Royal College of Anaesthetists

Supporting and managing anaesthetists with performance concerns

December 2024

Introduction

Anaesthesia is acknowledged as being a specialty which places high priority on safety. Occasionally, there are concerns about individual doctors which need attention. These may include issues of conduct, capability or performance. In most cases these can be resolved at a local level with appropriate support, guidance and remediation. Formal referral to the General Medical Council and subsequent sanctions are rare. The aim of this guidance is to maintain standards of practice and uphold patient safety whilst providing a supportive and fair framework.

Healthcare settings may have their own policies for responding to performance concerns which may overlap with this guidance. Anyone who holds managerial responsibility for anaesthetists should be aware of local policies and read them in conjunction with this guidance.

Doctors have a duty to provide support for their colleagues whilst maintaining patient safety at all times.[1]

The General Medical Council (GMC) sets out the standards of performance it expects from medical practitioners in its guidance *Good Medical Practice*, and its supplementary guidance *Leadership and management for all doctors* and *Raising and acting on concerns about patient safety.*[2] These include the provision of good clinical care, maintaining a proper professional relationship with patients and working constructively within medical and multidisciplinary teams. Serious deviation from set standards of practice may ultimately require regulatory involvement. This guideline is intended to support those who manage anaesthetists with performance concerns to get them back on track and avoid the need for regulatory referral and sanction.

Early recognition, empathetic support and appropriate management is crucial to allow for resolution. This guidance document will serve to draw together the key elements of the current publications and summarise the approach to be used by detailing:

- what is meant by performance concerns and the terms used in NHS England, NHS Inform (Scotland), NHS Wales, Health and Social Care (Northern Ireland), GMC and Medical Practitioners Tribunal Service documents
- how organisations and departments of anaesthesia can identify anaesthetists who need additional support or who are giving cause for concern in order to maintain patient safety and high standards of care
- guidance on how clinical leaders should proceed in the event of concerns arising about an anaesthetist's performance including objectives and procedures.
- organisations which can provide specific help and support to doctors with mental health issues

This guidance is aimed at:

- clinical leaders who are responsible for leading and managing anaesthetists
- operational managers with responsibility for anaesthetic services
- all colleagues who may be concerned about the performance of an anaesthetist
- all colleagues who support an anaesthetist whose performance is giving cause for concern.

This guidance applies to anaesthetists working in all settings in which anaesthetic services are delivered, including the NHS, military and independent sectors in the four nations of the UK. This guidance is not intended for anaesthetists in training, although some elements of it will be relevant to this group. There is an established framework for educational and clinical supervisors and college tutors to support anaesthetists in training with performance concerns.[3]

1 What performance concerns in anaesthetists can look like and their impact

An anaesthetist with performance concerns is one whose performance does not meet the acceptable standards of clinical practice and professional behaviour as described by their employer, the RCoA or the GMC. This encompasses the spectrum of perioperative care, critical care and pain management for which they are trained to provide as well as other roles in education, research and leadership. Concerns can range in severity from the seemingly trivial to the most serious, potentially criminal behaviour. The approach used should be proportionate to the severity of the concern and fictionalised vignettes are used in this document to illustrate the types of concern that could be seen.

Clinical leaders should approach performance concerns with an open mind. Deterioration in performance can be triggered by issues relating to doctors' mental or physical health (including addiction), stressors outside work, eg relationship breakdown, bereavement, birth of a child, or organisational issues. The latter may include bullying, racist or sexist behaviours from colleagues.[4] Individual anaesthetists may be struggling with aspects of their work due to diagnosed, or undiagnosed neurodiversity. International medical graduates, especially those new to work in the UK are particularly vulnerable and over-represented in terms of referral to the GMC.[5]

It is recognised that the practice of anaesthesia has unique stressors including relatively isolated clinical practice, onerous on-call or shift work, and episodes of very intense stress when a severe, critical or catastrophic event takes place. Anaesthetists have been identified as being one of the specialty groups more likely to end their life by suicide.[6]

Being under investigation of any kind provides additional stress and increased risk of suicide has been described for those under GMC investigation.[7] With good awareness and support, the vast majority of anaesthetists can be supported through periods of difficulty. The College's wellbeing hub provides links to specialist resources that can be accessed by doctors needing support.

