After many years of medical school, foundation and core training you have finally got your gastroenterology training number – well done and welcome!

You are now a member of a specialist community of clinicians and academics throughout the world.

As fellow trainees, we remember the challenges of being a first year registrar, therefore this booklet has been produced with the aim of providing a helping hand. We hope that you find it useful.

Louise China & Laith Alrubaiy
Chair/Ex-Chair of the BSG Trainees Section, on behalf of the section

The BSG Trainees Section is the sole national representative body for all Gastroenterology and Hepatology trainees (StRs/SpRs), having 18 trainee committee members representing the following regions of the UK:

Contact details for your regional trainee representative can be found here: www.bsg.org.uk/sections/trainees-general
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1. The BSG - your specialist society

The mission of the BSG is to maintain and promote high standards of patient care in gastroenterology and to enhance the capacity of its members to discover, disseminate and apply new knowledge to the benefit of patients with digestive disorders.

The Trainees Section is a very active and dynamic committee, offering a wide variety of educational activities to its members whilst being the only representative body for all 850+ UK specialist registrars on issues relating to training and political matters on a national and international level. The section is structured as follows:

Committee members represent trainees (on behalf of the Trainees Section) on a number of committees – both within and external to the BSG:

There are also trainees elected to each sub specialty section within the BSG.
As a member you can book these extremely popular courses at a heavily subsidised rate thanks to the support of the BSG and our industry partners.

BSG Trainees Education Weekend: run annually every October, this is not only a great educational programme but also a chance to meet and socialise with fellow trainees from around the country.
www.gastro-educationweekend.co.uk

BSG Management & Leadership Weekend: a 2 day/2 night residential course every February which fulfills requirements for Gastroenterology/GIM CCT.
www.gastro-managementweekend.co.uk

BSG Taster Weekend: this course is for FY/CMT doctors interested in a career in gastroenterology www.gastro-tastercourse.co.uk

Journal Access
The BSG co-owns three journals. Gut is Europe's highest ranked GI journal and the Society's oldest title. Frontline Gastroenterology focuses on clinical aspects of gastroenterology. The newest addition to the portfolio is the open access journal BMJ Open Gastroenterology.

Trainee Prizes
The BSG Trainees Section awards four major prizes each year to recognise the outstanding achievements of BSG trainees in Gastroenterology and Hepatology. The prizes (£1000+ each) are presented at the BSG annual conference.
www.bsg.org.uk/sections/trainees-awards

BSG Annual Conference and Trainee Bursaries
As a member you have markedly reduced conference registration fees. The Trainees Section run 3 symposia focusing on education that may not be available or possible on a regional level. In addition we run the hugely popular conference party with >450 attendees enabling you to socialise and network with colleagues. Thanks to our industry partners we have been able to run a competitive bursary scheme (>20 places) for trainees annually.

Trainees Section Survey
Our 2 yearly survey enables you to give feedback directly to the national training committees in order to improve future training.
BSG Trainees Section: The BSG Support Team and Structure

The BSG Trainees Section fits into the BSG society structure as below:

- **BSG Executive**
- **BSG Council**
- **BSG Sections including the Trainees Section**

The Section is supported by a number of crucial BSG support staff:

- **Mr Howard Ellison**
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The Trainees Section also receives administration support for its courses from MCI, a global events organisation company

- **www.mci-group.com**
- **mci-group-communication@mci-group.com**

In addition, it is supported by senior members of the BSG Executive:

- **Mr R Gardner**
  Chief Executive

- **Dr Cathryn Edwards**
  President-elect

- **Jess Williams**
  Education Committee Chair

- **Mr John Hayward**
  BSG Executive Secretary

- **Ms J Eaden**
  Senior Secretary

- **Dr M Lockett**
  Training Committee Chair

- **Professor M Lombard**
  President

- **Dr D Loft**
  Treasurer

- **Dr T Ellis**
  Specialty Advisory Committee Chair
2. Setting the Scene: Typical week in the life of Gastro SpR

Each post in your gastroenterology rotation should consist of:

1. Outpatient clinics
   - 2-3 per week covering a range of topics (hepatology, luminal gastroenterology, general gastroenterology) and with a variety of new patient and follow up appointments. You should be allocated 30 minutes for a new patient and 15 minutes for a follow up patient.
     - ST3-4  Direct consultant supervision (i.e. clinic cancelled if the consultant is away) and the opportunity to discuss all patients following clinic.
     - ST5+  Indirect consultant supervision (i.e. discussion of patients following clinic if required and a named consultant available in the hospital if the clinic consultant is away).

2. Endoscopy
   - A minimum of 1 training list per week
   - An additional service list, with the opportunity to gain exposure to therapeutics (banding/dilatation/PEG insertion)
   - Depending on your on rota, gastroenterology on calls may provide the opportunity for out of hours, emergency endoscopy exposure
   - Degree of supervision will depend on competence

3. Ward rounds
   - Usually 2-3 per week, with at least one consultant led & one SpR led

4. On call sessions – both in and out of hours

5. One free session per week
   - For admin, audit, research or private study

6. Meetings
   - Multidisciplinary meetings - radiology/pathology/oncology/surgical
   - Journal club

7. Exposure to procedures
   - Paracentesis
   - Depending on the department you work in, you may gain exposure to other procedures (i.e. percutaneous liver biopsy)

Any concerns regarding your rota should be discussed with your educational supervisor.
3. Career paths in gastroenterology

At some point in your training you will start to wonder or be asked about subspecialty interests. Consultants who practice general gastroenterology will often develop a subspecialty interest. A proportion may carve out a subspecialist role in a tertiary centre or teaching hospital. Depending on your aspirations, it would be wise to build your CV in the direction you want your CCT and career to take you once you gain a general idea of this. This usually happens towards the latter half of ST4 and throughout ST5, although some will already know what they want well before then. Below we outline the various subspecialty interests. It is important to bear in mind that there will be significant overlap between many of the subspecialties especially if you practice general gastroenterology.

Inflammatory Bowel Disease (IBD)
A host of diagnostic modalities and therapies are now available to investigate and manage IBD, with many novel therapies on the horizon. In addition to inpatient and outpatient encounters, those with an IBD interest will perform upper and lower GI endoscopy on a regular basis and participate in IBD MDTs. Advanced IBD fellowships are available for those who wish to pursue the subject in depth (completing the advanced IBD curriculum module) and this can often be linked to IBD and endoscopy research projects.

Hepatology
As a gastroenterologist you will often be asked to assess patients with abnormal liver tests, problems related to alcohol misuse or those presenting with manifestations of portal hypertension. Those delving deeper into hepatology may develop a subspecialty interest in metabolic, autoimmune or viral liver disease. Allocating time for these patients often means that hepatologists cut back on colonoscopy (though it is also not unusual to carry on) and focus on upper GI endoscopy and the endoscopic management of varices. Hepatologists may also perform ERCP in some centres as there can be overlap with pancreaticobiliary medicine. Some will choose to perform liver biopsies although these are increasingly perfromed by radiologists. Transplant hepatologists in tertiary centres will, in addition, be managing patients pre- and post-liver transplant. Accreditation in Hepatology by completing an Advanced Training Post would be very desirable if you wish to work as a transplant hepatologist or to develop a predominant hepatology interest. The ATP is usually your ST6 year (ST5 & ST7 years also considered) and follows competitive application on the Oriel website around November each year with approximately 15 posts available nationwide. There are also
plenty of Hepatology research opportunities available at transplant centres and local tertiary hepatology centres without transplant.

**Clinical Nutrition**

Your work would centre on patients with chronic intestinal failure, short bowel and high output stoma. You may also be commonly asked to assess patients for nasojejunal, gastrostomy or jejunostomy feeding. You will often encounter patients with coeliac disease, eating disorders or refeeding syndrome. Many consultants taking an interest in Nutrition will continue to perform upper and lower GI endoscopy and are usually expected to develop skills in placement of PEG, NJ, PEG J extension etc. In some centres you may manage a cohort of patients on home parenteral nutrition or patients pre/post small bowel or multivisceral transplant in a transplant centre. There are usually 4 Advanced Training Posts in Nutrition open to competitive application to trainees entering ST6 each year. Application opens on the Oriel website around November or December. There are usually 2 posts each for Oxford-Salford and Addenbrooke’s-St Mark’s rotations. There are also opportunities for fellowships with the option of tying in research projects in that time.

