It is true that more women than men are now entering medical school, and current predictions suggest that women will outnumber men on the medical register sometime after 2017(6). However, this isn't the only change to happen to the medical workforce over the last 10 years. Medical training has changed dramatically thanks to the implementation of modernising medical careers (MMC), and the European Working Time Directive, (EWTD). Gone are the days are when being a hospital junior meant years of working excessive and antisocial hours, and today’s generation of doctors are used to being able to combine a career in medicine with other commitments. The proportion of doctors training LTFT has therefore risen considerably in this time, year on year. In 2013, the GMC training survey showed that 9.1% of respondents were training LTFT, of which 86.4% were female (7). Whilst the survey didn’t break these figures down by speciality, it’s widely known that some disciplines have higher proportions of people training LTFT.
partly reflecting the gender balance in that speciality. However, once you look at the medical workforce as a whole (not just trainees), only 66% of the part-time medical workforce are female (8), and a survey in 2011 by the Royal College of Surgeons (2) indicated that 30% of all consultant surgeons would like to work part time at some point in their career, thus indicating that flexible working is something that both sexes may consider at some point in their careers.

There are many reasons people train less than full time. All trainee doctors are eligible to apply, provided they can demonstrate that they are unable to train full time for “well founded individual reasons” (EC directive 93/16/EEC). These reasons are divided into two categories:

Category 1
Doctors in training with:
- Disability or ill health (this may include those on in-vitro fertility programmes)
- Responsibility for caring (men and women) for children
- Responsibility for caring for ill/disabled partner, relative or other dependant

Category 2
Doctors in training with:
- Unique opportunities for their own personal/professional development, for example training for national/international sporting events, or short-term extraordinary responsibility, for example a national committee
- Religious commitment

involving training for a particular religious role which requires a specific amount of time commitment.
- Non-medical professional development such as management courses, law courses, fine arts courses or diploma in complementary therapies.

Category 1 applicants are usually given first priority.

Of note, both men and women can train LTFT for childcare reasons, although typically, it’s still women who choose to do so. We have had just one male visitor in the last three years to the LTFT advice zone at my own college’s annual careers fair, which is aimed at medical students and foundation doctors who are interested in joining the speciality. There are considerably fewer men going into O&G these days, but this does still reflect the GMC training survey’s results. However, society is changing, with the proportion of two working parent families rising. Reflected in these changes is an increasing demand for non-traditional working hours to fit around childcare commitments, and men and women in many industries now work flexibly. With this, and LTFT training in medicine becoming more common, maybe we’ll see a lessening of the gender divide over the coming decade?

People sometimes assume that doctors training LTFT will always stay that way, but in practice doctors often change their hours as their individual circumstances change, and they work out the balance that’s right for them and their other commitments. For those training LTFT for ill health, or category 2 reasons, their eligibility may change over the course of their training programme.

The GMC requires that people should undertake no less than 50% of full time training (9), unless there are exceptional circumstances. In practice, the proportion of full time
hours offered (e.g. 60%, 70%, 80%, and 90%) varies depending on speciality and region. Some LTFT trainees work in supernumerary posts, although in the bigger specialities they often slot-share with each other in full-time training posts. How much they get paid depends on the number of hours worked and the proportion of anti-social hours undertaken, with a completely different pay structure to full-time trainees (10). The proportion of on calls worked often varies from post-to-post, depending often of the service needs of the department. For example, some 60% of LTFT trainees undertake 100% of the on call commitment, and some 80% LTFT work 50% of the out of hours shifts, even in the same speciality in the same region. Many LTFT doctors therefore work in excess of 30 hours a week, a fact supported by the results of the Academy of Medical Royal Colleges’ 2012 survey of doctors working flexibly (11). Whilst this may be part-time for a doctor, this is close to full time work for most members of the general public, which is an important point to remember when debating the relative contributions of doctors working for the NHS.

There is also an argument to be had that two LTFT trainees in a slot-share is equivalent to more than one full time trainee. The GMC requires that LTFT trainees complete work-place based assessments pro-rata over the course of a calendar year; to expect them to complete the same amount of paperwork as their full time colleagues would be unnecessarily burdensome (12). However, over any given calendar year, LTFT trainees often contribute towards teaching, departmental meetings, audits, and quality improvement as much as their full time counterparts. Many LTFT trainees (and indeed consultants) find that working LTFT actually facilitates them to take on leadership roles, both within their departments, and on wider levels. At a recent regional meeting I attended, with specialty representation across many disciplines, the proportion of LTFT trainees in attendance was much higher than the expected 9%. Part-time work also enables greater work-life balance, which arguably protects against fatigue and burnout. Anecdotally, LTFT trainees often say that for them, working less enables them to be a better doctor; less tired, and less prone to compassion fatigue. There has been much criticism over recent years of the reduced training hours required before achieving CCT, and whether the consultants of the future will have the necessary skills, both medical, and managerial. LTFT trainees, whilst training for the same amount of time as their full-time colleagues, have more indirect exposure, as their training programmes last longer, thus contributing towards their overall experience.

Training LTFT isn’t without its difficulties, though. Juggling a demanding medical career with other commitments is challenging, and it can take time for LTFT trainees to work out how to combine the two. Trainees in specialities with practical procedures can find them difficult to learn whilst working at 60% or less, as realistically they perform them infrequently, and therefore often need to work out solutions to overcome this. In some specialities trainees feel less rewarded as their ability to provide continuity of care suffers; in specialities with full-shift patterns and the loss of the firm structure, this is less of an issue. Prejudice against LTFT trainees remains, with 58.6% of 251 respondents in the aforementioned Academy of Medical Royal Colleges Survey (11) replying that they had been subjected to persistent undermining behaviour as a consequence of their LTFT working. Whilst the numbers are too small to draw meaningful conclusions, it does highlight a
cause for concern. However, as flexible working becomes more commonplace, and LTFT trainees start to take up consultant posts, maybe attitudes will gradually change. One way to counter this is with strong leadership for LTFT doctors within trainee bodies, clear representation at training programme / college / national levels, and the development of mentorship schemes (11).

