Welcome to the fifth edition of The International Anaesthetist and the first for 2019.

I hope that you all had a happy and healthy Christmas season and that you, like me, are looking forward to the challenges and opportunities that 2019 has to offer.

We start the year looking forward, and it is certainly set to be a busy one for the Global Partnerships team. In the first half of this year, we are looking to liaise with your Country Champions, and get this function up and running. Our international membership is vital to the success of delivery of the College Strategic Plan, and specifically the Global Partnerships Strategy. If you are looking to be more involved in the work of the College, do take a look at our Get Involved pages on the website, where opportunities are advertised.

As I have mentioned previously, there are two key events this year, which we hope will be of interest to you as international members. We will be running a joint conference between the Australian and New Zealand College of Anaesthetists (ANZCA), the Hong Kong College of Anaesthesiologists (HKCA), the College of Anaesthetists of Ireland (CAI) and RCoA from 29 April to 3 May 2019 in Kuala Lumpur. Please put these dates in your diaries and attend if you are able. If you are planning to attend, do drop us an email via global@rcoa.ac.uk and we can let you know of any member gatherings that we arrange – it would be great to see as many of you as possible.

Bookings are now open for our second Global Anaesthesia themed event Global Anaesthesia: Engaging the Collective here at the College on Friday 22 March 2019. Those who attend will obtain a greater understanding of the challenges faced by multidisciplinary medical teams across the world, particularly in low- and middle-income countries, and will explore how the anaesthetic community, as a collective, can help to overcome these.

This edition covers a wide range of topics which we hope will be of interest to you. Please do let us know your thoughts!

I emphasise again that this is your e-newsletter, and we want it to be of relevance and interest to you. Please do continue to get in touch with us to make suggestions for topics, and write articles for us. Please email any thoughts to us at global@rcoa.ac.uk.

Happy reading,

Professor Ellen O’Sullivan
Chair of the Global Partnerships Committee and RCoA Council Member
@RCaNNews

February 2019

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A day in the life of...
An anaesthesiologist in Malaysia (and Singapore)

Dr Shahridan Mohd Fathil, Consultant Anaesthesiologist, Gleneagles Medini Hospital, Iskandar Puteri, Johor, Malaysia; Visiting Senior Consultant, Ng Teng Fong General Hospital, Singapore

I work in Gleneagles Medini Hospital, located in Iskandar Puteri in the southern state of Johor, Malaysia. This is a private tertiary hospital with a 120-bed capacity.

We currently have three resident anaesthesiologists and two regular visiting anaesthetists to operate the 2.5 operating theatres during office hours, and just one anaesthetist as emergency during out-of-hours. All the surgical specialties are available in the hospital, including cardiothoracic and neurosurgery. However, the bulk of our cases are obstetrics and gynaecology, orthopaedics, general surgery and paediatric surgery, with a significant number of gynaecological and surgical oncology. We perform regular perioperative ultrasound, particularly ultrasound guided regional anaesthesia, and hence, we get a small number of referrals for regional anaesthesia. Apart from anaesthesia, the anaesthesiologists also co-manage a ten-bedded intensive care/high dependency unit.

Iskandar Puteri, Johor’s second city, is located in Iskandar, an economic development corridor in Malaysia that has attracted talent from abroad. Consequently, we see a significant number of patients from overseas who reside in Puteri alongside a small number of patients coming from the nearby Indonesian island of Batam. Due to Iskandar Puteri’s geographical location and its proximity to Singapore, I also take a short drive across the border once a week to do visiting sessions at Ng Teng Fong General Hospital in Singapore, where I used to work as a permanent anaesthesiologist up until last year. This is a paperless public 700-bedded general hospital with all the specialties except obstetrics and gynaecology, cardiothoracic surgery and paediatrics. I am usually rostered to do a ‘blockable’ orthopaedic list and provide training to residents. I normally teach ultrasound guided regional anaesthesia to anaesthesiology residents. I am affiliated with the Society of Critical and Emergency Sonography, Malaysia and the Special Interest Group in Regional Anaesthesia, College of Anaesthesiologists, Malaysia. This means that I regularly conduct teaching in emergency/critical care ultrasound and regional anaesthesia throughout the country and the region.
Partners update
King’s Sierra Leone Partnership: the anaesthetic service in a low-income country

Dr Caroline Kane, ST3 Anaesthetist in Training, Royal Sussex County Hospital, Brighton
Dr Tom Jones, ST3 Anaesthetist in Training, Oxford University Hospital NHS Foundation Trust

We undertook a six-month out-of-programme training in Freetown, Sierra Leone, under the King’s Sierra Leone and Royal College of Anaesthetists Partnership fellowship.

