Chapter 1

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Evidence-based medicine

Definition
The conscientious, explicit, and judicious use of best evidence in making decisions about the care of individual patients. This involves finding, critically appraising, and using this evidence in our clinical practice.

Simply put, evidence-based medicine is about reading the right papers, at the right time, and altering one’s behaviour.

Steps for evidence-based practice
- Convert our information into answerable questions, i.e. formulate the problem.
- To track down the best evidence to answer these questions (evidence is usually from published literature searched via MEDLINE or Cochrane library: www.cochrane.org).
- To appraise the evidence critically (i.e. to weigh it up) to assess its validity (closeness to the truth) and its usefulness (clinical applicability).
- To use the results of this appraisal in our clinical practice.
- To evaluate our performance.

Levels or statements of evidence
Ia Evidence from meta-analysis of prospective randomized controlled trials.
Ib Evidence from at least one prospective randomized controlled trial.
II Evidence from at least one well-designed controlled study (non-randomized), e.g. prospective cohort or retrospective case-control study.
III Evidence from well-designed non-experimental descriptive study, e.g. comparative or case studies.
IV Evidence from expert committees or opinions and/or clinical experiences of respected authorities.

Evidence-based ENT practice
- 5000 papers are published each month of which >700 are clinical research papers.
- Only 10–15% have any scientific value.
- Positive studies are 20 times more frequently published than negative ones.
- 80% of ENT practice is based on descriptive case studies (Level 3 evidence).
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Statistics for the non-statistician

Definition of statistics
Statistics can be broadly defined as the use of data from samples to draw inferences about the relevant larger population.

Key questions in data analysis
- What is the nature of data (type/properties)?
- How is it distributed?
- Which statistical tools do you use to make inferences about general population?

Types of data
- Parametric (quantitative, numeric): where variables are related to each other and you can put a number to, e.g. height.
- Non-parametric (qualitative, categorical): where data are not related to each other, e.g. blood groups.
- Paired data: where two observations are performed on the same sample, e.g. lying and standing BP measurements on the same patients.
- Unpaired data: comparing two independent samples drawn from the same population, e.g. effect of drug A on study sample compared with placebo on controls.

Properties of data
- Mean is the cumulative total divided by the number of samples (‘average’).
- Mode is the most frequently occurring event.
- Median is the middle sample when the data is arranged in order.
- Variance, standard deviation, and standard error are all measures of spread of the data about the mean.

Distribution of data
- Normal (Gaussian) distribution: if a very large number of samples are plotted, this follows a bell-shaped curve with 95% of the data falling within 2 standard deviations of the mean.
- Skewed distribution: a non-normal distribution with the bulk of the data occurring on one side of the average.

Which statistical test is the most appropriate?
This depends on the nature of the data and its distribution. Some of the more common statistical tests are:
- Normally distributed parametric data: T-test, Pearson correlation test.
- Categories: Chi-squared test.

Some important statistical terms
Probability: the way of describing how likely an event will happen (0 = never happens, 1 = always happens).
**P-value**: probability value, i.e. the result occurred by chance. Arbitrarily set at 0.05 (5%), which means that 5% of the time the result we have on the samples is not representative of the whole population. If a *P*-value is less than 0.05(5%), results are described as statistically significant and unlikely to have occurred by chance.

**H0 = null hypothesis**: there is no real difference between the populations.

**H1 = alternative hypothesis**: there is a real difference between the populations.

**Type 1 error**: a false-positive result, i.e. rejecting the null hypothesis when in fact we should not.

**Type 2 error**: a false-negative result, i.e. failure to reject the null hypothesis when in fact we should.

**Power of a study**: probability we will make a type 2 error, i.e. fail to detect a difference when one exists. Usually because of the sample numbers are too small.

**Standard deviation**: indicator of the spread of the data about the mean.

**Confidence intervals**: usually set at 95%. We are 95% certain that the population mean lies in the given range. If the range crosses zero, the results may not be statistically significant.