Undermining behaviour can certainly contribute however, to the loss of confidence expressed by some LTFT trainees. This can also be caused by the period of LTFT training being immediately preceded by a career break (e.g. maternity leave). It’s therefore important for educational supervisors and college tutors, as well as LTFT trainees themselves, to recognise this, and put strategies in place, such as graded returns to acute disciplines.

Where does the future lie? In England, the introduction of the postgraduate tariff (13) currently scheduled for April 2014, is going to signal huge changes for the funding for full-time training posts, with the funding for LTFT posts still subject to negotiation. What impact, if any, these changes have on the availability and provision of LTFT posts remains to be seen. The changes to postgraduate medical training contained in the Shape of Training document, if applied, could herald huge changes to the profession, for all trainees. However, with more demand as a society for flexible working for both women and men, it seems likely that less than full time training will be here to stay, in one form or another.

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(5) http://www.nhsconfed.org/Documents/The%20Importance%20of%20LTFT%20Employees%20to%20the%20NHS.pdf
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Dr Susanna Crowe
Senior Registrar in Obstetrics and Gynaecology, Bart’s Health, London

Author Profile
In the environment of NHS structural change, it is important for junior doctors to engage with NHS reform and to keep up-to-date with future plans for how our NHS will actually run. It is also vital that we develop and use the skills required to be a good leader early on in our training, rather than realise we lack these skills at the time of interviews for consultant posts. We also need to know how to lead and run quality improvement projects, and improve patient care, right from the junior level. I attended the Leadership and Management Skills for Core Trainees course to gain more experience in all of these areas, and this review explains how it would benefit core trainees and specialty trainees of all levels.

Who organises it and who is it for?
This course is run by St George’s Hospital as part of the South West London Core Training Programme. It is aimed at Core Medical, Core Surgical and Dental Foundation Year 2 trainees, and hence attendees mostly consisted of trainees at CT1/CT2/DF2 level. It is mainly targeted at trainees in South West London training programmes (who pay only a £100 refundable deposit) but is also open to trainees outside this training programme area and other doctors, who pay a £200 non-refundable fee to attend.

When and where did I do it?
I attended the course on 3rd and 4th May 2013 as a CT1 core medical trainee. The course only required one day of study leave as the second day was a Saturday. Day 1 was from 8.30am to 7 pm and Day 2 from 8.30 am to 5.30 pm; both days were held at St George’s Hospital in Tooting, London. Refreshments and a daily £6 lunch
voucher to use at the hospital canteen were included.

Why did I do it?
I went on this course as it provided an excellent opportunity to cover a wide variety of important and topical areas in a two-day, focussed environment. With lots of courses and conferences on offer, and limited study leave available, this was important. I particularly wanted to update myself on NHS reforms, clinical commissioning and the future structure of postgraduate medical education, which, as a busy junior doctor, I have found difficult to do. I also wanted to learn more about how various personality qualities can affect clinical leadership and to gain insight into how my personality could help or hinder my ability to develop into an excellent clinical and academic leader. I felt that feedback from the short Myers Briggs Type Indicator (MBTI) assessment, which the course includes, would be a useful way to do this.

What did it cover?
Each day consisted of 6-7 sessions (lectures, workshops and group discussions), which covered a different topic within the following areas:

- Structure and reforms of local healthcare environment and the wider NHS
- Future hospitals and public healthcare
- Clinical commissioning, healthcare finance and funding flows
- Future medical education and training structures
- Patient safety, risk management and serious incidents
- Quality improvement projects
- Leadership, mentorship and management in practice

breaks for tea, coffee and lunch, and the refreshments were excellent.

Was there an exam?
No, but participants are required to carry out a short online MBTI assessment before the course, which they receive feedback on during the MBTI workshop. A certificate of course attendance is provided.

- Leadership qualities and MBTI

Although most sessions were lectures, they were always interactive. They were delivered by a large variety of experts in their field, ranging from trust medical directors to professors of medical education or public health, and from leaders in general practice to heads of quality and safety. Despite the prowess of the speakers, sessions remained relaxed and there were plenty of opportunities for sharing experiences and asking questions. There were examples of good and poor leadership and the practicalities of leading and managing teams. On the second day we split into small groups to plan quality improvement projects, practising the principles we had learnt in earlier sessions. The MBTI workshop enabled us to explore a spectrum of personality qualities, and we used our own pre-course MBTI assessment results to develop awareness of how we could become both better team members and team leaders.
Would I recommend the course?
I would thoroughly recommend this course. The quality of the speakers and the range of topics covered made it an excellent learning experience. I learnt more from this course in two days than I could envisage learning from weeks of self-study. I am much more informed about and interested in the current structural and political changes within the NHS, and more passionate about keeping myself up to date as things develop. NHS change will affect us and we need to know about it. All the speakers and sessions brought home the importance of taking the time to develop the non-clinical attributes inherent to being a good doctor and leader, which often get forgotten in the daily busy routine of shift work. It inspired me to get more involved in quality improvement projects and to get started with making a real difference to patients – not only those currently on the wards, but in the longer term and on a bigger scale. It did this by giving me some skills and confidence to start being a leader and manager at a local level.

As a result I am now leading a quality improvement project to improve the patient experience for Haematology cancer inpatients at my trust, meaning I liaise with patients, nurses, doctors, managers, patient information teams, quality improvement teams, printers and funders to work together on this project! Before this course this had seemed a massive and unachievable goal, but now, my initial ideas for change are becoming a reality. All of these experiences and skills will have a major impact on my training and practice for years to come.

Dr Ione Woollacott
ST2 Academic Clinical Fellow in Neurology, Dementia Research Centre and Department of Neurodegenerative Disease, UCL Institute of Neurology, London

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“Understanding how to ‘sell’ yourself and working through specific examples with someone with so much experience definitely accelerated the learning process for me and also made me much more confident that I’d done the right sort of preparation.