**Advanced Endoscopy**

Consultants who regularly perform endoscopy may develop an interest in a particular aspect of endoscopy or, less frequently, become employed as predominantly expert endoscopists with some outpatient commitments and contribution to the out of hours GI bleed on call. You may find yourself developing an interest in bowel cancer screening, Barrett’s surveillance, IBD surveillance and chromoendoscopy, enteroscopy & capsule endoscopy, complex polypectomy, or upper GI therapeutics and ERCP. Some centres are introducing techniques in submucosal therapeutic endoscopy and confocal endomicroscopy to the UK and there is potential to develop subspecialist skills in these areas as a tertiary endoscopist in the future. There are numerous endoscopy fellowships with opportunities to perform research in the UK and worldwide.

**Pancreaticobiliary Medicine**

Whilst gastroenterologists competent in performing ERCP do not necessarily specialise in PB medicine, if you do, you would increasingly be expected to be competent in endoscopic ultrasound (EUS) and would have a special interest in the investigation and management of obstructive jaundice, pancreatic cysts, biliary colic, chronic pancreatitis, autoimmune pancreatitis and IgG4 disease. PB medicine is an area where the development of new endoscopic
techniques and tools are most active using a combination of ERCP, EUS, cholangioscopy, biliary manometry and various accessories. This subspecialty will appeal to the gastroenterologist who likes to perform high impact endoscopy that involves much impromptu complex decision making. Many gastroenterologists will pursue a PB endoscopy fellowship before embarking on independent practice.

Neurogastroenterology
This is a relatively new area of gastroenterology specialising in the management of patients with motility disorders such as oesophageal dysmotility, gastroparesis and dyssynergic defaecation. You will also develop particular expertise in functional GI disorders such as functional heartburn, non-ulcer dyspepsia, idiopathic constipation, irritable bowel (IBS) and cyclical vomiting. There are now tertiary services seeing the most complex cases and there is opportunity in performing research in new therapeutic modalities which get considerable attention from pharma.

Academic Gastroenterologist
These are clinician-scientists or clinician-educators who have significant links to universities and medical schools and may take on a predominantly research or medical education role. Clinician-scientists involved in research will spend time mentoring their research fellows whilst testing hypotheses and networking with fellow experts in their fields of research nationally and internationally. Clinician-educators on the other hand will have significant roles in setting the curricula and maintaining teaching standards, and may supervise teaching fellows whilst conducting medical education-related research. Both will usually maintain outpatient and some inpatient clinical duties, often in a subspecialty linked to their area of research or teaching. Research experience or in depth experience in medical education are advantageous when venturing in the field of academic gastroenterology.

General Physician with Gastroenterology Interest
Some gastroenterologists may continue practising as a general physician (mostly participating in the acute medical take) whilst maintaining some clinic and endoscopy sessions related to general gastroenterology.
Endoscopy training is (perhaps) the most exciting part of becoming a gastroenterologist. It is certainly the newest skill to develop on embarking as an SpR. Liaise very early on with your trainers to identify dedicated lists – one of which should be reduced in number to allow for dedicated training time. You should have an endoscopy unit induction within the first couple of weeks.

Your first year as an SpR should be directed at competence at diagnostic upper GI endoscopy, this will allow the development of the hand-eye co-ordination skills required for more complex procedures. Your training is your own responsibility and like most things the more you put in the more you get out. Liaise with your colleagues, it is likely that due to GIM commitments, there will be periods of absence from the endoscopy training, so cross-cover each other’s lists to make the most of endoscopy training.

Many trainees find it difficult to attain confidence/independence in Upper GI bleeds. It is a good idea to liaise daily with the nurse co-ordinating the endoscopy lists – they will be able to identify which lists the bleeders are going on. Cases in theatre can be particularly good training opportunities.

If possible, identify early on if you have an interest in ERCP/EUS/Subspecialist endoscopy – inform your TPD’s as early as possible to ensure that you are placed in the appropriate centres – if you don’t start these early on it is almost impossible to be competent by the end of a 5 year training program without additional Advanced training modules or fellowships.

The JETs website ([www.jets.nhs.uk](http://www.jets.nhs.uk)) is a fantastic resource both for recording your logbook of procedures, as well as identifying training courses and educational materials. When you start at a new centre update your JET’s portfolio as early as possible. Every dedicated training session should have at least one DOPs for each procedure, don’t forget to give trainer feedback – this is actually reviewed by local endoscopy leads to optimise training opportunities.
5. Getting the best out of GIM

Each year, you will be required to attend for an Annual Review of Progress (ARCP), both within GI and GIM training. During these meetings, your training program director and a panel will review your progress, looking specifically at your JRCPTB e-portfolio for evidence of competency progression demonstrated on the curriculum with appropriately linked workplace based assessments, as well as your reflective practice and multisource feedback. ARCP decision aids allow specific targets to be defined for each year of training (https://www.jrcptb.org.uk/training-certification/arcp-decision-aids). It is important you have an educational supervisor that is practising in GIM; if you are dual training, this may mean having two supervisors at times during your training.

Remember to attend GIM regional study days to keep your knowledge up to date and help provide evidence of your understanding and competence in managing common (and less common) medical conditions. As a physician, it is likely on completing CCT and becoming a consultant that you will continue to look after patients with more than just gastroenterological issues! You should also bear in mind that within most deaneries, GIM training days are mandatory, with minimum percentage attendance requirements for a successful outcome in your yearly ARCP. Royal College of Physicians (RCP) symposia can also provide an excellent outlet for sharpening your knowledge of current guidelines across multiple subspecialties of medicine.

During certain job rotations within your specialty training, you may find that your General Internal Medicine (GIM) commitments clash with your GI training, especially if short rotas or frequent out-of-hours significantly affect your endoscopy procedure numbers or clinic attendances. It is important to remain proactive and insightful from the beginning into your specific training needs and to recognize early if your progress within GI training is being significantly hindered. Do not be afraid to seek advice from your Training Program Director (TPD) if you have concerns.

The best advice is to enjoy it - the best physicians are the ones who can think broadly, understand the relevance of other illnesses to their specialty and cope/show leadership under pressure. These are all skills you will acquire during your GIM training.
6. Sitting the SCE exam: Tips from those who have passed the exam

Gastroenterology SCE advice
The gastroenterology speciality certificate examination (SCE) was introduced in 2008. Successful completion of the SCE is now a mandatory requirement for trainees seeking a CCT in gastroenterology. The exam is organised by the BSG in partnership with the federation of the Royal College of Physicians.

When to take the exam?
There are no eligibility requirements for the gastroenterology SCE, so the exam can be taken at any stage of your training. The general advice from the RCP is that most trainees are expected to complete this exam by their penultimate year. The exam is held annually in April. There is a balance to be made between maximising clinical experience and knowledge prior to sitting the exam and ensuring there is sufficient opportunity to re-take if required prior to your CCT date. Most trainees sit the exam after at least 2 years of StR training.

Exam format
The gastroenterology SCE is delivered by Pearson VUE, which has a large network of centres across the U.K. These are the same centres that are responsible for administering the DVLA theory-driving test. It is also possible to sit the SCE examination in a number of venues outside of the U.K at an additional fee.

The exam consists of two three-hour papers of 100 questions each in the best-of-five format. Each candidate is allocated a computer terminal on which to complete the electronic examination. There is a lunch break between the two papers when the computers are locked. The exam is wide ranging testing all areas of clinical gastroenterology with some questions related to basic science, physiology and GI imaging.

Preparing for the exam
It is wise to consider early in your training when you plan to sit the SCE so that you take the exam at a time, which fits both your professional and personal life.

Your clinical training in gastroenterology will help you to prepare for this examination. It is however advised that you put some time aside to specifically prepare for the examination. Attending MDTs where complex
cases, histology and GI radiology are discussed will aid your preparation. Attending conferences, training days and the BSG Trainee’s education weekend will also assist you preparation.

In order to cover the large breath of material many trainees have found published and online question banks a useful resource. Sample questions are available on the MRCP website. Other useful resources included national and international guidelines. A number of deaneries provide training days aimed at preparation for the SCE and there are specific gastroenterology SCE courses.