**Bias**: the result we have is different to what it should be. This can be due to sampling error, unfair exclusions, incomplete response to questionnaire studies, incomplete blinding, not using matching controls, non-randomization, not including all the data in the analysis, analysing the data too early in the study, and using the wrong statistical test for the data.

**Confounding**: when part of the observed relationship between two variables is due to action of a third, e.g. alcohol consumption and lung cancer are both more common in smokers and if you are not aware of this, your analysis may indicate alcohol causes lung cancer.
Critical appraisal of papers

Definition of critical appraisal
The practice of systematically examining research evidence to assess the validity of methodology and results, and the relevance to our clinical work.

Standard appraisal questions
- Are the objectives of the paper clearly stated? Is the question worth asking?
- Do the authors or their institution have expertise in the subject area? Do the authors have bias?
- Did the authors have the right type of study to address the research question (see below)?
- Was the sample size justified? Was a power calculation performed?
- Are the measurements likely to be valid and reliable?
- Are the statistical methods described?
- Did untoward events occur during the study?
- Was the basic data adequately described?
- Do the numbers add up? Were patients excluded, lost to follow up, or die?
- Was statistical significance assessed?
- What do the main findings mean? What were the outcome measures?
- How are the null findings interpreted?
- Are important effects overlooked?
- How do the results compare with previous reports?
- Were the aims fulfilled in the discussion?
- What implications does the study have for your practice? Are the patients similar to your unit?

Additional questions for specific studies

Surveys
- Who was studied?
- How was the sample obtained?
- What was the response rate?

Cohort studies (for papers addressing prognosis)
- Who exactly was studied?
- Was a control group used or should one have been used?
- How adequate was the follow-up?

Clinical trials (for papers addressing effectiveness of drug treatment)
- How were the treatments randomly allocated?
- Were all patients accounted for?
- Was analysis performed on an intention-to-treat basis (i.e. according to the groups they were initially randomized to?)
- Were the outcomes assessed blind?
Case controls (for papers addressing causation)
- How were the cases obtained?
- Is the control group appropriate?
- Was data collected in the same way for cases and controls?

Review papers
- How were the papers identified?
- How was the quality of the papers assessed?
- How was the result summarized?
Medico-legal issues in clinical practice

The most important issues facing a doctor in their everyday work are:
- Capacity of a patient.
- Principles of consent (see p10).
- Issues of patient confidentiality.
- Notification to coroners court.
- Access to medical records.
- Clinical negligence.

Capacity of patient

**Definition**

‘Mental competency of patient to make a decision’.¹

The patient has to be able to comprehend what is being said to him and be able to weigh up this information to make an informed decision.

**Basic principles**

- Adult is competent until proved otherwise.
- Once proved incompetent, the patient remains so until proved otherwise.
- Burden of proof lies with the doctor in changing mental capacity.

A mentally competent adult can make an unwise decision against good advice, e.g. a patient on hunger strike may not be force fed but a patient with anorexia, in certain circumstances, may be.

A doctor may have to assess capacity before providing medical treatment or before witnessing a legal document, e.g. a will (patient must understand what making a will means and the value of the property to be disposed of).

Confidentiality

Doctors have an ethical duty not to disclose personal information about patients to third parties. Written permission is required from patients before disclosure is permitted. Confidentiality does not end with the death of the patient and permission should be sought from the next of kin.

**Important exceptions**

- Sharing information with registered medical practitioners involved with the patient’s clinical management.
- If disclosure is in the patient’s best medical interest and the patient is incapable of giving consent or if seeking consent may be harmful to the patient.
- Notification of certain infectious diseases.
- Where children are at risk, e.g. suspected child abuse.
- Where public safety is at risk.

Notification to coroner’s court

The purpose of an inquest is to determine who died, where, when, and how. The following deaths should be reported:
- Any deaths occurring during operation or before recovery from anaesthetic (within 24h of surgery).
- Suspected ill treatment or neglect.