Further information
The next course will take place on 4th and 5th April 2014 at St George’s Hospital. For further information please email Paula Fernandez, MDEC Administrator at St George’s Hospital: CoreMedical.TrainingCMT@stgeorges.nhs.uk or telephone 02087254026

Competing interests
I have no competing interests or personal or financial connections with the organisers of this course.

Top tips:
- This course is popular so book early
- Make sure you do the MBTI online assessment well in advance to give time for your feedback report to be produced, as some participants left it too last minute
- Think of an idea for a quality improvement project that you wish to carry out before the course, so you can use the various workshops to develop your strategy

Author Profile

Dr Ione Woollacott
ST2 Academic Clinical Fellow in Neurology, Dementia Research Centre and Department of Neurodegenerative Disease, UCL Institute of Neurology, London
CORE SKILLS IN CLINICAL & SERVICE AUDIT

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FINING THE RIGHT LEADERSHIP COURSE FOR YOU!

Take a look at our helpful guide on choosing the right leadership course today.
I’ve had a long standing interest in medical leadership and management since medical school, having been elected as a course representative and BMA rep as a student, progressing and developing these parts of my career.

When I saw that academic medicine could include a stint in leadership and management, I applied for an academic foundation programme during my final year of medical school. In many ways it wasn’t an overly different application compared to the more traditional foundation programme application; I had to list all the academic activities I’d completed as a student—posters, prizes, publications, extra degrees etc. much like you would in a national foundation programme application. At that time, “White space questions” were in existence, again, I had a couple of questions to answer, no different to my peers applying for a non-academic pathway. Indeed, the only part that I felt differed from an academic foundation programme interview compared to a ‘national’ programme was I had an academic interview.

The interview focussed on ‘clinical’ competencies, asking how I might consider approaching an emergency scenario, an ethical dilemma on the wards and other personal qualities I could demonstrate. The clinical components were what you might realistically expect if asked about your approach to a patient in an emergency and ethics, given the applicants were all final year medical students. Reeling off the “ABC” approach to an emergency with a few sensible differentials for the gentleman with chest pain and how each differential might alter my management, followed by discussing the communication and ethics behind how I might deal with a difficult colleague. The ‘academic’ part of the interview involved giving a short pre-prepared presentation, talking about my ambitions for the foundation programme and how I perceived the future of medical leadership and management in healthcare. I was asked about qualities that make for an academic, and again, the questions were as could be expected for the interview; I do not recall being asked any odd, abstract questions and emerged unscathed from the interview. I was fortunate to be given an offer, and took up my first job as an FY1, with the FY1 year being much like any other programme (i.e. 100% ‘clinical’), and expected to achieve the same competencies as any other FY1 doctor. My Academic Foundation post includes protected time for leadership and management activity, with about a third of my whole FY2 year dedicated to developing these skills. It also involves completing 60 credits worth of postgraduate assignments from the University of Leicester, leading to the award of a Postgraduate Certificate in Clinical Leadership and Management. The programme comprises of two rotations, each of 6 months duration with about one third of the whole year protected academic time. Again, like the FY1 year, there is expectation to complete
the competencies expected of an FY2 doctor, but with a reduction in time to complete this. Perhaps arguably helping demonstrate your time-management skills in juggling these two competing demands?

The degree involves a number of contact days with the university, attending courses relating to differing leadership and management theory. The sessions are very interactive, with little of the content being didactic. Instead, the tutor leading the course provides a number of activities helping you consider leadership and management as applicable to your own situation. The small-group activities help share experiences and provide a different perspective to how you might proceed with an objective, and plan for handling challenges that present themselves. The pace is maintained and the teaching enjoyable with the approach employed, and the tutor has considerable experience in delivering the course. Having about 10 days spread throughout the year certainly makes it manageable, and with notice and commitment, could be completed by those not on the programme—two fellow participants are undertaking the degree, one a senior registrar and the other a newly appointed consultant. The teaching is to help consolidate knowledge and gives a chance to discuss areas that aren’t clear, and you should allow time to read around the subject matter. There are a number of excellent textbooks, web articles and published papers on leadership and management, though as with anything, some are more interesting and readable than others. There are three assignments on the Leicester programme, each helping you to consolidate leadership and management theory and applying it to your situation, helping increase its relevance, rather than be some abstract concept of no use to you. The first assignment was completed about 3 months into the course, and required application of theory to a topic of your choosing. Writing 3000 words was not something I’d practiced since GCSE English some years prior, so it was a challenge to get the rusty cogs of writing moving again. At first, it was daunting, but as I became more emerged in the reading and considered how the theory could be applied, where theory could work and where it would falter, the writing became a little easier, setting aside a few afternoons to complete it. The second assignment was a management report; this involved some project work, which early in the course you identify a project you’d like to work on with the support of a tutor (usually someone with an active management or leadership role). Colleagues have worked on projects relating to doctor’s morale and sickness, responding to clinical warnings and my own project relating to memory clinics following the national dementia strategy.
The final assignment comprising 50% of the credits is a portfolio of smaller articles and reflections, covering a wide spectrum of your experiences; from times you’ve observed someone lead well and learnt from it, to a situation you have failed. I’ve yet to complete the assignment, but if you’ve managed to write a few-thousand words and a report, writing shorter articles shouldn’t pose a problem. Remember, you have peers completing it alongside you, with university study days interspersed and the tutor available to guide you if you’re struggling.