2 Striving for good performance: the role of clinical leaders

The culture within an anaesthetic department is central in maintaining high standards of anaesthetic practice. The College's Guidelines for the Provision of Anaesthetic Services: The Good Department are written with the aim of providing a framework which individuals, departments and Clinical Leaders can follow to maintain high clinical and professional standards of performance. This framework, set by the RCoA, is one within which all anaesthetists are expected to practise, and therefore provides benchmarks by which they may be assessed.

A supportive and effective anaesthetic department will pay attention to all elements of integrated clinical governance. Predefined and well recognised standards of care are useful to refer to when having conversations with anaesthetists with performance concerns. For example, existing departmental Standard Operating Procedures (SOPS) or guidelines based on RCoA or Association of Anaesthetists publications, or national audit recommendations, which have passed through rigorous local governance processes and been agreed, are a good starting point when discussing expected levels of performance.

Even in the best–run departments anaesthetists can get into difficulty so anaesthetists in general and Clinical Leaders in particular also need to understand the procedures to be followed if seriously deficient performance in a colleague is suspected (see below).

The overarching aim of Clinical Leaders should be to identify potential deteriorations in practice and professionalism and act early to stop it worsening.[8] Given the negative impact of poor professionalism and performance concerns on both patient outcomes and departmental, hospital and institutional culture, Clinical Leaders must be observant for colleagues who have performance

concerns.[9] They need to identify early if this is a capability, capacity or conduct issue, and then support with structured plans to enable this individual to reach their full potential.

In some cases, concerns will need to be formally escalated. Most Medical Directors are also, for the purposes of revalidation, the Responsible Officer (RO) for their organisation and can consult their regional GMC Employer Liaison Advisor (ELA). Employer Liaison advisors describe GMC referral thresholds and procedures relating to performance issues. NHS Resolution should also be consulted at an early stage and are a source of invaluable advice.

For each of the following guidance sections, there should be clear delineation of:

- the individual anaesthetist's personal responsibility for professional standards
- departmental responsibility for providing a high quality service
- managerial responsibility for providing the necessary staff and facilities to achieve this.

3 Being alert to concerns

It is important to listen to, and act upon, feedback from both colleagues and patients. This is an important part of creating a departmental culture that supports psychological safety at work. If teams working with anaesthetists with performance concerns do not feel psychologically safe, they may not raise patient safety concerns. Outcomes are worse for patients under the care of doctors who demonstrate poor professional behaviours.

Concerns about a doctor's conduct or capability can come to light in a wide variety of ways, for example:

Type	Tool
Concerns from colleagues	Soft information or 'noise', particularly when they come from multiple sources, eg Clinical and non-clinical colleagues including anaesthetists in training. These are statements of concern about an identifiable doctor which have not been articulated as a formal complaint or as part of a formal process.
Concerns via organisational processes	Review of performance against job plans
	Concerns raised at appraisal
	Disengagement from the appraisal process
	Concerns arising from multi-source feedback
	Concerns from another area of practice, eg in the independent sector, military or from a locum agency. Usually this will be via the RO
	Concerns raised to Freedom to Speak Up guardians or other whistle-blowing mechanisms
	Incident management system
	Patient complaints, including litigation
External organisations	GMC
	Public Service Ombudsman
	Medical Examiner service
	Coronial process
	Police

When an anaesthetist with performance concerns works in more than one setting, eg in the NHS and the independent sector, cooperation is needed between the clinical leaders in each area.

4 The role of appraisal

It is unusual for performance concerns to first come to light at appraisal.

If potentially serious performance issues do become apparent during the appraisal process, the appraisal should be suspended whilst the appraiser ensures that these issues are addressed urgently, especially if they pose a threat to patient safety.

Failure to engage with the appraisal process may be indicative of a capacity, capability or conduct issue, and therefore, a process should be in place whereby the Responsible Officer should be made aware of any doctor who does not engage in local appraisal processes. This includes failure to act on opportunities to collect the required supporting information for appraisal. The Responsible Officer may notify the GMC that the doctor is failing to engage in revalidation which can potentially result in the GMC withdrawing the doctor's license to practice (see the GMC Responsible Officer Protocol – Making Revalidation Recommendations).