• Crime-related deaths.
• Death from septicaemia.
• Poisoning of any type, including food poisoning.
• Death of patients detained under the Mental Health Act.

If in doubt, discuss the case with the coroner.

**Access to medical records**

Courts have the absolute power to order the disclosure of medical records. Patients also have the right to access their medical records, unless information about another patient will be revealed from their records.

As medical records may be used as part of a legal action, they must be legible, dated (possibly timed), and signed. Do not write anything that you would not be prepared to show the patient and never make unfounded or unprofessional observations.

**Clinical negligence**

This occurs when:
1. a person is owed a duty of care by a health care provider, i.e. he/she is a patient.
2. there is a breach of that duty.
3. the patient suffered harm as a result.

Breach of duty is usually judged by the Bolam test, i.e. care must be provided with accepted medical practice as determined by experts in the field. Nowadays, many units have protocols or care pathways in keeping with best practice.

Medical defence organizations have no role in litigation against NHS employees because, from 1990, NHS hospitals began indemnifying their employees against patients’ allegations of medical negligence. Therefore doctors are not sued directly. Trusts became defendants in legal proceedings and the NHS accepted financial responsibility for claims.

However, NHS indemnity does not cover you for:
• Disciplinary procedures by your trust or GMC.
• Good Samaritan acts outside your hospital.
Consent

Definition

‘Patient authorizes the doctor to initiate a medical plan’.  
It is more than just a signature. For consent to be legally valid:
- The patient has to be properly informed.
- The patient has to be competent (have the capacity) to give consent.
- The patient has to give consent voluntarily and without coercion.

Consent and the law

Two main areas of relevant law are:
- Battery: if one person touches another without consent, this may constitute battery even though no-one suffered harm as a result of the incident.
- Negligence: patients need information when choosing whether or not to accept a treatment, e.g. nature of treatment, benefits, risks, and alternative. If a doctor does not provide this information prior to consent, then he or she may be negligent.

Types of consent

Implied

Patient consent is needed before an examination. However, we don’t obtain specific consent for these procedures as the courts recognize the concept of ‘implied consent’, e.g. ‘I would like to examine your throat’ and patient opens his mouth. However, if a competent patient refuses to be examined and the doctor ignores this and proceeds to examine him, this constitutes battery. The fact that the patient came to see the doctor or is admitted to hospital does not imply consent to examination, investigation or treatment.

Expressed

Whereby specific written consent is obtained, e.g. prior to surgery.

Surgical consent form

The patient has to sign a consent form before surgery because:
- Legally, it provides evidence that the patient has given permission for a procedure.
- It communicates the patient’s wishes to other members of the healthcare team.

For consent to be legally valid, the patient needs to understand the requirement for treatment and the consequences of not having it, its risks, success rates, and other alternatives. The patient should be informed of all life-threatening or life-changing risks, no matter how unlikely.

Ideally, the consent should be obtained by the consultant or the person carrying out the procedure. A competent patient can withdraw consent at any time.

2 Reference Guide to Consent for Examination or Treatment. Department of Health Website.
Decision-making for incompetent patients
- Best interests: doctor makes a decision in ‘best interests’ of patient, e.g. life-saving surgery. Doctor is legally accountable and this may be assessed by the Bolam test.
- Proxy: a proxy, e.g. next of kin, takes the place of an incompetent patient and makes decisions for the patient.
- Substituted judgement: ‘If the patient was competent, what treatment would he chose?’ The doctor uses evidence from patient’s past, by knowing the values of the patient and from the experience of relatives.
- Advance directives (‘living will’): statement written by patients when fully competent, making decisions about their medical care and what they want and don’t want in the future, if they become incompetent.

Minors and consent
The law is complex here. In general, do not deny urgent life-saving treatment to a child under 18 years of age because of lack of consent from the minor or parents.

Child age 16–17 years
Presumed to have capacity to consent until proved otherwise. If patient refuses consent, parents or courts can over-ride decision and can give consent in child’s best interests.