I’ve not quite finished the degree, and this is certainly a target to complete before the end of my FY2 year. However, I have found setting aside blocks of time to write a section of the assignment is helpful, alongside reading of publications. Writing 300-400 words at a time over a couple of weeks makes it a lot more manageable than setting out to write 3000 words in one go. Contacting your project tutor to try and agree goals in advance is helpful, as well having a ‘plan B’ if things don’t work out (I initially had some problems, requiring modification of the project). In fact, some of the things I’ve learnt have been through the experience of them not going correctly first time and the measures I took to rectify them. It’s also important to recognise what you might feasibly achieve during the time you’ve got, and negotiating with your supervisor what is and isn’t going to be achievable is imperative to success; something smaller and more manageable is likely to succeed. There are a number of other organisations dedicated to medical management and leadership such as the Faculty of Medical Leadership and Management, which offer a wealth of advice and opportunities to develop and showcase medical leadership and management success, a number of resources I have used and found to be helpful. So I guess you could say I was a convert to the importance of developing management and leadership skills from the beginning. The importance of medical management and leadership regularly makes it into the national news, medical journals and trust emails, and it’s not going to go away anytime soon. Adopting a more proactive role in management and leadership roles as a doctor in training has been rewarding. It has increased my appreciation and perspective of how political, economic and other ‘non-medical’ demands all need to be addressed for something to succeed. If at the end of completing a leadership and management qualification you decide you don’t want to be driving the frontier of change, you’ll have a qualification useful to your CV, develop a useful skill set and hopefully enjoy learning. There have been times where I have felt out of my depth, but through it all, I have absolutely no regrets about applying, and convinced it was the right thing for me to do.

Jonathan Mills is an Academic Foundation Year 2 Doctor in the Leicestershire, Northamptonshire and Rutland Deanery (LNR) and is currently completing an academic post in Medical Leadership and Management as his Academic component.
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**DAY 1 & 2 – Leadership, Strategy & Context**
- The context of leadership today - setting the scene
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- The leader as catalyst
- Transformational leadership
- The WILL, SKILL, CAPACITY, AUTHORITY model
- 6 Core Components of Effective Leadership
  - (an application model)
  - Inspiring trust & confidence
  - Clarifying purpose and direction
  - Aligning systems & processes
  - Knowing the people
  - Releasing potential
  - Influencing, communicating and engaging
  - Understanding each component in depth
  - Practical application of each component
  - Applying the principles to change and culture
  - Overcoming inertia and paralysis
  - Leading through consensus
  - Creating distributed leadership & responsibility
  - Leadership in challenging circumstances

**DAY 3 – Management of People, Projects & Performance**
- The management imperative for modern services
- What is management really?
- Key differences between management & leadership
- Understanding medical management responsibility
- 4 Cornerstones of Management Effectiveness
- Management pitfalls and their clinical implications
- Management planning and organising
- Developing robust performance management systems
- Introducing a measurement-feedback-correction cycle
- Robust framework for managing people
- What does the team around you need from you?
- The people in organisations - essential understanding
- Deploying people for maximum effectiveness
- Assigning responsibility and fostering accountability
- Setting compelling goals for self and others
- Core principles in effective delegation
- The SMART plus framework for goals, objectives and delegation
- Planning your shifts appropriately
- Utilising team members based on skills & preferences
- Creating an environment for effective teamwork
- Motivating your team to better performance
- Management styles and how to apply them
- Communicating effectively with your team

The programme focuses on practical application of knowledge, skills, insight & principles across a series of typical care scenarios. It is challenging, provocative and highly hands on. You will not find finer preparation anywhere for the true rigours of today’s environment.
I spend upwards of 150 days per annum working with distinct groups of individuals in a development capacity. When conducting our leadership programs I tend to ask early why people are attending the course, in part because armed with this knowledge I can ensure that the course delivers for them. However, an increasingly common answer, particularly in trainees within a couple of years of completing their CCT, is “because I need to go on a course as part of my curriculum, or to get shortlisted”. Whereas both may be true, these answers tell me much about an individual’s true commitment to leadership development, something that I know will most likely be reflected in their CV as well.

The minimum versus the ideal
We are constantly dismayed when we find individuals about to apply for posts with no evidence of having attended a leadership development programme at all. We know that without this evidence, the individual is going to have to apply for many posts before even being shortlisted and there is no guarantee that they will be shortlisted at all. There is no question today that having a leadership course on your CV is an essential component, the absence of which comes close to guaranteeing no selection. Yes, it’s that important. However, if having the course on your CV is essential, then it stands to reason that everybody being interviewed has the same.

If we consider from moment that the word leadership is on the lips of just about every agency and senior person in healthcare, this suggests that not only is leadership a primary factor in the choice of individuals interview but also that a sensible career strategy would be to develop a wholly different level of leadership capability, properly evidenced by what you’ve done and how you’ve utilised it. We consider this to be sufficiently important that on our three-day leadership and management program for latter year trainees, we specifically devotes time to providing advice on how best to address this even if time is short until your CCT.

Let’s consider then, some of the options for deepening your leadership experience.

Steering deeper development
My first piece of advice is to start that journey as early as possible and adopt a framework that you can utilise to steer your downstream development. A good early leadership course (by early I mean one that occurs early in your training) will demonstrate a number of models of leadership, some of which have assessment tools against which you can benchmark yourself. A good example of this is the (outgoing) NHS Leadership Framework. This framework breaks leadership down into seven distinct dimensions, five of which are aimed specifically at clinicians. By understanding leadership through the framework lens, you can then undertake development activity or projects that emphasise your commitment to developing distinct facets of leadership. Let’s look at an example.

One of the dimensions on the NHS Leadership Framework is that of
Setting direction has always been one of the fundamental components of leadership activity. Many trainees often consider that they have little involvement in setting direction, given that it mostly comes from more senior staff. However, having established that this is an area where skills must be developed, it is perfectly possible to adopt career stage specific strategies to focus on the specifically. For instance, at FY level you could lead an improvement project, in which case the success of that project will be partly dependent on how well you set an articulate direction to the other people involved. Not only should your CV highlight the project that you undertook and the outcome achieved but also the leadership learning that you experienced in the area of setting direction. If you are a latter year trainee, you could extend your direction setting experience to a whole new dimension by undertaking a strategic review of the service’s strategy, perhaps in conjunction with an established consultant, to evaluate how it needed to change in response to changing system. This activity would not only be a perfect demonstration of setting direction but also an indicator of a modern mindset valued particularly by good Trusts.