Useful Resources

Books
- Best of Five MCQs for the Gastroenterology SCE, 2013 (C. Rutter, Oxford Higher Speciality Training)
- Sleisenger and Fordtran’s Gastrointestinal and Liver Disease, 10th Ed, 2016 (E Qayed, S Srinvesa, N Shahnaz, Elsevier)

Courses
- SCE exam course St Mark’s [http://www.stmarksacademicinstitute.org.uk/courses/gastroenterology-sce-course/]
- SCE exam course Nottingham
- Oxford Handbook of Gastroenterology and Hepatology 2nd Ed, 2011 (S Bloom, Oxford Medical Handbooks)

Websites
- MRCPUK - [https://www.mrcpuk.org](https://www.mrcpuk.org)
- JRCPTB - [https://www.jrcptb.org.uk](https://www.jrcptb.org.uk)

Guideline sources
- NICE - [https://www.nice.org.uk](https://www.nice.org.uk)
- SIGN - [http://www.sign.ac.uk](http://www.sign.ac.uk)
- AGA - [http://www.gastro.org/guidelines](http://www.gastro.org/guidelines)

Online question banks (some you have to pay for)
- [https://www.123doc.com/exams/sce-gastroenterology/](https://www.123doc.com/exams/sce-gastroenterology/)
- [http://www.onexamination.com](http://www.onexamination.com)
7. OOPE

This can be an exciting period, but is not compulsory. It can provide you with a break from the routine, add more experience to your CV and reconfirm your choice of subspecialty for the future should you wish to do so. However, it means that you will have to extend your CCT date and your annual pay increment may freeze at the time of your OOP, but this does not apply to all OOPs.

There is a range of options for your OOP. Most common is OOPR (out of programme for research). This may include PhD, MD, etc. Other OOP includes ‘Experience’ (OOPE) such as a management role or an Education Fellowship, ‘career break’ (OOPC), or other ‘training’ in a post approved by the JRCPTB (OOPT).

Plan in advance, go and meet with the people that you are planning to apply to work with during your OOP time. Please be aware that the TPD needs to know about this as he/she may need to refill your current or upcoming post. Ensure you start planning in advance and provide plenty of warning (6 months) of your intentions as it might be a long process and without organization you may miss out on certain opportunities.

If the post you are going to be working in is not a recognised training post and you want it to count towards your CCT then JRCPTB (https://www.jrcptb.org.uk/training-certification/out-programme) approval must be applied before starting the programme. Posts cannot be approved retrospectively as stipulated in the Gold Guide (http://specialtytraining.hee.nhs.uk/news/the-gold-guide-sixth-edition-now-available/).

Funding will vary on your choice of OOPE; this varies from fully funded posts including the cost of fees to clinical commitments and on-calls required to provide a basic salary and banding.

OOPE can take place abroad as long as approval is given by your TPD. Career breaks can be requested and may be approved with appropriate justification.

Similar projects can be done after completion of CCT which would not require TPD or JRCPTB approval. Please watch out for all the wonderful opportunities circulated to all the trainees in your deanery by your friendly BSG TS Committee representative.
8. Research opportunities – why, how, when?

Research opportunities will present themselves throughout your gastroenterology training. Pressures from clinical jobs often restrict how much time we are able to devote to research interests in programme however you can complete your GCP training (NIHR website) and recruit for clinical trials your hospital may be participating in. Therefore, many trainees will choose to take time out of programme (OOP) for research (OOP-R), whilst others may apply for an academic clinical fellowship post (ACF). This section focuses on these two research options.

Out of Programme: Research (OOPR)

Why OOPR?
The main advantage of OOPR is that it provides time away from your usual clinical commitments to dedicate towards research projects. The length of OOPR can vary depending on your needs/project but do not usually exceed 3 years. For anyone wishing to undertake basic science research this time is particularly required for you to learn the techniques required. You can apply for a higher degree (MD, PhD) but this is not a necessity.

Where to OOPR?
This will vary considerably for each individual as to where your priorities lie. Within limits (see below) you can OOPR wherever your project is – this could be in the same deanery, elsewhere in the UK or abroad.

How to apply for OOPR
You require approval from your TPD to leave programme for research. This should be done with as much notice as possible, but many will ask for a minimum of 6 months notice before your intended start date (although local exceptions will undoubtedly exist) to allow for sufficient time to fill your post. It is advised that if you are planning OOPR at some point during your SpR years that you inform your TPD early to establish a dialogue on expected notice period etc. Your deanery will have a specific application form to complete. Once approved, your deanery will then seek approval from the GMC for your OOPR (further details: http://www.gmc-uk.org/doctors寻求approval.asp).
Can I count any of my time OOPR towards CCT?
Yes – how much will depend on how much clinical work you participate in during your OOPR:

- 12 months (the maximum credit) can be applied for if you have weekly clinical interaction
- 3 months can be applied for even if you have no clinical interaction (on account for presumed transferable skills developed)

You must apply prospectively to the JRCPTB (they will not accept retrospective applications) once your OOPR has been approved by your TPD and the GMC (above). JRCPTB will review your application and decide how much credit you can count towards your training. However, you do not have to count any of your OOPR towards training if you do not want to, in which case you will not need to sanction your OOPR with JRCPTB. Further details can be found at: https://www.jrcptb.org.uk/training-certification/out-programme

Funding options

- National fellowships: these are available regularly e.g. annually, from numerous sources. Examples:
  - Core (http://corecharity.org.uk/research/research-awards-information/)
  - Wellcome (https://wellcome.ac.uk/funding/research-training-fellowships)
  - Medical research council (http://www.mrc.ac.uk/funding/)

- Local fellowships: usually involving a degree of clinical work these are funded by local trusts (often teaching hospitals). These posts are usually advertised including a salary. The salary offered will not necessarily cover the cost of any lab running costs (if applicable) or costs of registering for a higher degree

- Local funding opportunities: most hospital trusts have associated charitable trusts that offer funding opportunities for various projects including research

- Pharma: many pharmaceutical companies support research if it is aligned with their research strategy. Examples include e.g. Shire (http://shiresupport.com)

More information can be found at: https://www.healthcareers.nhs.uk/i-am/working-health/clinical-academic-careers/clinical-academic-medicine/securing-funding.
Integrated Academic Training Pathways

The integrated academic career path was created in the wake of the 2005 Walport to support trainees wishing to pursue an academic career by providing a more clear and robust training pathway. This career path combines both clinical and academic work and can be followed from the beginning of your career as a foundation programme doctor, although there are several other points of entry as demonstrated on the below diagram.

For SpR grade doctors without a higher degree, the natural entry point is as an academic clinical fellowship. These 3-year posts combine specialty training (75%) with academic work (25%) during which time it is anticipated that trainees would collect data to support application for a fellowship to undertake a higher degree. Trainees can then either enter OOPR or return to programme.

SpR grade doctors already with a higher degree may apply for clinical lectureships, a four-year posting where clinical and academic work are undertaken in equal proportions. It is anticipated that most trainees will finish their clinical training during this posting.

It is worth noting that both ACF and clinical lectureship roles count towards training and therefore are not anticipated to delay your CCT date unless you undertake OOPR in addition. Pay for both posts is equal to non-academic counterparts.

Further information:

https://www.healthcareers.nhs.uk/i-am/working-health/clinical-academic-careers/clinical-academic-medicine/academic-clinical

http://careers.bmj.com/careers/advice/The_road_to_a_clinical_academic_career
Handling and Processing a Referral

Each hospital will have a system in place with regards to when it is your turn to take referrals. There may well be an ‘oncall’ gastro bleep that you carry in addition to your usual bleep. There is variations between hospitals as to whether you will have any of your usual clinical commitments cancelled whilst you are the SpR taking referrals.

1. How will referrals be made? Most referrals will be through your bleep. Some referrals will be taken by the Gastroenterology secretaries and will be paper referrals that you will need to collect from them.

2. Who will the referrals be made by? Anyone! Referrals can be made by any doctor within your hospital. Some referral may be also made by specialist nurses.

3. What do I do after I receive a referral? Have somewhere safe to keep a record of the referral details (Excel spreadsheet etc.) so that they don’t get lost and you can refer back to it at a later date if required. Once anonymised, this spreadsheet can be uploaded at regular intervals to your portfolio library as evidence of experience. In addition to taking the details of the patient always take a contact number for the referring clinician so you are able to contact them back if required. Go and see the patient that has been referred to you in a timely manner, remember the referring team are asking for your help and advice.