Child aged <16 years
Presumed not to have capacity to consent unless they satisfy health professionals that they do have such capacity. Tested by ‘Gillick competency’ whereby a child <16 years is deemed to have sufficient mental maturity to understand need for treatment and come to a reasoned decision. If child refuses consent for life-saving treatment, parents or courts can over-ride it.

Child who is not competent
Parents should give consent. However, if parents refuse and the doctor feels it is not in the child’s best interest, then the courts should be involved. In an emergency, when there is no time for consent or to involve the courts, the doctor should treat the child to preserve the child’s life.

Consent for photos and videos
BMA, GMC, and the Institute of Medical Illustrators all publish guidelines indicating that the patient has the right to be given as much information as possible on where an image might be used. Specific consent should be obtained for all images, especially if the patient can be identified.
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-breaking bad news-

Most doctors feel uncomfortable breaking bad news to patients and relatives. It requires expertise, knowledge, and skill, as well as compassion. In the past, doctors avoided telling patients bad news as they may have felt the patient did not want to know or they were trying to protect the patient in some way, but these attitudes have now, quite rightly, changed.

Patient and family reaction to bad news

Five stages of dying are:
- denial.
- anger.
- bargaining.
- depression.
- acceptance.

If the doctor breaking bad news is aware of these reactions and which stage the patient may be in, he can be more thoughtful and prepared, and the overall experience of being told bad news can be less traumatic.

Approaches to giving bad news

- Allow ample time for consultation and take precautions to avoid unnecessary interruptions whilst with the patient, e.g. switch off phones, place ‘Do Not Disturb sign’ outside room.
- Use a suitable private room, furniture arranged appropriately and tissues to hand.
- Ensure you have a member of staff with you, to help you and support the relatives.
- Check case notes in detail beforehand to ensure you have all the information you need. Take notes with you to the consultation.
- During the consultation, give the patient a warning that they are about to receive significant information so that they prepare themselves, e.g. ‘I have some important news’.
- Allow the patient to have somebody with them for support and to help absorb the information during the consultation.
- Use appropriate body language, eye contact, and voice tone.
- Determine what the patient already knows or believes about their illness, e.g. ‘What have you been told about your illness?’.
- Determine what the patient and their family want to know before you tell them, e.g. ‘Would you like me to tell you the full details of the diagnosis/results?’.
- Most patients only remember approximately 40% of what they are told and it is likely the information will need repeating or writing down. Consider drawing diagrams to explain what you are saying more clearly.
- Respond to the patient’s concerns and hopes as accurately as possible without being unrealistic or falsely reassuring. Be honest—if you don’t know something, say so and find out the information for them.
- Avoid using medical jargon when talking to patients, e.g. use blockage rather than stricture.
• Some patients may be too shocked or bewildered to make informed decisions about their treatment.
• Arrange for a follow-up appointment to discuss further patients' questions and plan management. Specifically, patients will often want to know the size of the tumour, the different treatment options, and their side-effects.
• Make sure all people being told the bad news are given the same information with the same options, including the offer of a second opinion.
• Provide patients with sources of information, e.g. Cancerlink, Macmillan, and hospice support, written information about their condition and its treatment, internet links, relevant social support.
• Inform the patient’s GP promptly of the discussion so that he/she can deal effectively with the patient. Make sure the medical records are fully updated with the notes of your discussion to set a baseline for future explanations.

Dealing with relatives when a terminally ill patient dies
• Most of the above points are also relevant when dealing with bereaved relatives.
• If possible, collect all family members for one meeting. This will avoid repetition.
• Use clear, unambiguous language, e.g. ‘died’ rather than ‘lost’.
• Help the bereaved obtain the information they need to understand why their loved ones died and to say goodbye to the body of the deceased, if they so wish. Viewing the body enables the bereaved to begin to accept that death has happened.
Communicating with patients and colleagues

With patients

Because of changes in the NHS, the care of the patient is often fragmented. Patients are often placed wherever a bed is available, not necessarily on an ENT ward, and often looked after by nurses not familiar with their specific clinical needs. Also, with the reduction in junior doctor hours, it is less likely a familiar doctor will be available to talk to relatives. Attitudes and expectations of the public to doctors have also changed.