Understanding yourself
One of the most frequently misunderstood aspects of leadership development is that there is no formula the leadership. Different individuals adopt different leadership approaches, which should be tailored to the circumstances in which they are leading and the nature of the people they lead. However, it is rare to find an exceptional leader who also appears to have little insight into themselves and how they think and act, as well as the impact of their actions on others. What we are saying here is good leadership starts from within, by developing a deep understanding of self and how that influences your decisions and actions.

To address this very specific development requirement often requires undertaking 360° assessment so that you can receive direct feedback from other individuals, which is often most valuable in gaining a wider perspective on the impact of your behaviour on them. Although the feedback can sometimes be uncomfortable, a good leader recognises that whether it is good or bad it is a gift that allows them to develop behavioural approaches that have maximum impact but with minimal adverse consequence. To help motivate you to undertake this process, I would offer you the comforting thought that someone’s feedback actually tells you far more about them than it does about the inner you. What I mean by this is that the feedback is far from personal and much more a reflection of how they like to be treated, rather than a direct criticism of what you get wrong (even if it doesn’t feel that way). However, what a good leader appreciates is that although the feedback does not necessarily mean you do something wrong, it is an accurate reflection of how they like to be treated, rather than a direct criticism of what you get wrong (even if it doesn’t feel that way). However, what a good leader appreciates is that although the feedback does not necessarily mean you do something wrong, it is an accurate reflection of how they like to be treated, rather than a direct criticism of what you get wrong (even if it doesn’t feel that way).
Another important piece of leadership development is that of gaining a picture of your psychological make-up. The reason behind this is that your individual psychology can heavily influence the leadership styles that you adopt and more importantly can result in a default leadership style that you utilise whether or not it is appropriate to the circumstances. Psychological assessment can be undertaken in a number of forms, each of which has both merits and disadvantages. In the NHS by far the most common is MBTI (Myers Briggs Type Indicator), although there are a number of other tools such as the Strength Deployment Inventory or Insights that are equally as good, if not better under certain circumstances. What is important is that the feedback is provided in conjunction with a good mentor or coach who can help you understand just what the feedback is telling you. A really good coach will help you identify examples of behaviour that are linked to your underlying psychology and then develop an understanding of the implications of this behaviour and its impact on others.

In summary
As you have probably gathered by now, the journey of true leadership development has many components. More importantly, my advice is that you undertake these components as early as possible so that you may put them into practice with sufficient time to provide considerable evidence of your leadership commitment by the time you need to demonstrate it to somebody. This represents, for many, and almost complete reversal of their leadership development approach, which typically involves concentrating on clinical development in the early stages and then a leadership course towards the back end. I am advocating putting a good leadership course at the front-end to provide a solid leadership framework from which you can base subsequent leadership development.

Once you have a framework in place, you can then systematically assess yourself against that framework over time and select either areas of weakness or areas that you believe will be particularly important and create a development plan specifically for them. This cyclical approach to understanding, assessing, addressing and then evidencing different aspects of your leadership pathway will result not only in an exceptional leader but also one that looks exceptional on paper. The end goal is to ensure that you move from being shortlisted in spite of only having a leadership course on your CV to being shortlisted because of your clear and exceptional commitment to leadership evidence by a systematic approach over time to self-development in this area.

Andrew Vincent
Partner, Academyst LLP and Editor-in-Chief, Clinical Business Excellence,
REDEFINING HEALTHCARE: CREATING VALUE-BASED COMPETITION ON RESULTS

This insightful and thought-provoking book depicts a scenario of a U.S. healthcare system in crisis.

In redefining Healthcare: creating Value-Based competition on results, the internationally renowned healthcare experts Michael E. Porter and Elizabeth Olmsted Teisberg examine the challenges facing the US healthcare system and reveal their prescription for change. Many of the ideas are relevant to the UK and we think it’s worth a read because the Government places much stock in its authors – coming to a system near you!

The authors lay out a framework for redefining health care competition based on patient value over the full cycle of care—from prevention and diagnosis through recovery or long term disease management. The book has something for all and provides a great perspective on how we may see our system change. Don’t be put off by its US baseline.

About the Authors:
Michael E. Porter is the Bishop William Lawrence University Professor at Harvard Business School and a leading authority on competitive strategy and the competitiveness of nations and regions. Professor Porter’s work is recognized in governments, corporations, non-profits, and academic circles across the globe.

Elizabeth Olmsted Teisberg is Professor of Community and Family Medicine at Dartmouth’s Geisel School of Medicine, and a Senior Institute Associate at Harvard’s Institute for Strategy and Competitiveness. Professor Teisberg has developed frameworks and cases to enable the implementation of health care delivery transformation by physicians, provider systems, employers, health plans and governments.

A 90 minute presentation by Professor Porter on Value-Based Healthcare Delivery is available to view on YouTube at: http://www.youtube.com/watch?v=Z3fK6yWydweo
This section of your journal is devoted to direct assistance in the form of advice and answers to specific career questions. You can submit these questions to sara@clinicalcareer.co.uk with ‘Ask Sara’ as the first bit of the subject line.
About Sara

I am a Consultant Neonatologist and Clinical Service Lead at University College London Hospitals NHS Foundation Trust, with over 15 years’ experience as a consultant and more than 8 years in senior service & network leadership roles. I have been an educational supervisor for many years, college tutor and mentored more trainees than I could possibly remember. I am author of The Consultant Interview, published by Oxford University Press and I have a formal coaching training from the country’s leading coaching school, The Coaching Academy.

Ask Away!

As this is the first edition, I don’t have any submitted questions yet. But we’d like some!

Ask questions in the following areas:

- Career strategy advice
- Career dilemmas
- Problems you are experiencing
- How to… questions
- Options and opportunities
- Worries and fears
- Almost anything else career focused

We’ll try to answer as many as possible and publish the best ones for the benefit of all (anonymised, obviously). Again, you can submit these questions to sara@clinicalcareer.co.uk with ‘Ask Sara’ as the first bit of the subject line.
WHISTLE BLOWING ON CONCERNS
When and who can a doctor turn to for help?