4. What do I do when I get to the ward the patient has been referred from? Review patient notes before seeing the patient so you are clear on the patient’s medical history, the events of this admission and the gastroenterology problem that has arisen. Review the patient, taking your own history of the current events and examine the patient as appropriate to the problem you are advising on. Explain fully to the patient what you think the cause of the problem is, any investigations you advise and whether you will be reviewing the patient again. Clearly document your assessment in the notes. It is courteous to contact the referring team after you have completed your assessment so they are clear on your advice, what investigations need requesting, what they should do with any investigation results and who to contact if further advice is needed.

9. Top tips for on the job
5. Who requested the investigations you suggest? If it is a straight forward case it is appropriate to advise the referring team on the investigations that need to be requested and what to do with the results. However if it is a complicated/urgent case or an endoscopic procedure needs arranging it is often prudent to arrange the investigations yourself. The endoscopy staff will know you well and you will be able to discuss the case with you so they can accommodate the patient requirements, especially if the procedure needs to be done by a particular consultant on a particular list. If there is no space on the required list, it is sensible to speak directly to the consultant doing the list to discuss the urgency of a case and see if there is any flexibility. Complex patients that require urgent radiological investigations can either be discussed with the oncall radiologist or if there is less urgency they can be added to the GI x-ray meeting so the case can be discussed with the radiologist and consultant Gastroenterologists and appropriate advice and investigations arranged following this.

6. Do I discuss my referrals with my consultant? In the early days it is advisable to discuss all of your referrals with your supervising consultant (or the oncall consultant if your consultant is not around) as this is an excellent learning opportunity but also safeguards patient care. It is helpful to document this conversation in the patient’s medical notes. If there is a patient that you would be keen for your consultant to review, then it sensible to ask if they would see the patient with you at the end of their ward round. As your experience increases, you may find that straightforward referrals do not need to be discussed. www.uptodate.com is an excellent resource to refer to when seeing referrals as are the current BSG guidelines.

7. Do I need to see all the referrals that come through? Some referrals will be for advice, e.g. anticoagulation around an endoscopic procedure. If it is safe to do so you may find some referrals you are able to give advice without reviewing the patient, but have a low threshold for reviewing the patient if there are any concerns or complicating factors.

8. Do I have to see all the referrals the same day? You should see referrals in a timely manner as any delay may affect patient care. However on very busy days you may need to prioritise urgent referrals. Ideally all referrals should be seen the same day, although occasionally when things are very busy you may have to defer non-urgent referrals to the next day. It is useful to let the referring team know this. Remember though if you are taking referrals for a whole week it is important to keep on top on of the referrals on a daily basis so you don’t end up with a back log causing unnecessary delays to patients being seen.
9. Which patients do I follow up? In straightforward cases where you have given advice on management you often do not need to see the patient again. You may ask the referring team to contact you with the results of scans or other investigations you have suggested so further advice can be given. However some patients (e.g. those in ITU or complicated problems) it is sensible to take a more proactive approach and review regularly. In addition some patients may have a GI problem that requires follow up in outpatients and this will need arranging on discharge (either by you or the referring team).

10. When do I take over a patient's care? It is appropriate to take over the care of a patient if they are well known to your team and have been admitted with a recurring problem that the gastroenterology team have previously dealt with. It is also appropriate if it is a new referral with an acute gastroenterology problem that requires ongoing specialist input and the patient's initial reason for admission to hospital has been resolved. Always discuss with your consultant before agreeing to take over a patient's care. It is also courteous to let the nursing staff on your ward know that you have accepted a patient so they are prepared to be contacted by the bed manager and can reserve a bed for the patient when a discharge occurs.

11. GP referrals You may well receive phone calls from GPs for gastroenterology advice. This can be tricky as you do not have the opportunity to review the patient yourself. Often you will be able to review blood results on your computer system and this can be helpful. You may be able to give the GP straightforward advice. However if you think the patient need so be seen then you need to assess and advise on whether that needs to be an acute admission today or whether the GP can refer as a 2WW/routine outpatient appointment. If the GP requires advice about a patient well know to the team, it is helpful to let the specialist nurses know about the phone call and the advice you have given. These referrals can all be discussed with your supervising consultant and GPS contacted back if any additional advice is required.

12. Handing over referrals As you reach the end of your period of taking referrals, there may be ongoing issues for patients that need following up or complicating patients that need handing over so the team are aware. Always hand over any outstanding issues to your colleague that is taking over being oncall for gastroenterology so if they receive phone calls regarding results of patients you have advised on they are clear as to the assessment you made and the advice that has been given. Teamwork is crucial. Always ask for help if
you are stuck or overwhelmed with referrals. Colleagues are always happy to help and advice if you ask!

**Working with non medical members of the team: secretaries, nurses, dieticians, OT, Physio, histologists, surgeons etc.**

Teamwork in Gastroenterology is important as many patients are complex and require MDT input in order to provide the best patient care. Always be kind and courteous when approaching other members of the team for input and remember they will often be as busy and stressed as you are!

**Rotations**

StRs rotate jobs annually on the first Monday of September. The job allocation is determined by the TPD and is determined according to your seniority & preferences. You will be asked to indicate your preferences in the spring of each year and the rotation will be approved by the training committee in May and then sent out via e-mail. You will be required to spend 2 years in district general hospitals and the rest of your time can be in the teaching hospital setting. Although 5 years of training sounds a long time, it will pass quickly and therefore in order to make the most out of your training it is important to try and plan your subspecialty early on and tailor your hospital preferences accordingly. You will also need to consider whether you would like to undertake a subspecialty training year (hepatology, nutrition) and if so this will need to be planned well in advance. Recruitment for these posts is a national process that occurs annually. You will need to talk to your TPD about being released from your deanery for 12 months to complete this post. Talking to your educational supervisor early with regard to your pathway though training and which rotations suit your needs will make your goals much easier to achieve.

**Tips for effective outpatient clinic letter**

- Keep your clinic letters concise, GPs are busy people and appreciate this
- Make sure current problems, previous problems, any changes to medication, plan from clinic and follow is very clear
- Always clarify with the patient whether they wish to have a copy of the clinic letter; in many trusts this is standard practice.
A suggested clinic letter template for an example patient:

Dear Dr,
Height: 
Weight: 

**Current Gastroenterology problems:**
- New onset abdominal pain

**Previous Gastroenterology problems:**
- Distal UC diagnosed 2005
- No flares of disease since diagnosis
- No previous surgery

**Previous Gastroenterology Investigations:**
- Last colonoscopy 2015, quiescent disease on biopsy
- USS abdomen 2015 for RUQ pain- normal

**Other PMH:**
Hypertension

**Drug History:**
Asacol 400mg TDS
No changes to medication at this appointment

**Social History:** lives alone
Retired
Fully independent
Non smoker
Alcohol per week: 7 units

**Plan from clinic appointment:**
- Full set of bloods in clinic today
- CT abdomen- I will discuss this at our x-ray meeting prior to the next clinic appointment

**F/U** 6 weeks with the results of the CT.

I saw this gentleman in the clinic today…..
Yours sincerely,
The number of complaints from patients against doctors has been increasing over recent years\(^1\). In most cases, these complaints relate to clinical events, often in overworked or under-resourced situations, although breakdown in communication also is a common factor.

It is important to remember that the complaints system exists to protect patients and to allow healthcare workers to learn from adverse situations. That said, a number of emotions including anger, shock, disappointment and depression are often felt by the doctor receiving the complaint\(^2\).

**What you should try to do:**
1. Understand that you are not alone. Every doctor will be involved in a complaint at some point in their career.
2. Contact your Medical Defence Organization as they can provide you with advice and legal representation.
3. Contact your BMA representative, especially if you are not a member of a defence union.
4. Seek advice from your occupational health department – your employer should be able to provide this for you for counseling and confidential support should you need it.
5. Talk. Seek advice from your Consultant/Education Supervisor or Mentor – work colleagues can often provide the reassurance and support that you need.
6. Reflect on the situation – there may be learning opportunities for you and colleagues.

**What you should try not to do:**
1. Harbor negative feelings about the complainant, the complaints procedure or yourself.
2. Fear stigma/judgment from your colleagues.
3. Allow the complaint to affect your psychological or personal health. The GMC sets clinical and behavioral standards for doctors\(^3\) – whilst adhering to these will not prevent complaints from happening, they should serve as the basis from which to practice in a safe and consistent manner.