The King’s Sierra Leone Partnership (KSLP) is an organisation of clinical academics engaging in long-term capacity building between King’s Health Partners in London and key partner institutions in Freetown. The KSLP aims to help strengthen Sierra Leone’s health system by improving training, clinical services, policy and research. We were placed at Connaught Hospital, the country’s principal tertiary adult referral centre. The experience and skills gained throughout those six months were invaluable.
The KSLP taught us about the importance of partnership working. We learnt about the challenges and complexities of development work within a resource-poor setting. This led us to reflect on ‘sustainability’ and the impact of non-governmental organisation work in a health system.

As is the case for many low-income countries, it is mainly trained nurses, who have pursued a higher level of training, who deliver the anaesthetic service in Sierra Leone. We observed that the nurses had high levels of motivation and an eagerness to learn. They kept asking us questions, and as it became clear to us that there was a general appetite for developing their skills, Tom, together with the nurses, arranged teaching sessions on topics of their choice.

Working conditions in Sierra Leone were challenging to say the least. Imagine a three-year-old undergoing elective hernia repair in a theatre where you frequently lose power and oxygen. A senior nurse anaesthetist is responsible, and you are present in a ‘support’ role. After gas induction with halothane and laryngeal mask airway insertion, the surgeon infiltrates lidocaine and starts operating (without a cannula). The boy develops laryngospasm, desaturates and becomes bradycardic. Preparation is poor; you send someone to find a syringe and offer to give intramuscular suxamethonium, but are firmly told ‘no’. You voice concerns, but are told by the senior nurse, who is calm and preparing to intubate, to ‘stop panicking’, and that ‘the child will be fine’. What do you do? What does ‘clinical support’ mean in a system which is not your own, and wherein you are relatively junior, working with experienced local nurses? Do you have a responsibility to treat the child, because you are there? Or, do you prioritise your relationships with staff in the interest of your organisation, to preserve a future of partnership working? This boy survived, and the experience raised important questions for Caroline: ‘I focused on teaching by example, and believe that motivating one trainee, or empowering one nurse to drive change are great achievements’.

As in many other developing countries, induction drugs were in short supply and the nurse would stockpile some drugs for emergencies. There were often power cuts, which meant the fridge never worked. It was questionable if the refrigerated drugs actually worked, but they always had halothane and a spinal. Despite this, the nurses managed as best they could.

Documentation of the anaesthetic was limited and it was something the department wished to address. With support and guidance from us and several drafts, the nurses produced an anaesthetic chart that was piloted and then adopted for Connaught Hospital, with plans to use it nationally.

Upon our return to England, Tom received a message from one of the nurse anaesthetist students. They had all passed their exams and were being sent ‘up country’ to be fully fledged anaesthetic nurses. The sense of their achievement was overwhelming. We were proud of them all. It is a moment we will never forget.
Ethiopia is one of the most populous countries in the world with over 102 million inhabitants. However, there remains a shortage of anaesthesia providers with a little over 50 anaesthesiologists centred mainly in the capital city, Addis Ababa, and a density of anaesthesia providers of 0.05 per 100,000.

Bahir Dar, in the north of the country, is the capital city of the Amhara region. The city’s main government referral hospital, Felege Hiwot, serves more than eight million people from the surrounding area and faces a number of challenges typical to a low resource setting. The hospital has nine operating tables providing more than 5,000 surgeries each year, an eight-bedded medical intensive care unit (ICU), and a surgical ICU under development. To meet service demands of the high population and broad geographical area served, Bahir Dar University opened Tebebe Ghion Hospital in November 2018, with eleven operating tables and a nine-bedded ICU. University medical staff and anaesthetists operate across both hospitals and the two hospitals act as training sites for medical and anaesthesia programmes. Bahir Dar University began anaesthesia training programmes in the last three years, offering three- and four-year BSc Anaesthesia programmes with a possibility to commence the MSc programme in the near future.