The appraiser plays an important role in supporting anaesthetists with performance concerns in terms of how they engage with addressing these via reflection and an effective professional development plan.

5 Principles in supporting and managing anaesthetists with performance concerns

Four fundamental principles should be followed as below.

- Protect patients from harm. This is the primary objective which must always be uppermost.
- Ensure that the anaesthetist is treated justly. Procedures should be fair and open.
- Provide opportunities for the anaesthetist to improve their performance where possible.
- Identify appropriate standards and milestones against which improvement can be assessed, and criteria for success or failure of remediation.

Additionally:

- in the initial exploration of performance concerns it is important to be clear about **what** the concern is and to consider **why** the anaesthetist is underperforming, so that early support mechanisms can be put in place, eg referral to occupational health, GP, counselling, mentoring etc
- anaesthetists who are the subject of procedures dealing with performance concerns should always be given the opportunity to have an advocate or supporter with them at informal or formal meetings. All discussions should be documented (even if the concern is low) and the anaesthetist should be allowed to verify what has been recorded
- at all stages the possibility of ill health should be considered. Anaesthetists should be signposted to the confidential services available to them, which are noted on the College's wellbeing hub and the Association of Anaesthetists' Emergency Contact – I need help now page
- any statements should be written contemporaneously, signed and dated. Records must be kept of everything: conversations, telephone calls, meetings and interviews. These may be needed at a later stage
- it is important to maintain confidentiality to protect all parties.

6 Procedures to be followed

Unless the performance concerns are severe, informal processes should be used first before escalating the concerns to more formal processes as required. Even when the performance concern is suspected or has been detected externally or when external agencies are involved, there will always be some level of local involvement in order to support and manage the anaesthetist. Involvement of an external agency, eg Practitioner Performance Advice, should be considered if the performance concern is complex. The most serious concerns, which bring into question whether the anaesthetist's fitness to practice is impaired will need discussion with the GMC. Involvement of an external agency or referral to the GMC runs concurrently with local procedures.

Concerns which are initially non-specific and where patients may or may not be immediately at risk

Vignette 1

The clinical lead has been made aware that Dr X, a consultant is regularly late for work. This delays the start of the lists and has led to some elective patients having to be cancelled and colleagues having to stay late to finish the work.

Gather, discreetly, as much information as possible. Ignore hearsay evidence and try to establish the facts. Unless using formal anonymous reporting mechanisms within the trust/board, anyone making an allegation against a colleague must be prepared to support it in writing. All Individuals who raise concerns particularly via the Freedom to Speak Up guardian or other confidential processes need careful and considerate support. It is usually helpful to consult trusted, senior colleagues before deciding how to proceed.

If a concern appears to be well-founded but not serious it may be sufficient for one or two colleagues to bring it informally to the anaesthetist's attention, together with appropriate advice. This is sometimes referred to as a cup of coffee conversation. All concerns – including those deemed as low level – should also be reported to the Clinical Director in the first instance (and in some organisations the Medical Director), in order that the Clinical Director has oversight of the issues and is aware of and can advise on any low-level interventions. Repeated low level concerns about an individual anaesthetist over a period of time may represent a pattern of behaviour which needs addressing more formally, and raising such concerns with the Clinical or Medical Director may help to reduce the risk of them escalating to a high level performance concern. It is important that written records of all conversations, telephone calls, meetings and interviews are kept as these may be needed at a later stage.

Vignette 1 continued

An experienced colleague met informally with Dr X at the Clinical Director's request to explore the reasons for the lateness. Dr X confided that stress at home was causing her late nights, and insomnia which made getting up for work in time challenging. She was aware this was problematic for patients and colleagues and wanted to do better. The experienced colleague offered some informal advice and suggested Dr X contact her GP. She also put Dr X in touch with the wellbeing support team in the hospital and signposted her to the wellbeing resources on the Association of Anaesthetists and RCoA websites.

A month later they met again and things were much better for Dr X. The stress was resolving, her sleep pattern had improved and she was managing to get to work on time to start the lists promptly.

The experienced colleague wrote to the doctor and summarised the concerns, and the progress the doctor had made to resolve her stress and improve her performance. This 'informal but documented' approach ensured that if there was a recurrence the people involved with supporting the doctor would not be starting from scratch.