The key to this problem is good communication between medical and nursing colleagues, as well as with patients and relatives.

Tips for a good outpatient consultation

- Stand up and greet the patient. Use handshake, if appropriate, as well as the correct eye contact.
- Listen carefully to what the patient has to say, and try and answer all their concerns in turn.
- Avoid using medical jargon. Use terms and analogies the patient will understand.
- Consider writing things down and drawing clear diagrams for patients to look at after the consultation.
- When discussing treatments, give the pros and cons of each option. If the patient is included in the discussion, they are more likely to comply with the final treatment choice.
- Never hurry a consultation. Switch off phones and make the patient feel your time is solely for them.
- Try and supplement the consultation by giving the patient and relatives the appropriate information leaflets.
- At the end of the consultation, stand up and escort the patient to the door. Ensure follow-up arrangements are understood.

With colleagues

To be ‘successful’ as a doctor, one has to be perceived as such by your colleagues.

Tips on what makes a good colleague

- Most doctors prefer a friendly, affable, optimistic colleague rather than a taciturn, abrasive, and pessimistic one.
- First impressions are very important, e.g. shaking hands, eye contact, being well-dressed, and remembering the name of a new acquaintance.
- You must communicate effectively on clinical, academic, and management matters. Communication can be verbally or, more commonly, by letters and emails.
Dealing with difficult patients and colleagues

Tips on handling difficult patients

- Have a third independent person present, if only to corroborate your version of events at a subsequent enquiry.
- Try to be on the same level with the other person. Avoid looking down on them, as they will feel threatened.
- Keep your own voice as level as possible. Communicate calmly with the person.
- Allow them plenty of personal space, as getting too close may make them feel threatened.
- Acknowledge the patient’s feelings with an empathetic statement. The irate patient, when realizing that you understand, will no longer have to prove their anger.
- Indicate you are paying attention by reflective listening and repeating back a summary of what was said.
- Try turning difficult questions back on the patient, e.g. you can ask them, ‘What makes you ask that question?’.
- If you are unsure how to respond to an angry patient, it is best to stay quiet. Faced with silence, most people run out of steam and begin to feel foolish.
- Avoid questioning an angry patient.
- If you are in a closed space or room, check you are well positioned for leaving quickly, or at least ensure that a large piece of furniture separates you from the complainant.
- If the patient is abusive, terminate the interview as soon as possible. Document the occurrence and inform the risk manager of the hospital, possibly with corroboration from the independent witness. Report the patient to their GP and ask the GP to refer the patient elsewhere.
- If the patient threatens violence, never lose your temper as this only makes things worse. If the person needs restraining, always involve hospital security staff or police, who are trained in the proper techniques. Remember your job is to treat the patient.
- If the patient is making an informal complaint, give them an explanation of what went on and, if necessary, an apology. Remember an apology is not necessarily an admission of guilt. Try and put a human face on the problem. Reassure the patient that steps will be taken to stop the problem happening again. It is vital the whole team learn from any mistakes.
- Try and remain polite, honest, caring, and dignified at all times.
- If you feel the patient does not believe your professional opinion, consider referring them to a colleague for a second opinion.

Tips on handling difficult colleagues

Many so-called ‘difficult colleagues’ are simply people we would not choose to associate with socially. A truly difficult colleague may continue to act this way because no one has ever discussed their inappropriate behaviour with them.
Reasons for talking to a colleague about their conduct include:

- Excessive alcohol consumption.
- Drug abuse.
- Actions that affect the health and safety of others.
- Behaviour that may be offensive or embarrassing to others, e.g. workplace bullying.

Usually the best course of action, after establishing the facts, is to confront the individual, bringing your concerns to their attention and then attempting to address the issues. Try and resolve the situation with a sympathetic discussion.