\(^1\) Bourne T et al., Doctors’ experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data. BMJ Open 2016;6:1-10.
Conflict with colleagues is not uncommon and often occurs in stressful situations where one or both of those involved are feeling burnout. It is important to remember that you are colleagues and have a vested interest in resolving the conflict for the benefit of your patients. You should:

1. **Define acceptable behavior** – whilst it is understandable that conflict can sometimes occur, rude or aggressive conduct should not be tolerated.

2. **Hit conflict head on** – try to resolve the situation sooner rather than later – if possible, try to achieve this privately.

3. **Ask** – if you don’t understand your colleagues viewpoint. It will also serve to diffuse a situation when you show a willingness to investigate their feelings.

4. **Reflect**, and if you are wrong apologise for anything you may have said or done to intensify the conflict.

5. **Mediation** – seek external intervention if you are unable to resolve amongst yourselves.
11. Developing management & service improvement skills

Developing as a clinical leader has become an important aspect of postgraduate training, which is reflected in your curriculum. Gastroenterologists make great leaders and throughout your training you will have opportunities to develop your skills. There are many local, regional and national opportunities which may interest you. A few of them are described here.

Quality improvement is a big thing within the NHS and as trainees who will have undoubtedly rotated into a number of trusts, you will have seen countless examples of good practice (and probably a few examples of less good practice!) and solutions to problems which you may be able to introduce in your new workplace. Most rotations for ST3+ gastroenterologists are 1 year, giving you plenty of time to find a good project in your host trust. It may be useful to liaise with your peers within your region to see what has been done before.

The BSG trainees section organises and delivers a BSG management weekend every February. This innovative educational weekend is for BSG trainee members only and covers many aspects of clinical management and leadership. A leadership and management course is required for CCT and this course fulfills those requirements.

The NHS leadership academy offers a number of leadership programmes for people who wish to be introduced to clinical leadership, all the way up to aspiring chief executives. The Edward Jenner programme is a practical and patient focused programme which is free to access. For those interested, please see the NHS leadership academy website for further details at http://www.leadershipacademy.nhs.uk.

For those with a keen interest in leadership, there are many management and leadership fellows offered regionally and nationally. A number of the ‘deaneries’ offer leadership and management fellows which run alongside clinical work. The London leadership academy offers the Darzi fellowships, full-time leadership development programmes during which fellows are expected to complete one main project. The National Medical Directors Clinical Fellow scheme is a prestigious opportunity run through the Faculty of Medical Leadership and Management in which fellows are placed for a year within another health related organisation. Information about these fellowships can be found on the FMLM website.
12. What is an ARCP?

Each year your training programme director and a committee of consultants will review your progress over the past year to determine whether you can progress onto the following training year. Much of this is determined by your e-portfolio completion as per the following grid:

<table>
<thead>
<tr>
<th>Blueprint Sections</th>
<th>Assessment</th>
<th>ST3</th>
<th>ST4</th>
<th>ST5</th>
<th>ST6</th>
<th>ST7</th>
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<tbody>
<tr>
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<tr>
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<td>Specialist Exam *</td>
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<tr>
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<tr>
<td>Common Competencies</td>
<td>mini-CEX / Cbd</td>
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<td>Evidence of engagement ₢</td>
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<tr>
<td>Basic and Applied Science</td>
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<tr>
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<td>Formative DOPS ₢ / Summative DOPS a</td>
<td>2 DOPS</td>
<td>F-DOPS</td>
<td>S-DOPS</td>
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<tr>
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<td>3 mini-CEX and 6 Cbd</td>
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<td>Evidence of engagement ₢</td>
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<tr>
<td>Nutrition</td>
<td>mini-CEX /Cbd</td>
<td>3 mini-CEX, 6 Cbd and 3 DOPs</td>
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<tr>
<td>Total SLEs (mini-CEX / Cbd) per year</td>
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<td>Workplace based assessments</td>
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<tr>
<td>Endoscopy</td>
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<tr>
<td>Educational Supervisor Report</td>
<td>Satisfactory</td>
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<td>Satisfactory</td>
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Notes:

a) Specialist Exam: Can be attempted in ST4 onwards, must be achieved for attainment of CCT.

b) Six SLEs in total (mini-CEX; CbD) per year to cover curriculum requirements, to be guided by the core outcomes blueprint grid. One SLE in each major domain 1-5 covered during placement, with endoscopic procedures assessed more frequently. If progression is inadequate, as evidenced by SLEs/WBA's and supervisor report, then ARCP outcome 2 or 3.

c) Indication of percentage of curriculum to be explored. Will help to identify gaps in training in particular nutrition / hepatology where experience may be focused into a specific training period.

d) Endoscopy: should have a formal formative DOPS x 10 in all procedures being practiced each year (since all procedures will be directly supervised this is easily accomplished). Summative DOPS for JAG accreditation can be taken when appropriate. Other procedures should be assessed by a total of DOPS x 2 annually.

e) MSF should be carried out at end of years 1, 3, and as required. If there are no concerns, two MSFs over the specialty training would be satisfactory. If there are areas for improvement, there is the option to add in further MSFs as necessary.

f) There should be evidence of audit undertaken on an annual basis, which has been assessed by the ES.

g) A patient survey should be carried out during years 2, 4, and as required. If there are no concerns, two patient surveys over the period of specialty training would be satisfactory.

h) Common competencies: evidence such as reflective logs, courses, teaching and SLEs should be used to demonstrate exploration of these curriculum competencies. The following common competencies will be repeatedly observed and assessed but do not require linked evidence in the e-portfolio:

- History taking
- Team Working and patient safety
- Clinical examination
- Managing long term conditions and promoting patient self-care
- Therapeutics and safe prescribing
- Relationships with patients and communication within a consultation
- Time management and decision making
- Communication with colleagues and cooperation
- Decision making and clinical reasoning
- Personal Behavior

Your ARCP meeting is also a chance for you to define your training (and personal) needs so you are placed correctly for the following years. Take advantage of the experience of the Consultants that are there to guide you.

https://www.jrcptb.org.uk/training-certification/arcp-decision-aids
13. Educating future gastroenterologists – how to control your education and how to educate others

Whilst informal education like bedside teaching is extremely valuable and important to the trainees particularly at an early stage of training, this has become more challenging in the recent years due to service demand and busy ward rounds.

We suggest planning your ward round teaching and training ahead. For instance, choosing a particular topic to highlight to your consultant to be debated and discussed during the ward round or after reviewing inpatient referrals or OP clinic. Furthermore, discussing cases after each clinic can be an extremely enriching learning opportunity.

Some curricular and extracurricular gastro topics will not be covered during the formal training days. It is recommended to set up these topics as part of a personal development plan and aim to get them covered in some way or another, for instance at a weekly journal club or additional courses like the BSG Education Weekend, which focus on topics less commonly taught. Setting up a teaching rota to be shared by the junior and senior team members and delivering short presentations are very doable and enjoyable experiences.

There are other ways to implement day to day or week to week education. For example, setting up departmental teaching once or twice a week during lunch time. In big teaching hospitals this can be very intense and full morning or afternoon session can be booked for adequate teaching.

Attending MDT meetings on a weekly basis is highly recommended. Getting the habit of knowing the cases and even presenting them and debating the management plan can rapidly increase your learning curve. This is often the only radiology/histology teaching you will receive and is incredibly useful for the SCE. Furthermore, observing endoscopy procedures performed by different endoscopists in your spare time will be beneficial.

The mortality and morbidity meeting is an excellent event to learn from. It is held once a month and cases are usually allocated to the consultant to review the care provided during certain episodes. Occasionally trainees get
involved, for example in reviewing post endoscopy death to work out if the endoscopy has contributed to the morbidity or mortality.

Becoming an educator
You can maximise your teaching skills during placements in different ways, for example by delivering formal talks to medical students or junior doctors. It is always recommended to obtain formal feedback from the attendees to supplement your e-portfolio. Asking your supervisor to observe you teaching to identify your area of weakness and strength to build up on them.