Concerns are serious or patients are clearly being put at risk, or informal discussions have failed to resolve the problematic issues

Vignette 2

Dr Y is sixty-one and works as an associate specialist. His behaviour has become erratic in recent weeks. Trainees and theatre staff have reported multiple cases of inappropriate language in theatre, and patients have complained about his rudeness. Surgeons have asked that he be moved off their lists. Earlier informal discussions have not made any difference and Dr Y appears to have no insight as to how serious the allegations are. He is accusing colleagues of mounting a witch hunt against him. The behaviours are completely out of character.

The Clinical Director and Medical Director should be contacted urgently. The Medical Director should contact Practitioner Performance Advice (optional in Scotland), especially when exclusion is being considered.

Vignette 2 continued

The Clinical Director takes advice from the medical director and meets with the doctor following local policy. The human resources team provide support, and the doctor is accompanied by a colleague. The doctor is combative and aggressive in the meeting and does not provide any explanation for his behaviour.

With the agreement of the medical director and following advice from PPA it is agreed that the doctor should take a short period of medical leave. An occupational health assessment is arranged and he is advised to see his GP. He is signposted to wellbeing resources.

An investigation into the allegations is commissioned.

PPA agree to undertake a behavioural assessment but in the meantime Dr Y's family become increasingly concerned and he develops unilateral weakness. Urgent investigations reveal a frontal lobe brain tumour. Dr Y eventually takes medical retirement from his post.

Exclusion from work

In the context of this guidance document, the phrase 'exclusion from work' is used to avoid confusion with 'suspension' of the right to practise which may be imposed by the GMC. Whenever exclusion is being considered, there is a requirement for the case to be fully discussed by the trust/health board Chief Executive, Medical Director, Director/Head of Human Resources, Practitioner Performance Advice and other interested parties such as the police when there are criminal allegations.[8] Advice from the regional GMC Employer Liaison Advisor should also be sought and the GMC must be involved in discussions at the earliest opportunity following the exclusion.

Exclusion from work and GMC referral are associated with an enormous degree of stress, anxiety and morbidity for the individual anaesthetist. There is evidence to show that doctors in this kind of situation are at higher risk of suicide and self-harm. This should be acknowledged, with recommendations for support to be put in place for the individual who is being excluded or referred to the GMC.

Restricting a doctor's practice or excluding a doctor for long periods can also lead to isolation and loss of clinical skills. Exclusions should therefore be considered as a last resort, and regularly reviewed with the aim of getting the doctor back to work as soon as possible.

In most circumstances a doctor can have a named colleague to support them during their investigation. It is acknowledged that a doctor's closest friends may also be their colleagues, but the integrity of the investigatory process must not be undermined by breaches in confidentiality.

Support for excluded doctors can be provided from outside the employing organisation by their professional body, their defence organisation, their GP, Practitioner Health in England, Canopi in Wales, and Workforce Specialist Service in Scotland.

GMC Fitness to Practice procedures

The criteria for referral to the GMC's Fitness to Practice procedures include situations where:

- local action by the trust/health board, with or without advice from Practitioner Performance Advice, would be impractical or has been tried but has failed to resolve the problem
- local action has resolved the immediate local issue but the matter has wider implications
- the problems are so serious that immediate referral to the GMC is clearly required regardless of whether or not local action may also be appropriate.

Referral should be considered if the anaesthetist fails to display appropriate insight into the problems, has left the district but may have taken those problems to another area of the country or has moved exclusively into private practice. In particular the GMC may be the only body able to take effective action where serious problems arise in relation to a doctor working as a transient locum or working solely in non-NHS practice.

Vignette 3

Dr Z is consultant and is on-call for general theatres. The resident anaesthetist (Dr A) has called Dr Z at 8pm to ask for support with a high-risk patient. Dr Z advises her to carry on and declines her request for him to come into the hospital. When the patient deteriorates Dr A cannot contact Dr Z and asks Dr B, the consultant on-call for critical care to help. Dr B realises that Dr Z was doing private practice at the time and reports him to the clinical director.

The Clinical Director has a formal meeting with Dr Z emphasising that this was inappropriate and must not happen again. She gives Dr Z a directive that he must reflect on the episode in his appraisal.

One month later, the CD notes that Dr Z is not at the mandatory clinical governance meeting. She has had complaints about him not turning up for training sessions and has been told informally that Dr Z is spending several days a week at the local private hospital.