If a colleague’s behaviour continues to be a problem, especially if substance abuse is involved or patients are at risk, then the clinical or medical director should be informed. It is better to act and stand by a colleague as a friend than to feel that the best way to support them is not to report the issue. Remember, your primary duty of care is to your patients and you should report your colleagues for any such professional breach of conduct at work.
Clinical governance

Definition
‘A framework through which all NHS organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’

Essential principles
- Setting of realistic and evidence-based standards of care.
- Monitoring of performances against these standards.
- Implementation of change to ensure that these standards are reached and, if possible, exceeded.

Five pillars of clinical governance
- Multidisciplinary clinical audit.
- Clinical effectiveness.
- Clinical risk management.
- Quality assurance.
- Staff development/continual professional development.

Clinical governance focuses on a team approach to patient management and addresses the whole patient journey (rather than just the patient’s treatment).

Clinical audit
The monitoring of performances within a given area with comparisons with others’ performances; reasons that account for that difference are identified and then changes are put in place to improve performance. Reassessment should confirm that a better outcome has been achieved. All steps of the patient journey can be audited with the goal of improving the quality of care. The results of audit have to be open and accountable to outsiders.

Clinical effectiveness
The evaluation of effectiveness of a particular therapy, e.g. by monitoring morbidity and mortality, cure rate, etc. Also involves the use of evidence-based medicine in clinical practice, i.e. there is no point providing a treatment that is ineffective. Evaluating clinical effectiveness ensures that ineffective treatments are identified and discontinued, and effective treatments are administered to the highest possible standards. Often, ‘care pathways’ are used to ensure consistently high quality care.

Clinical risk management
The near misses, device-related incidences, drug reactions, discussion of medical negligence cases. By recognizing and reviewing adverse events that occur, we can identify ways to prevent them. Goal of risk management is to reduce occurrences and consequences of adverse events. Adverse events can be reported by any healthcare worker. Near misses are much more common than minor or major injuries and as such constitute important ‘free lessons’ by which more serious incidents can be avoided.

Quality assurance
The monitoring and measuring of performances against standards. There is some overlap between quality assurance and clinical audit. Quality assurance programmes are important in screening, e.g. radiology (breast screening). Also review of formal patient complaints may identify failings in service and problems in the patient pathway.

Staff development/continual professional development
In the past, staff development in the NHS was a passive process. However, appraisal and assessment have been introduced and all staff must provide evidence of continual medical education to demonstrate they are keeping abreast of recent developments.
Principals of clinical audit

Definition

“The systematic critical analysis of the quality of medical care which includes the procedures used for the diagnosis and treatment and the use of resources and the resulting outcome and quality of life for the patient.”

An alternative definition is:

“A system whereby a process/outcome is analysed with respect to targets/standards, change is instigated and the process/outcome is re-evaluated to ensure improvement.”

Aims

- Improve the delivery of healthcare to patients by identifying opportunities to raise the standards of clinical practice by implementing change.
- Secondary benefits are improved knowledge and work satisfaction, publication opportunities, and better communication with colleagues and managers.

Audit is an essential part of clinical governance. It is now a contractual requirement for doctors in the hospital and community services and this is supported by the Royal Colleges.

Building-blocks of audit (by Auedis Donabedian)

- Structure (resources and facilities available for care).
- Process (activities of care).
- Outcome (resultant effect on patients).

Each of these building blocks can be analysed as part of the audit process. At least two loops of the audit spiral should be completed to ensure any changes have resulted in improvement to the services. Guidance and practical support from the clinical effectiveness and audit department can be invaluable when setting up an audit design and during data collection and analysis.

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5 National Institute for Clinical Excellence 2002.
Preparing for the consultant interview

Before the interview

- Anticipate everything and be prepared for all possible situations! There may be traffic jams delaying your arrival, difficulty finding the interview venue, and tricky questions during the interview. If you arrive late, you may have difficulty regaining composure and also it gives a bad first impression to the interviewers.
- Dress to reassure the members of the panel that they are looking at a young consultant and a future colleague.
- Go into the interview room positively, smiling and determined to enjoy it!