Sara was asked: What do I do when I am struggling to be heard on a Safety Issue?

In the post-Francis era it is sad to find that individuals are still having trouble getting safety concerns heard. However, this is the subject of my Ask Sara section this edition, given that its implications for safe care are so great. I am addressing this one substantially with the following article, as a guide but I am also interested to gauge wider experiences in this matter as I feel it requires wider work.

Call for Response
I am interested to know who else has raised concerns and either ‘eventually’ had them heard or has struggled to get them heard. I am really keen to know:

• Nature of the concern
• What you did to raise it and get it heard
• What happened in response
• How it affected you (personally or professionally)
• How you responded to the Trust attitude
• What finally tipped the balance when you did get heard

As always, anonymity is important in something like this and fully respected.
Whistleblowing is the popular term used when someone raises a concern regarding quality or safety to someone in a position to and willing to do something about it. As a doctor, whether junior or senior, we have a duty to protect patients and colleagues. As such every trust has a policy on raising concerns. Furthermore we are protected in law from harassment and bullying when we raise a concern.

Good Medical Practice states:
“If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them.”

Protecting patients can also mean raising concerns about your colleagues. The GMC states:
“You must also protect patients from risk of harm posed by another colleague’s conduct, performance or health by taking appropriate steps immediately so that the concerns are investigated and patients are protected where necessary.”

This sounds straightforward but where do you actually turn for good independent advice if your concerns do not appear to be being listened to? And perhaps how far are you prepared to take your concern as a junior when your future may depend on a good reference from the very people you have concerns over.

All employers should have a formal policy for raising concerns, which will usually be known as the ‘whistleblowing policy’, and you should familiarise yourself with this at an early stage when tackling a concern you have. This can usually be found on the Trust Intranet site or by contacting the HR department or if this fails your Local Negotiating Committee Chair or BMA representative.

CliniCal Career

If you want to be protected under the Public Interest Disclosure Act 1998 (PIDA). The policy itself usually involves raising the concern with someone senior in your department (usually your line manager). If this does not deliver the expected outcome the concern should then be raised with the Medical Director followed by the Chief Executive.

As a junior doctor it can be hard to know whether a situation should be raised as a concern. The BMA suggests that you should be guided by the following question:

“If you let the situation carry on is it likely to result in harm to others?”

If in doubt, you should always err on the side of raising the concern with your manager/ immediate superior, and you should do it as soon as you can. They suggest a number of issues that you might have concerns about and examples include:

- Systemic failings that result in patient safety being endangered e.g. poorly organised emergency
response systems, or inadequate/broken equipment
• Poor quality of care
• Malpractice
• Welfare of subjects in clinical trials
• Acts of violence, discrimination or bullying towards patients
• Acts of fraud
• Health and safety violations – blocked fire exits, dangerous structures, etc.
• Illness that may affect a doctor’s ability to practise in a safe manner
• Substance and alcohol misuse affecting ability to work
• Negligence
• Fraud or corruption
• Deliberate attempt to cover up any of the above

Some organisations have arranged access for their staff to free, independent, confidential helpline facilities where staff can seek further advice on reporting a concern. Alternatively you may wish to approach the National Whistleblowing Helpline (http://wbhelpline.org.uk). Established in December 2011 and commissioned by the Department of Health but run by MENSAt this provides free, independent advice and support to staff within the NHS and Social Care. The purpose of the helpline is to help individuals clarify whether they actually have a whistle blowing concern; talk through the process of raising a concern; and provide advice on how to escalate a concern if you feel the issues raised have not been addressed appropriately by the organisation. What it is not is a disclosure site although it can advise you of your rights under the Public Interest Disclosure Act 1998 (PIDA). This act is aimed at protecting those who raise a patient safety, or other issue in the public interest by following the correct procedures.

The helpline can be contacted on 08000 724 725 by emailing enquiries@wbhelpline.org.uk.

Only when you have exhausted your local workplace policies and procedures should you consider raising your concern externally. If the concern is about a colleague the most appropriate place would be the GMC and if about a service or organisation the Care Quality Commission (CQC), although the CQC advises first getting advice from your professional regulatory body (GMC) or your trade union (BMA).

In December 2012 the GMC launched its own confidential helpline (tel 0161 923 6399) which offers both advice and enables doctors to disclose concerns re safety. At the same time the GMC also launched an online ‘decision aid’ to help doctors report patient safety concerns. Depending on the disclosure made, the GMC may take it forward themselves or if it is about an organisation, refer the doctor on to the Care Quality Commission.

The Care quality commission can be contacted by telephone on 03000 616161 or by email at enquiries@cqc.
All concerns are dealt with by a local Compliance Inspector for the service in question. He or she will use the information along with other information they may already have to help decide what to do next. Again, like the GMC, they will notify another regulator or official body if it is more appropriate for them to look into your concern.

The CQC have produced a Quick guide to raising a concern with CQC booklet that has useful advice and a step-by-step approach to raising concerns with them. It’s accessible at:

http://www.cqc.org.uk/content/whistleblowing-quick-guide-raising-concern-cqc

If you are hesitating about reporting a concern in case it has a negative effect on your career, working relationships or results in a complaint about you, you should bear the following in mind as stated by the GMC:

- You have a duty to put patients’ interests first and act to protect them, which overrides personal and professional loyalties.

- The law provides legal protection against victimisation or dismissal for individuals who reveal information to raise genuine concerns and expose malpractice in the workplace.

- You do not need to wait for proof – you will be able to justify raising a concern if you do so honestly, on the basis of reasonable belief and through appropriate channels.

The protection the GMC describes is through the Public Interest Disclosure Act. Under the act as long as you acted honestly and responsibly when raising a matter internally or to a regulator (e.g. the GMC and CQC you are protected). This protection exists even you’re your contract appears to contain a gagging order. Wider disclosures e.g. to an MP may be protected in some circumstances but are subject to more rigorous test. If your career as a doctor suffers as a result of raising a complaint you can bring a claim for compensation in the Employment Tribunal where awards are uncapped and based on the losses suffered.