The CD contacts the medical director and HR for advice and, following local processes commissions an investigation which reveals that Dr Z is regularly carrying out private practice when he is job-planned for NHS work. This is a probity issue and puts patients at risk. Dr Z is referred to the GMC and subsequently receives a sanction. He also receives a written warning from the organisation.

During the investigation Dr Z discloses the financial pressures he is under, relationship difficulties and an increasing dependence on alcohol to deal with the stress. Alongside the GMC process Dr Z is supported by Practitioner Health. The BMA signpost him to independent financial advice.

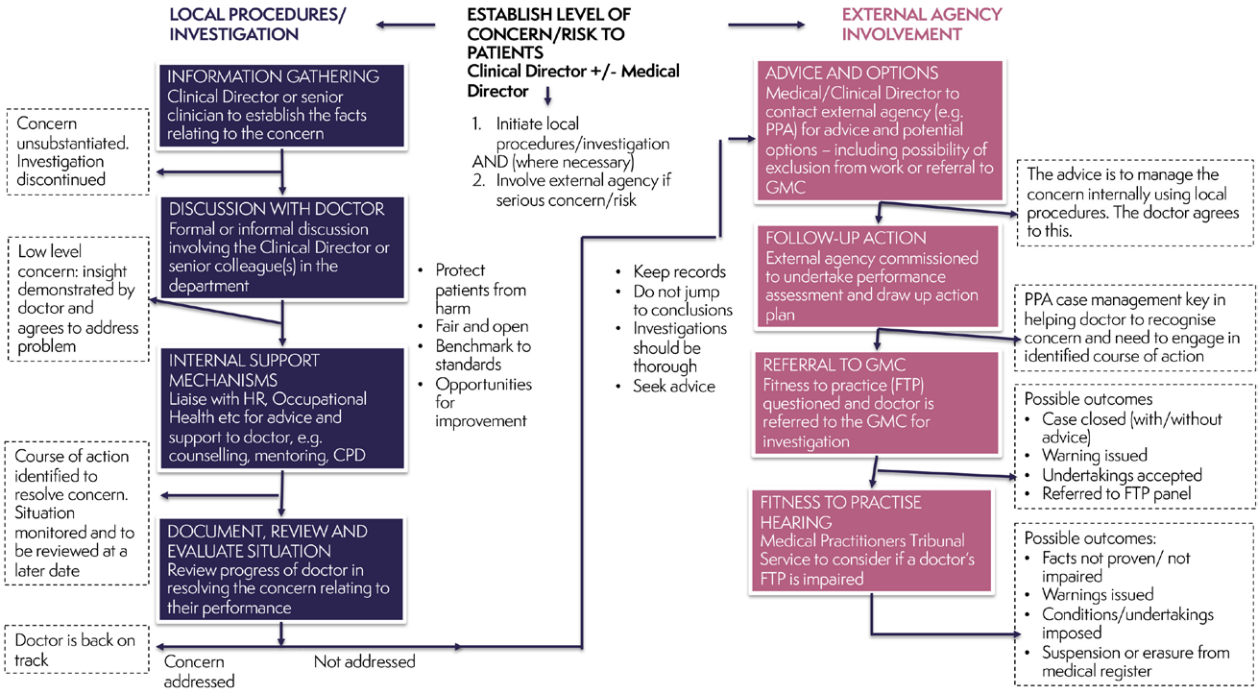
Twelve months later Dr Z is healthier and has changed his lifestyle to live within his means. His private practice is limited and takes place in uncontracted time. He is given a further directive to discuss the issues in his appraisal and a record is kept of all the discussions with the doctor and external agencies along with the investigation and GMC referral.

Performance and health issues are unlikely to require immediate referral to the GMC if the anaesthetist has insight into the problem and is willing to co-operate with local initiatives to help resolve the concerns.