During the interview

- Your main aim is to convince the panel you will make a delightful colleague and achieve your goals.
- Remember, it's normal to feel nervous and the opening question from the interviewers is usually to relax you and settle you into the rest of the interview. Also, not all members of the panel will know each other, so they may feel nervous too.
- Be relaxed but business-like, sit upright and look at the chairperson initially, who should ask you the first question.
- Be friendly and smile with a degree of authority. Show enthusiasm for the job.
- Address your answers to the questioner but do look around to try and engage all the panel with your answers.
- If you don’t understand a tricky question, say so. Make sure you answer the question asked. Take your time to formulate your answer rather than saying something quickly and ill-considered.

Specific interview questions

- Opening questions are usually concerned with a review of your CV and asking you about any unusual features or gaps in your training.
- There will be questions to try and get you to talk about yourself. Do so with confidence, intelligence, charm, honesty, maturity, and occasional humour.
- Inevitably, there will be a question of your research and audit experience.
- There may be questions on recent government reports and agendas, and the implications on your proposed service.
- Questions on your strengths and weakness are always worth thinking about beforehand.
  - What can you do to improve on your weaknesses and past mistakes? (this tests your virtues, intellectual honesty, maturity, and self awareness).
  - What are your strengths and greatest achievements? (this tests your standards, leadership style and ability).
- What are your relationships like with your colleagues? (this tests your personality: social or self contained, conforming or independent, extrovert or sensitive).
• Why do you want this job? This is an opportunity to show you have researched the hospital. Have you identified any challenges that the institute faces? What visions do you have for the future of the department and hospital?
• Where do you see your career going?

At the end of the interview
• Usually you are invited by the panel to ask any questions you may have. As you will have researched the job beforehand, it is acceptable not to ask anything.
• You should remain in the hospital grounds until all the interviews are over. Leave your contact details with the personnel officer.
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Appraisal

Why participate in appraisal?
- It helps the trainee to reflect on experience and assists in the acquisition and development of understanding of new concepts. It is done by a senior colleague whose opinion is important to the trainee.
- It is part of the revalidation process.

Types of appraisal

Formative
Formative appraisal attempts to measure skills, behaviour, attitudes, and knowledge, and encourages the trainee to identify and fix weaknesses. Appraisal is usually conducted through a series of meetings by an experienced consultant. The first meeting is at the beginning of the job and sets up a training agreement and defines goals. The second meeting is halfway through the attachment and reviews progress and revises the learning goals. The final meeting is at the end of the job and reviews the trainee’s experience and assists the trainee to reflect on experience gained. The records of formative appraisal are usually confidential.

Summative
Summative appraisal measures the ability of the trainee in order to permit progress over a performance hurdle, e.g. RITA assessment. Summative assessment also tests skills, behaviours, and attitudes but is regulatory (i.e. tests to certain standards). The methods and criteria are set by examiners on behalf of an assessing body. Examiners themselves will have been trained in summative assessment methods. The aim of summative assessment is to identify trainees not ready for independent practice. Its outcome will enhance or impede career progression. The results of summative assessment are not confidential.

Aims of appraisal
- To help identify educational needs at an early stage.
- To assist in the skills of self-reflection and self-appraisal that will be needed throughout a trainee’s career.
- To provide a mechanism for reviewing progress and to identify problems in time for remedial action to be taken.
- To provide a method for giving feedback of the quality of training provided.

What is discussed at an appraisal?
- Preparation for exams. What courses to go on.
- Advice on research projects.
- Clinical experience and skills.
- Appropriate knowledge level.
- Organization and planning ability.
- Teaching skills of trainee.
- Career pathway.
- Personal skills and attributes (interpersonal communication, decisiveness, teamworking, flexibility and resilience, thoroughness, drive and enthusiasm, probity).