Ideas for teaching in clinic:
http://www.faculty.londondeanery.ac.uk/e-learning/explore-further/teaching_and_learning_in_outpatients_settings.pdf

Ideas for small group teaching – give the students a case each and discuss when you meet:

There are formal teaching skills courses worth considering if you are interested in teaching:
https://www.rcplondon.ac.uk/education-practice/courses/topic/teaching
https://www.ucl.ac.uk/medicalschool/cpsc/teaching
https://www.bma.org.uk/advice/career/progress-your-career/teaching
https://www.amee.org/amee-initiatives/esme-courses/amee-esme-online-courses/esme-online

Many gastroenterology StRs are now also undertaking OOPE years working as a teaching fellow at local deaneries or medical schools. You should ask your TPD about posts within your deanery and watch out for emails from your local BSG rep advertising posts. It is also possible to undertake a part time MSc (3 years) in Medical Education without taking an OOP. These courses are run face to face (e.g. RCP) or via distance learning (e.g. Cardiff University).
14. Alternative working patterns

*Why train less than full time?*
You may wish to consider less than full time training for various different reasons including:

**Category 1**
- Disability or ill health (this may include those on in vitro fertility programmes)
- Responsibility (men and women) for children
- Caring for ill/disabled partner, relative, or other dependent

**Category 2**
- Unique opportunities for personal/professional development
- Service to the wider NHS
- Other reasons e.g. religious

Normally requests in category 1 will be granted whereas those in category 2 may be funded depending on local funding availability.

*What are the pros and cons?*
Working less than full time has many benefits but it also comes with its challenges.

**Pros:**
- Improved work–life balance
- The opportunity to spend more time with your children or undertake caring responsibilities
- Support in managing your health
- Greater ability to enjoy your work when you are there
- Increased ability to manage and prioritise your workload
- Longer time in training allows personal and professional development

**Cons:**
- Training will take longer to complete
- Less take-home pay – you are paid pro rata to full time trainees
- It may take longer to become integrated with the team
- Contact with the consultants can be time-constrained
- Less continuity with patients and handover issues
**How does it work?**

Normally trusts try to accommodate eligible applicants using slot shares (two LTFT trainees occupying a single slot) and working in ‘full time’ placements with reduced hours. Except in exceptional circumstances LTFT can be undertaken at a minimum of 50% full-time and may be supported, dependent on arrangements, up to 80% of a full-time post.

**How can I apply?**

Most local education and training boards require at least three months notice for those hoping to make a LTFT application. Local arrangements will be in place to determine eligibility and make arrangements. A good first point of contact is the associate dean of postgraduate training at your deanery. You will also need to liaise with your training programme director.

**For more information:**

Maternity and Paternity Leave

**Maternity Leave:**
All pregnant employees, regardless of their length of service in the NHS or hours of work, are entitled to a period of 52 weeks Maternity Leave. This is made up of:

- 26 weeks of Ordinary Maternity Leave (OML) and:
- 26 weeks of additional Maternity Leave (AML), beginning the day after OML finishes.

To be eligible for OML Employees must:

- Have 12 months’ continuous service with the NHS by the 11th week before the Expected Week of Childbirth (EWC) and
- intend to return to work in the NHS for a minimum of 3 months.

Occupational pay is made up of 8 weeks full pay and 18 weeks half pay.


**Maternity Support (Paternity Leave)**
All employees are entitled to ordinary maternity support of two weeks within 8 weeks of the baby’s birth or can apply for extended leave of up to 26 weeks. This applies to the father of the child (including adoptive fathers), the mother’s husband or partner (whether opposite or same sex), or nominated carers. For more details see:

15. How to make the most out of your interaction with pharmaceutical companies

As a trainee, you may be visited or asked to meet representatives from pharmaceutical companies. Whilst the visit aims to promote or introduce their products, trainees should be aware the information they receive may be biased in favour of the product to alter their prescription behaviour. However, interaction with pharmaceutical companies can be a great source of information to trainees and should be used to learn about the new drug such as its efficacy, safety, target group, cost etc.

All representatives receive intensive training about the drug with regard to its characteristics, competing products, safety and efficacy. You do not have to meet pharmaceutical representatives but if you do, make sure you ask all the right questions about the product and make most of your interaction with them. Example of questions:

- What is the existent evidence (e.g. NICE guidelines) that support the use of the new drug?
- Efficacy: What is the efficacy of the new drugs in comparison to the existent drugs that are currently in use?
- Feedback from other physicians and patients who have used the drug?
- Its use in special patients groups such as elderly, pregnant patients, patients with renal failure or liver conditions.
- Its interaction with other drugs such as Warfarin, antiepileptic, contraceptive pills etc.
- Practical information that commonly asked by patients such as when to take the drug, relationship to food, drug formulation (solution, tablet, capsule, its size ..).

Pharmaceutical companies have a certain budget for educational purposes and can support trainees in attending meetings, conferences and courses. Some may advertise research grants or bursaries. They should all follow a code of conduct drawn by the Association of the British Pharmaceutical
Industry (ABPI). It is always worth asking if they can support your attendance to educational meetings or training courses especially if it is mandatory to your training curriculum.

In summary, interactions with pharmaceutical companies representatives can be used to boost your knowledge and support your training. They are usually well trained individuals with good communication skills and keen in assisting you to understand more about their products and related condition. A combination of respectful communication and critical approach will ensure you get the most of the representatives’ visits.

www.pmcpa.org.uk/training/Pages/E-learning-for-health-professionals.aspx
www.gmc-uk.org/guidance/ethical_guidance/21161.asp
16. Preparing for a consultant job

When you get towards your final year of training, it is always wise to start thinking about what your plan is after obtaining your CCT. Unless you are planning to undertake a post CCT fellowship or training, it is very important to start exploring potential consultant jobs. A consultant job is a germinant job so it is very important to invest some time in choosing the right job for you. You may consider the following:

- Start by searching job adverts at BMJ careers or NHS jobs. This will give you a feel of what jobs are available and in what subspecialty.

- Location: things to consider: family commitments, children school, local communities, house prices, travel links e.g. proximity to motorways, train stations, airports etc.

- Potential colleagues in the department and hospital: it is always good to meet them or ask someone who worked in the place before. Many hospitals have a ‘meet & greet’ afternoon prior to interview.

- If you are interested in research or education, enquire about existent links to university and medical students.

- Support from other specialities: gastroenterology involves a lot of interaction with other specialities such as surgery, radiology, palliative care, dieticians etc.

- Career progression: what support is available to underpin your CPD, revalidation and appraisal as a consultant.

- Number of sessions in your potential job plan: is there appropriate admin time? Will there be paid sessions for research/training/education?

- Finance including salary and private practice: trust’s financial duties such as payment by results, hospital directorates and divisions. The British Medical Association is a very useful source of information.

- Although not mandatory - attending one of the consultant interview courses is always good to prepare you for the consultant interview. The BSG Trainees Management Course dedicates almost a whole day to CVs and Consultant interviews therefore is well worth attending towards the end of your training.
17. Conferences and meetings

Each year, general gastroenterology and subspecialty societies hold conferences or meetings in major cities in the UK and around the world. The aim of these meetings is for like-minded people to share their scientific findings to improve clinical care. It is also a great opportunity to network with experts and industry representatives. Given the limitation of study leave and budget, it can be challenging to decide which national or international meeting one should attend. This section aims to provide you a guide to help you to make that decision.

National Conferences/Meetings

British Society of Gastroenterology (BSG) Annual Meeting
As you already know, the main gastroenterology conference in the UK is the BSG Annual Meeting, which is held in June each year at different venues throughout the UK. It runs over 4 days. As most conferences, the first day is dedicated to the Postgraduate Programme which is clinically focused, incredibly useful and well attended. It is a good meeting to submit abstracts to, attend lectures on the latest research and for networking with trainees and other colleagues throughout the UK. You may want to use it as an opportunity to contact and meet a future supervisor (e.g. for OOPR or fellowship opportunities). All StRs are encouraged to attend & present research or audits. Compared to other national gastroenterology conferences, this meeting gives a lot of weight to good clinical service improvement abstracts. All abstracts are published in a supplementary issue of Gut.

Time of year: June
Frequency: Annual
Length of conference/meeting: 4 days
Location: Rotates to centres around the UK i.e. Birmingham, Glasgow, Liverpool, Manchester, London
Average cost of full registration for trainees: £190 (early bird), £220 (advanced), £250 (on-site)
Website: www.bsg.org.uk
Endolive
Organised by the BSG, this is the largest live endoscopy event in the UK. The inaugural event that was held in 2015 in Birmingham was very well received. All the big names in advanced endoscopy share their tips and tricks in all things endoscopy. For those budding endoscopists, this is a must to see what can be done and how it’s done.