Finally, in the post-Francis, Keogh and Berwick era and with changes to the CQC inspection regime it is hoped that all organisations are developing cultures which are open to listening to staff concerns and responding appropriately to them. If this is indeed the case then hopefully the need to whistle blow externally will become a feature of the past and all from medical student to consultant will feel safe in raising concerns about patient safety.

Author Profile

\[\text{Dr Sara Watkin}\]

Clinical Service Lead & Consultant Neonatologist, University College London Hospitals NHS Foundation Trust & Medical Director, Academyst LLP
Management Fundamentals & Core Principles

CPD POINTS: 6  DURATION: 1 DAY

DESCRIPTION

Clinical staff frequently find that the technical & medical knowledge they’ve worked hard to gain is only part of the story when managing people, projects and performance. This one-day comprehensive programme seeks to fully address that by covering all the essential topics in a very practical way, enabling you to really develop your management skills in the clinical context. It’s built on robust principles and models to ensure that you develop a consistently successful approach.

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• The management imperative for modern services
• What is management really?
• Key differences between management & leadership
• Understanding medical management responsibility
• 4 Cornerstones of Management Effectiveness
• Management pitfalls and their clinical implications
• Management planning and organising
• Developing robust performance management systems
• Introducing a measurement-feedback-correction cycle
• Robust framework for managing people
• What does the team around you need from you?
• The people in organisations - essential understanding
• Deploying people for maximum effectiveness
• Assigning responsibility and fostering accountability
• Setting compelling goals for self and others
• Core principles in effective delegation
• The SMART plus framework for goals, objectives and delegation
• Planning your shifts appropriately
• Utilising team members based on skills & preferences
• Creating an environment for effective teamwork
• Motivating your team to better performance
• Management styles and how to apply them
• Communicating effectively with your team
• Dealing with difficult situations & people

www.medmeetings.co.uk
Time Management & Personal Effectiveness for Junior & Middle Grade Doctors

4 HOUR ELEARNING COURSE WITH 4 CPD POINTS

DESCRIPTION
Aimed specifically at doctors in training, this is probably the most powerful course in personal effectiveness you will find anywhere. The successful junior or middle grade doctor needs a unique combination of skills combining a high team orientation with strong time management & organisational skills coupled with a delicate balancing act between learning and delivering. There is an ever increasing demand for results, as well as a low tolerance of mistakes. Packed full of practical strategies to plan & prioritise effectively, manage the never ending influx of work and regain effective work-life balance. This is probably the most powerful personal effectiveness course you will find.

COST
£72 + VAT

PROGRAMME
- Understanding the key determinants of personal effectiveness
- Learning to avoid the performance pitfalls
- Interpersonal performance & interdependency - everyone’s agenda
- Developing the qualities of consistently high performers
- Mental processing of consistently high performers
- Understanding people, their beliefs and how this affects you
- Developing behavioural flexibility to influence others with more ease
- The power of personal vision and a goal-focus
- Deciding what you want, clinically & professionally, and achieving it
- Doing the most important things, consistently
- Utilising a priority grid to balance importance & urgency
- Physiological strategies for high performance
- Continual evolution - improving your performance incrementally
- Act, evaluate & adapt - strategy for ultimate success
- Essential time management strategies for successful people
- Achieving work-life balance and career success
### Assertiveness without Aggression

| Cost: £195.00 + VAT | Event Type: 1 day Course | CPD Points: 8 | Provider: Grow Medical LLP |

Assertiveness without Aggression is probably the most comprehensive, practical programme available, designed to help consultants, other doctors and healthcare professionals adopt the right behaviour, communication and approach to have the right impact. The resulting effect is greater achievement, more self-control and a greater level of emotional self-mastery. All of this is achieved without ever trying to change the inner you whilst enhancing confidence, self-mastery, impact and interpersonal effectiveness.

**Find Out More**
http://www.medmeetings.co.uk/training/all/assertiveness-without-aggression

### Consultant Interview Skills Session 1 - Strategy, Skills & Techniques

| Cost: £125.00 + VAT | Event Type: Half day Course | CPD Points: 3 | Provider: Grow Medical LLP |

With training becoming more standardised and competition for consultant posts getting ever greater, it is vital that you stand out from the crowd in order to secure the perfect post for you. That means getting the edge. The edge consists of having the right insights and demonstrating it, adopting the right overall strategy and how well you perform on the day.

**Find Out More**
http://www.medmeetings.co.uk/training/all/consultant-interview-skills-session-1-strategy-skills-techniques

### Consultant Interview Skills Session 2 - Questions, Practice & Feedback

| Cost: £125.00 + VAT | Event Type: Half day Course | CPD Points: 3 | Provider: Grow Medical LLP |

With training becoming more standardised and competition for consultant posts getting ever greater, it is vital that you stand out from the crowd in order to secure the perfect post for you. That means getting the edge. The edge consists of having the right insights and demonstrating it, adopting the right overall strategy and how well you perform on the day.

**Find Out More**
http://www.medmeetings.co.uk/training/all/consultant-interview-skills-session-2-questions-practice-feedback

### Management Fundamentals & Core Principles

| Cost: £195.00 + VAT | Event Type: 1 day Course | CPD Points: 6 | Provider: Academyst LLP |

Clinical staff frequently find that the technical & medical knowledge they’ve worked hard to gain is only part of the story when managing people, projects and performance. This one-day comprehensive programme seeks to fully address that by covering all the essential topics in a very practical way, enabling you to really develop your management skills in the clinical context. It’s built on robust principles and models to ensure that you develop a consistently successful approach.

**Find Out More**
http://www.medmeetings.co.uk/training/all/Management-Fundamentals

### Presentation Excellence for Clinical Professionals

| Cost: £195.00 + VAT | Event Type: 1 day Course | CPD Points: 6 | Provider: Grow Medical LLP |

Effective presentation skills form one of the core backbone elements of a successful career in healthcare. Faced with a diverse range of scenarios, from teaching staff to interview presentations right through to a presentation of an international multi-centre trial or Trust board meeting, it is surprising that few have ever received any formal training in this vital area. This programme takes a single, intensive day approach to dealing with the core elements of effectiveness in presenting with poise and impact.