A factsheet providing an overview of the GMC's Fitness to Practise procedures can be downloaded from the GMC website.[9]

Examples of concerns	Who needs to be involved	Processes to follow	Examples of possible action
Improvements in skills, knowledge or behaviour are required, eg deviation from standard practice; persistent lateness; incivility	Clinical leader Occupational health (not always necessary)	Local (trust/health board) procedures	Offers of support Referral to occupational health Adjustment to job plan Period of increased supervision Offer of retraining Appointment of a mentor, coach, or both Clear expectation of improvement set out and agreed by all parties
The anaesthetist's conduct, capability or competence is seriously impaired and there has been no improvement following local processes, eg complete breakdown in team working; persistent disregard of organisational and professional standards of behaviour	Clinical leader and medical director with support from HR professionals. Occupational Health Practitioner Health (England); Canopi (Wales); National Wellbeing Hub (Scotland)	Local (trust/health board) procedures Disciplinary procedures using trained investigators and case managers, eg MHPS (England); UPSW (Wales) In England, Wales and Northern Ireland, Practitioner Performance Advice (PPA) should be involved In Scotland the use of PPA services is not mandatory; however, they remain available to advise where invited	Instigation of formal internal investigation by trained investigator and following local/national policy Adjustment to job plan Medical leave Restriction of practice Suspension from some, or all duties Exclusion from the workplace Suspension and exclusion are rarely necessary and the decision to do so must always involve the Responsible Officer, or their equivalent
The anaesthetist's fitness to practice is impaired and local attempts at resolution have failed Or The anaesthetist is guilty of a criminal offence, eg domestic violence, driving under the influence of alcohol	Clinical leader and medical director with support from HR professionals. General Medical Council employer liaison advisor Local authority if there are safeguarding concerns	Disciplinary procedures using trained investigators and case managers (if not already started), eg MHPS (England); UPSW (Wales) Discussion with the GMC Employer Liaison Advisor which may be followed by formal referral to the General Medical Council (GMC)	Instigation of formal internal investigation (if not already started) by trained investigator and following local policy Adjustment to job plan Medical leave Restriction of practice Suspension from some, or all duties Exclusion from the workplace Suspension and exclusion are not always necessary and the decision to do so must always involve the Responsible Officer, or their equivalent. The GMC must be aware of any actions the organisation takes to safeguard patient safety

Procedures to be followed diagram



7 Areas of special consideration

Military anaesthetists

Defence Medical Services (DMS) anaesthetists practice clinically within the NHS. Anaesthetists in Training are managed by the Defence Deanery but hosted by schools of anaesthesia across the country whilst consultants are placed within host NHS trusts. Anaesthetists in Training and consultant anaesthetists are usually in clusters in key teaching locations or preferred partner trusts but there are small groups and individuals in locations across the devolved nations.

All DMS anaesthetists are employed by the Ministry of Defence (MOD) but will hold an honorary contract with their host trust whilst a commercial contract will exist between the trust and MOD. Similarly, Anaesthetists in Training are employed by the MOD but placed within their host trusts and an agreement exists between Health Education England and the Defence deanery.

Low level concerns could and should be managed by the host trust or training programme using the standard trust or school policy, but it would be good practice to keep the parallel military management (or 'Chain of Command' CoC) informed. More serious concerns must involve the military CoC as the employer. This is to enable the MOD as the employer to discharge its duty of care, ensuring for example that appropriate occupational health concerns are considered and that any additional support structure available can be offered. The key military points of contact will have been identified in the commercial contract.

The Defence Consultant Advisor for Anaesthesia and Pain Medicine (DCA) is the Regional Advisor for Defence Anaesthetists in Training and is supported by two Deputy Regional Advisors (DRAs). The Responsible Officer for Defence Anaesthetists in Training is the defence Dean who is supported by geographically placed Military Associate Deans.

Every Defence Consultant Anaesthetist will have a Military Clinical Director (MCD) and a Commanding Officer who will be identified in the commercial contract. The MCD is a senior military consultant at either the host trust or the nearest preferred partner trust to a singleton placement. The MCD should be the initial point of contact for any concerns or questions about Defence consultants and they will discuss any specialty specific concerns with the DCA and involve the Commanding Officer as appropriate.

Defence consultants have the same pressures as their civilian colleagues but also have the additional challenges of multiple chains of command and management as well as also having deployed and operated in combat areas over the last two decades which may cause additional concerns. There have been recent tragedies which have highlighted these potential additional pressures and reinforce the need for additional care and concern.

If there are any concerns or difficulties in identifying or contacting military management then involve the DCA who will be able to contact the correct individuals and involve appropriate support services.