**Time of year:** March  
**Frequency:** Biennial  
**Length of conference/meeting:** 2 days  
**Location:** Birmingham with live feeds from centers around the UK  
**Average cost of full registration for trainees:** £120 (early bird registration), £150 (late fee)  
**Website:** [http://www.endolive-uk.org.uk](http://www.endolive-uk.org.uk)

British Association for the Study of the Liver (BASL)
Attendance in the BASL Annual Meeting is ever increasing. This popular meeting of all things hepatology is usually held in September every year and follows on from the annual meeting of the British Liver Transplant Group. It is a great opportunity for trainees to network with fellow hepatology trainees and the national leaders in liver medicine.

**Time of year:** September  
**Frequency:** Annual  
**Length of conference/meeting:** 3 days  
**Location:** Rotates to centres around the UK  
**Average cost of full registration for trainees:** £180 (members), £360 (non-members)  
**Website:** [http://www.baslannualmeeting.org.uk](http://www.baslannualmeeting.org.uk)

British Association of Parenteral and Enteral Nutrition (BAPEN) Annual Conference
BAPEN holds their annual meeting in November every year. This is a subspecialty meeting that is a must for those who have a specialist interest in nutrition. The pre-conference teaching days contain live learning modules that have been endorsed by the European Society for Clinical Nutrition and Metabolism (ESPEN). The meeting is well attended by national and international experts in nutrition, gastroenterologists, dietitians and pharmacists.

**Time of year:** November  
**Frequency:** Annual
**Length of conference/meeting:** 2 days  
**Location:** Rotates to centres around the UK  
**Average cost of full registration for trainees:** £75 (early bird registration for members), £110 (early bird for non-members), £95 (late registration for members), £130 (late registration for non-members)  
**Website:** [http://www.bapen.org.uk/resources-and-education/meetings/annual-conference](http://www.bapen.org.uk/resources-and-education/meetings/annual-conference)

### International Meetings

**Digestive Disease Week (DDW)**
DDW is by far the world's largest conference in general gastroenterology. This North American meeting is jointly organized by several gastroenterology societies including the American Society of Gastroenterology, American Society of Gastrointestinal Endoscopists and American Association for the Study of Liver Diseases. The registration for this meeting is free for trainees who are members of any one of the organizing societies, so it is worth becoming a trainee member of one of these societies. Furthermore, trainee membership of these societies is usually heavily subsidised.

**Time of year:** May  
**Frequency:** Annual  
**Length of conference/meeting:** 4 days  
**Location:** Rotates to centres around the US  
Average cost of full registration for trainees: The registration fees vary every year so best to check the website. However, see above about free registration for trainees.  
**Website:** [http://www.ddw.org](http://www.ddw.org)

**United European Gastroenterology Week (UEGW)**
The European equivalent of DDW, this annual meeting is hot on the heels of its American counterpart in regards to size, prestige, and quality of presentations. The conference starts with a two-day postgraduate programme that provides an excellent update to gastroenterologists and trainees alike. Full conference registration is not required for the post-graduate day. UEG is very supportive of trainees and do offer financial support in the form of travel grants. Please see their website for more details.

**Frequency:** Annual  
**Length of conference/meeting:** 4 days  
**Location:** Rotates to centres around Europe
Average cost of full registration for trainees: €200 (if paid by May), €225 (if paid by early September), €250 (if paid after early September)
Website: https://www.ueg.eu/week/

European Colitis & Crohn’s Organisation (ECCO) Congress
This is the world’s largest meeting on inflammatory bowel disease. Scientific and medical experts from a broad range of fields related to IBD, including gastroenterology, internal medicine, surgery, paediatrics, epidemiology, endoscopy, imaging, nursing, pathology and dietitians come together from around the world to learn about the latest in IBD research and clinical care.

**Frequency:** Annual

**Length of conference/meeting:** 4 days

**Location:** Rotates to centres around Europe

**Average cost of full registration for trainees:** There is no reduction in fees for trainees. However, there are considerable savings to be made if you sign up to be a member of ECCO. For members: €250 (early bird registration), €320 (late registration), €400 (on-site registration). For non-members: €605 (early bird registration), €685 (late registration), €770 (on-site registration)

**Website:** https://www.ecco-ibd.eu/ecco17

Top Tips for trainees: ‘Capitalising on Conferences’:
- Register early to take advantage of early bird rates
- See if travel bursaries are available those can be sponsored by the BSG or pharmaceutical companies.
- Submit an abstract(s) - prizes for best orals and posters
- Try to attend for the whole conference
- Check out the programme before the conference and pick out the must see presentations so you don’t miss what you want to see
- Download the app:
  - Build your agenda
  - All abstracts are on the app at the BSG annual conference
  - Vote during interactive sessions
  - Tweet!
  - Email your notes
- If you have an oral presentation – practice in front of colleagues beforehand (helps with tips for delivery & what questions you might get)
- Quiz the judges when they’re judging your posters to ask how to
improve your research

● Network with leaders in the field in which you’re interested (they like it!)
● Speak to experts about patient management
● Ask around about upcoming job and research opportunities
● Visit the industry exhibition
  - Without them the conference wouldn’t exist!
  - Learn about new drugs
  - “Play” with endoscopy equipment
● Get involved with charity events e.g. Gastrocycle
● Go to the conference party
● See if lectures & slides can be viewed post conference e.g. BSG TV

Oh, and wear comfy shoes!

Dr Jayne Eaden, BSG Secretary (Conference Lead)
18. Training courses and online learning

Courses in gastroenterology can be expensive but only two are mandatory in the early years. Check your local study budget. Try to spread courses throughout your training to avoid a rush in the final two years. Look out for the first day of major conferences as often they run valuable education days.

All endoscopy courses can be found and booked via the JETS website: [http://www.jets.nhs.uk/](http://www.jets.nhs.uk/)

Many BSG-approved courses are available on the BSG website: [http://www.bsg.org.uk/events/index.html](http://www.bsg.org.uk/events/index.html)

### Mandatory courses

<table>
<thead>
<tr>
<th>COURSE</th>
<th>TIMING</th>
<th>2016 COST</th>
<th>COURSE LENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Skills in UGI Endoscopy</td>
<td>ST3</td>
<td>£900-1050</td>
<td>3 days</td>
</tr>
<tr>
<td>Basic Skills in Colonoscopy</td>
<td>ST4-5</td>
<td>£1050</td>
<td>3 days</td>
</tr>
<tr>
<td>Management Course</td>
<td>ST6-ST7</td>
<td>Variable (£150 for BSG course)</td>
<td>2-3 days</td>
</tr>
<tr>
<td>Advanced Life Support Recertification</td>
<td>Every 4 years</td>
<td>~£250</td>
<td>1 day</td>
</tr>
</tbody>
</table>

### Optional courses

<table>
<thead>
<tr>
<th>COURSE</th>
<th>TIMING</th>
<th>2016 COST</th>
<th>COURSE LENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCE Exam Course</td>
<td>Any</td>
<td>St Mark’s £150</td>
<td>2 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nottingham £75</td>
<td></td>
</tr>
<tr>
<td>BSG Education Weekend</td>
<td>Any</td>
<td>£75 for BSG Members</td>
<td>2 days</td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training the Trainers</td>
<td>ST6-7r/q to be a trainer</td>
<td>£800</td>
<td>2 days</td>
</tr>
<tr>
<td>Basic Skills in UGI Therapeutic Endoscopy</td>
<td>Any</td>
<td>£500-100</td>
<td>2 days</td>
</tr>
<tr>
<td>Basic Skills in EUS</td>
<td>ST6-7</td>
<td>£1200</td>
<td>3 days</td>
</tr>
<tr>
<td>ERCP Skills Training</td>
<td>ST6-7</td>
<td>£1250</td>
<td>4 days</td>
</tr>
</tbody>
</table>
The following websites all have free registration with many Gastro & GIM modules that can be used for continuing medical education. These could be used to make up some of your external training if for example you found you were unable to attend the required number of training days (GIM is particularly difficult to swap if you are on call or on nights for example).