**Find Out More**
http://www.medmeetings.co.uk/training/all/presentation-excellence-for-clinical-professionals
### Insights - Understanding the Evolving Healthcare Landscape

**Cost:** £95.00 + VAT  
**Event Type:** 1 day Course  
**CPD Points:** 6  
**Provider:** Academyst LLP

Our ground-breaking, renowned Insights programme is designed to take individuals from an inadvertent state of naive vulnerability to one of informed insight, allowing you to set a sensible strategic direction, seize opportunity and mitigate the myriad of risk in the emerging system. Going well beyond just information and facts, it provides a deep level of interpretation and insight as to how our new system is likely to play out in reality.

**Find Out More**  
http://www.medmeetings.co.uk/training/all/insights-understanding-evolving-healthcare-landscape

### Leadership & Management Masterclass for Latter Year Trainees & Newer Consultants

**Cost:** £585.00 + VAT  
**Event Type:** 3 day Course  
**CPD Points:** 29  
**Provider:** Academyst LLP

Aimed primarily at those within sight of their CCT or recently into their first consultant post and specifically at those who recognise the unquestionable importance of true leadership and management effectiveness both in demonstration of your personal value to a prospective organisation and operationally in post.

**Find Out More**  
http://www.medmeetings.co.uk/training/all/ultimate-leadership-management-programme

### Leadership Fundamentals & Core Principles

**Cost:** £195.00 + VAT  
**Event Type:** 1 day Course  
**CPD Points:** 6  
**Provider:** Academyst LLP

Our Leadership Fundamentals programme is aimed at taking those with no formal leadership training to the point of a thorough understanding of leadership, what really makes it work and how to start applying it in every day practise. It is designed to build very solid foundations on which individuals can build ever greater leadership expertise over time. It's thoroughly people-focused and designed to sit in the context of our very challenging times.

**Find Out More**  
http://www.medmeetings.co.uk/training/all/leadership-fundamentals-1

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**Good medical leadership is vital in delivering high-quality healthcare. All medical professions (students to consultants) should be able to identify situations where things could be done differently, and have the initiative and the skills to improve them. No doctor should “leave it for others to sort out”**.

**Speciality applications: Clinical Radiology**

**Cost:** From £15 + VAT  
**Event Type:** Evening Course  
**CPD Points:** -  
**Provider:** Royal Society Of Medicine

With training becoming more standardised and competition for consultant posts getting ever greater, it is vital that you stand out from the crowd in order to secure the perfect post for you. That means getting the edge. The edge consists of having the right insights and demonstrating it, adopting the right overall strategy and how well you perform on the day.

**Find Out More**
http://www.rsm.ac.uk/yf/tre01.php

**Speciality applications: Core surgical training**

**Cost:** From £15 + VAT  
**Event Type:** Evening Course  
**CPD Points:** -  
**Provider:** Royal Society Of Medicine

The RSM Trainees Committee is proud to host this trainee event aimed at informing prospective candidates wishing to apply into Core Surgical Training about the application process, portfolios and interviews. The event is primarily aimed at FY2 trainees, although more junior trainees are welcome to attend.

**Find Out More**
http://www.rsm.ac.uk/yf/tre03.php

**Speciality Applications: Core medical training**

**Cost:** From £15 + VAT  
**Event Type:** Evening Course  
**CPD Points:** -  
**Provider:** Royal Society Of Medicine

This event is part of a series covering specialty applications. Applying to Core Medical Training will be discussed with details about the application process, portfolios and interviews. This event is primarily aimed at FY2 trainees or more junior trainees wishing to get an early idea of what is involved.

**Find Out More**
http://www.rsm.ac.uk/yf/tre04.php

**Speciality applications: General Practice**

**Cost:** From £15 + VAT  
**Event Type:** Evening  
**CPD Points:** -  
**Provider:** Royal Society Of Medicine

The RSM Trainees Committee is hosting this trainee event to provide information about applying into General Practice at ST1 level. The application form, written examination component and format of the practical assessment will be discussed.

**Find Out More**
http://www.rsm.ac.uk/yf/tre05.php
Teaching skills for doctors: Small group teaching
Cost: From £105 + VAT  Event Type: 1 day Course  CPD Points: -  Provider: Royal Society Of Medicine
Friday 15 November 2013
Venue: Royal Society Of Medicine, 1 Wimpole Street, LONDON, W1G 0AE
A joint meeting with the Trainees Committee

Find Out More
http://www.rsm.ac.uk/yf/tre07.php

Radiology for foundation doctors
Cost: From £35 + VAT  Event Type: 1 day Course  CPD Points: -  Provider: Royal Society Of Medicine
The objective for this one day course is to cover the most important radiological topics relevant to foundation doctors.
Course participants will be provided with useful tips and tricks for systematic interpretation of radiological cases as well as multiple examples of common, important and interesting cases, taught to MRCP/MRCS standard.

Find Out More
http://www.rsm.ac.uk/yf/tre08.php

Research methods and critical appraisal course
Cost: From £90 + VAT  Event Type: 1 day Course  CPD Points: -  Provider: Royal Society Of Medicine
Understand the strengths and weaknesses of the different study designs in observational research and know the circumstances in which it is appropriate to use them
Understand the principles that underlie randomised controlled trials and realise how easily they can be undermined or subverted by poor design or execution

Find Out More
http://www.rsm.ac.uk/academ/rpe01.php

Future orthopaedic surgeons conference (FOSC)
Cost: From £35 + VAT  Event Type: 2 day Conference  CPD Points: -  Provider: Royal Society Of Medicine
Saturday - Sunday  7 - 8 December 2013
Venue: Royal Society Of Medicine, 1 Wimpole Street, LONDON, W1G 0AE

Find Out More
http://www.rsm.ac.uk/academ/ore03.php
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