Contact details for Responsible Officers can be obtained from the GMC, for the DCA and DRAs from the College and for the Dean and Military Associated Deans from the Defence Deanery.

Independent sector

Anaesthetists practicing in the Independent Sector often do so in concert with practice in the NHS and in these circumstances, it is usually the latter that leads in raising and managing performance concerns. However, it is important that whole practice is considered and that all sites where an individual undertakes anaesthesia are informed of any ongoing concerns that pose a risk to patients so that they can take action to protect patients and support the individual anaesthetist.

Working in the Independent Sector sometimes brings additional challenges to anaesthetists; It is commonly an isolated environment with limited colleague support and this may exacerbate performance issues. Concerns may initially be raised in the independent sector and if so, the same principles apply in that if these pose a risk to patients, all sites at which the individual practices should be informed. This duty of communication rests primarily with the anaesthetist themselves, but the provider (be it NHS or independent) at which the concerns are first raised must assure themselves that where there are risks to patients, these concerns have been communicated.

Contact details for Responsible Officers at Independent Providers can be obtained from the GMC.

10 Further sources of information

An anaesthetist's local team act as a first point of contact for advice in relation to the procedures and processes to be taken in managing a performance concern. Other advice and support can come via the following:

Practitioner Performance Advice

Established in 2001 (formerly as the National Clinical Assessment Authority), Practitioner Performance Advice (PPA) works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to healthcare organisations and to individual practitioners. PPA provides services in England, Wales and Northern Ireland under national direction, and is available as an option for use in Scotland.

Members of a trust or health board can seek advice from PPA about a doctor they think has performance concerns at any stage in the handling of the case, although it is usually the Medical Director who makes the referral to PPA. A staged approach to the services PPA provides to NHS organisations and practitioners has been developed. This involves:

- immediate telephoned advice, available 24 hours
- advice, then detailed supported local case management
- advice, then detailed clinical performance assessment
- support with planning and implementing recommendations arising from assessment.

The PPA website has a number of excellent guidance documents and templates for use in planning the management of poorly performing doctors.

Medical Practitioners Tribunal Service (MPTS)

The MPTS, launched on 11 June 2012, is an impartial adjudication service for the medical profession in the UK. It runs hearings for doctors whose fitness to practise is called into question and has powers to impose sanctions against the doctor's registration where necessary, to protect the public. The MPTS is part of the GMC but is operationally separate and is accountable to Parliament.

There is operational separation from the GMC's investigation and case presentation work, and hearings which were previously run by the GMC are now be run by MPTS. More information about MPTS can be found on their website.

Royal College of Anaesthetists

The College provides guidance and resources on professional standards, which are freely available on the RCoA website. For general advice on issues relating to expected professional standards, contact the Clinical Quality Advisor at clinicalquality@rcoa.ac.uk.

The College's wellbeing hub provides links to specialist resources that can be accessed by doctors needing support.

Association of Anaesthetists

The Association of Anaesthetists provides advice on wellbeing and support. This includes an Association mentoring scheme.

Members of the Working Party

Dr Emma Hosking, Chair of the working party, Consultant Anaesthetist

Dr Sarah Hare, Clinical Leader, East Kent Hospitals NHS Foundation Trust

Dr Angela Jenkins, Consultant Anaesthetist, RCoA Scotland Board Member

Dr Sophie Lawton, Anaesthetist in Training, Bradford Royal Infirmary

Dr David Lee, Training Programme Director, RCoA Northern Ireland Board Member

Dr Kirstin May, Representative of RCoA SAS committee

Colonel James Ralph, Defence Consultant Advisor in Anaesthesia and Pain

Dr Robert Self, Consultant Anaesthetist, Association of Anaesthetists representative

Dr Isabel Smith, Medical Director for Strategy and Transformation, University Hospitals Dorset

Dr Ashish Wagle, Consultant Anaesthetist, RCoA Welsh Board Member

Dr Sue Walwyn, Regional Advisor, Health Education Yorkshire and Humber

Dr Timothy Wigmore, Consultant Anaesthetist, Independent Healthcare Providers Network representative

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Royal College of Anaesthetists
Churchill House, 35 Red Lion Square, London WC1R 4SG
standards@rcoa.ac.uk

rcoa.ac.uk