1. Doctors.net.uk electronic Continuing Medical Education (eCME)
2. Medscape Education
3. BMJ Learning

Here is a brief description of each:

http://about.doctors.net.uk/Member-Benefits/Education

Doctors.net.uk electronic Continuing Medical Education (eCME) modules are designed to fit with any busy schedule. Doctors can begin a module then stop part way through, knowing they can pick it up again at their own convenience. The modules cover a vast range of subject matter, tailored to very specialist areas as well as being suitable for more general interest. Around 240 free, accredited eCME modules are used by 30,000 doctors per month, written by doctors, for doctors. Its clinical and professional content is revised annually. As it is online, the doctor’s personal record of completed eCME modules is saved automatically. Members can start, stop and resume a module at any time from any Internet-connected computer in the world. eCME is used by thousands of doctors every month.
Medscape Education (medscape.org) is the leading destination for continuous professional development, comprising 30+ specialty-focused websites offering thousands of free CME/CE courses (ranging from 0.25 credits to 2 credits AMA PRA credits) and not-for-credit activities for physicians, nurses, and other healthcare professionals. Accessible via the desktop and mobile platforms, Medscape Education is always available to inform and educate clinicians through a variety of formats that include Clinical News Briefs, Patient Simulations, Clinical Cases, Expert Commentary Videos, Conference Coverage, and more. Medscape, LLC is accredited with commendation by the ACCME (Accreditation Council for Continuing Medical Education) as a provider of certified physician education. All of our accredited activities are independently developed by a dedicated team of scientific directors who work in cooperation with leading faculty from major academic institutions, including leading physician experts in the areas of Oncology, Cardiology, Diabetes & Endocrinology, Neurology, and more.

BMJ Learning is an evidence-based, independent and peer reviewed CME and postgraduate training website, offering health care professionals a fast and convenient way to test their knowledge and keep up to date with the latest developments in medicine. It contains over 1000 interactive learning courses across 70 specialty areas that are accredited for CME/CPD points in several countries.

Up to date (www.uptodate.com) provides an excellent summary of current clinical evidence and CME points are accumulated when you review topics.
19. Who’s who in training?

Educational supervisor
A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee’s educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee’s Educational Agreement.

All trainees must have a named Education Supervisor and the trainee should be informed in writing/email of this. The Educational Supervisor should meet regularly with the trainee to review educational progress and to encourage reflection and the collection of appropriate supporting information. They should: support the trainee, oversee the education of the trainee, act as their mentor, monitor clinical and educational progress & ensure the trainee receives appropriate career guidance and planning.

GMC guidance suggests an educational supervisor meets the trainee in the first week of the programme (or delegate to colleague if absent on leave), ensure the structure of the programme, the curriculum, portfolio and system of assessment are understood and establish a supportive relationship. The educational agreement should be signed (e-portfolio) and a Personal Development Plan with clear objectives agreed.

They should provide the trainee with opportunities to comment on their training and on the support provided and to discuss any problems they have identified. Review meetings should be held regularly, in protected time and in a private environment. The portfolio should be reviewed to ensure satisfactory progress against the curriculum and personal development plan. Feedback should be given; this may require the educational supervisor to have discussed with the clinical supervisor, those involved in clinical supervision and other key professionals with whom the trainee has worked during the placement. The mechanism of obtaining this information should be clear to the trainee.

Any complaints and/or serious incidents should be discussed and a reflective note written in the portfolio and included on the Educational Supervisors Report & Enhanced Form R for the ARCP. At the end of the year the final appraisal session consists of reviewing all the assessments, the portfolio of evidence of learning and ensuring that all the learning objectives of the
programme have been satisfied.

All the necessary documentation needs to be completed and returned to the Programme Director to enable satisfactory completion of the end-of-year paperwork at ARCP.

**Clinical supervisor**
A trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee’s clinical work and providing constructive feedback during a training placement. Usually, one or more Consultant Gastroenterologists at your current hospital. It may or may not be the same person as the Educational Supervisor, if this is the same person as the Educational Supervisor; both roles then should be clearly understood.

All clinical supervisors should:

- Be involved with teaching and training the trainee in the workplace and should help with both professional and personal development
- Offer a level of supervision of clinical activity appropriate to the competence and experience of the individual trainee. No trainee should be required to assume responsibility for or perform clinical techniques in which they have insufficient experience and expertise. Trainees should only perform tasks without direct supervision when the supervisor is satisfied regarding their competence so to do
- Support the trainee in various ways: Direct supervision, in the ward or clinic close but not direct supervision, e.g. in the theatre suite, in the next door room, reviewing cases and process during and/or after a session
- Engage in regular discussions, review of cases and feedback. He/she may delegate some supervision to consultant colleagues, specialty trainees, appropriately experienced non-consultant career grade doctors and other healthcare professionals such as advanced nurse practitioners etc.

www.gmc-uk.org/Final_Appendix_2___Roles_of_Supervisors.pdf_53817452.pdf

**Training programme director (TPD)**
Responsible for managing specialty training programmes including StR/SpR/ Fixed Term Specialty Training Appointments. A TPD organises placements, training days, annual assessments (RITA/ARCP) and helps the postgraduate dean in managing trainees in difficulties.
Specialist Advisory Committee (SAC)
Part of the Royal College / JRCPTB setup, there is a SAC for each specialty. Roles include advice on specialty training, writing and reviewing specialty curricula, providing external assessors for PYAs, and recommending CCTs.

Joint Royal College of Physicians Training Board (JRCPTB) (replaced JCHMT & JCBMT)
Through all 3 UK Royal College of Physicians, develop curricula and assessments for the medical specialties. You must enroll in order to be registered as an ST3 on the e-portfolio.
https://www.jrcptb.org.uk/training-certification

General Medical Council (GMC)
The GMC merged with the Postgraduate Medical Education Training Board (PMETB) in 2010 and took over its roles of establishing standards of postgraduate medical education and training; securing these standards and requirements; and developing and promoting postgraduate medical education and training. It is required to: safeguard service users; ensure the needs of trainees are met; and ensure the needs of employers are met.
http://www.copmed.org.uk/publications/the-gold-guide

Postgraduate Deanery
Regional unit responsible for implementing specialty training in accordance with PMETB approved specialty curricula. Postgraduate Deans work with Royal Colleges/Faculties and local healthcare providers to quality manage the delivery of postgraduate medical training to PMETB standards.

Joint Advisory Group on GI Endoscopy (JAG)
It was established in 1994 under the auspices of the Academy of Medical Royal Colleges [AMRC] specifically through the Royal College of Physicians, Royal College of Surgeons, Royal College of Radiology and the Royal College of General Practitioners. The JAG has a UK wide remit.

The JAG’s core objectives are:

- To quality-assure endoscopy units
- To agree and set acceptable standards for competence in endoscopic procedures
- To quality-assure endoscopy training
- To quality-assure endoscopy services

http://www.thejag.org.uk
A huge thanks to all of the support staff at the BSG, with a special thanks to Howard Ellison, without whom the section would not be able to function!

Elected SpR/StR regional representatives of the BSG Trainee Section have produced the sections of this booklet as follows:

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2. Dr Laura Kitto, East of Scotland
3. Dr Max Hu, Northern
4. Dr Fergus Chedgy, KSS
5. Dr John Eccles, Northern Ireland
6. Dr Suranga Dharmasari, Wessex
7. Dr Steve Dixon, Severn/Peninsula
8. Dr Durayd Alzoubaidi, East Of England
9. Dr Ellie Taylor, Yorkshire & Humber
10. Dr Hasan Haboubi, Wales
11. Dr Liam Morris, North West
12. Dr Louise China, North East Thames
13. Dr Sinan Al-Rubaye, Mersey
14. Dr Elaine Robertson, West of Scotland
15. Dr Laith Alrubaiy, Wales (Ex-Officio)
16. Dr Laith Alrubaiy, Wales (Ex-Officio)
17. Dr Kesavan Kandiah, North West Thames
18. Dr Sujata Biswas, Oxford
19. Dr Lottie Ford, South Thames

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This is Version 1 (2016) of the Introduction Handbook for Gastroenterology Trainees – if you have any constructive feedback for future versions please email bsgtschair@gmail.com
Sponsors

Many thanks to our sponsors for supporting the trainee sections’ activities:

Sponsors had no input with regards to the content in this handbook