A partnership has been developed between Bahir Dar University, Felege Hiwot Referral Hospital, the University of Aberdeen, The Soapbox Collaborative and NHS Grampian, beginning in 2014. The partnership was born from the work of The Soapbox Collaborative, a charity focused on prevention of healthcare-associated infections, which was evaluating a national maternal death review system in Ethiopia and explored the potential for a broader partnership. The partnership has supported numerous areas, including quality improvement, collaborative research, student and staff exchange schemes and medical school elective placements. A significant area of focus has been within anaesthesia.

In the past four years, partnership projects have included piloting the World Health
Organization (WHO) Safe Childbirth Checklist (SCC), introduction of a modified obstetric early warning system (MOEWS), The American Academy of Paediatrics Helping Babies Survive Essential Care for Every Baby package, the WHO Surgical Safety Checklist (SSC), surgical site infections, sepsis management bundles, supporting expansion of the ICU and maintenance services. The SCC has led to improvements in neonatal resuscitation and hygiene related practices with uptake of checklist use at 77 per cent of cases at one year, the MOEWS has led to improved monitoring with 100 per cent utilisation at one year, and use of the WHO SSC rose to 94 per cent with 60 per cent full completion. There has been a number of training initiatives to support these projects and training sessions in resuscitation, pain management, intensive care, obstetric emergencies and anaesthesia. Projects have kindly been supported by the Tropical Health and Education Trust, the Association of Anaesthetists International Relations Committee and the British Medical Association.

The Aberdeen-Bahir Dar Partnership now offers the opportunity for an Anaesthesia Fellowship to support development of the anaesthesia services at both Felege Hiwot and Tebebe Ghion Hospital, and anaesthesia training programmes. Posts are available for a minimum of six months to UK anaesthetists in training above ST5 level or CCT holders, and are supported by the College’s Global Partnerships department.

For more information, please contact Dr Jolene Moore, Consultant Anaesthetist, NHS Grampian on: jolenemoore@abdn.ac.uk

Tibebe Ghion Hospital, Ethiopia
Anaesthesia or anesthesiology?

Dr Adrian Hendrickse, Associate Professor of Anesthesiology; Director University Anesthesiology Simulation Programme, University of Colorado Anschutz Medical Campus

I was spoilt by spending a year doing a critical-care retrieval and teaching fellowship in Sydney, Australia.

When I returned home, I found it hard to settle back into the grey and cloudy UK, so when I was offered a chance to relocate to an academic post at a university in Colorado, USA, I jumped at the chance.

Before I finally made the move, I was a consultant anaesthetist in the south of England. My anaesthesia department was mostly made up of consultants with some associate specialists and anaesthetists in training. We covered general theatre work along with obstetric and intensive care. Most of the time I planned and performed my own cases and everything anaesthesia related was my responsibility. How much difference could a simple change of location possibly make?

Academic anaesthesiology in the United States is indeed a different beast, and there are even variations at the institutional and geographical level. Anaesthesiologists are an integral part of what is known as the Anesthesia Care Team. Apart from the occasions where we personally provide services, care is also "directed and/or supervised by the physician anaesthesiologist". Tasks are delegated to trainee anaesthesiologists or to non-physician providers of anaesthesia care, certified registered nurse anaesthetists (CRNA), or certified anaesthesiologist assistants (CAA). This can mean that an attending anaesthesiologist may be responsible for up to four operating rooms at a time. In reality, having four rooms happens less frequently, but directing two or three is common and requires a different skillset from the anaesthesiologist than that required to personally manage a single case. It was challenging at first to make the transition to a supervisory role, but I was pleasantly surprised to find that the scope of my training and broad experience had prepared me well for managing different clinical scenarios in multiple...
locations with numerous personnel. At the hospital and departmental level, using this approach ensures an efficient way to provide quality care to patients, and allocating staff to operating rooms becomes more predictable. In addition, billing and collections can be efficiently maximised with most charges captured. Regulatory bodies such as the Center for Medicare and Medicaid Services are kept onside whilst the insurance companies grudgingly pay up.

Supervising other anaesthesia colleagues can be uncomfortable at times. It requires a degree of finesse and excellent interpersonal skills to manage it well. Advanced practice providers, with multiple years of nursing or technical experience as well as specialised training in anaesthesia, do not always care to be overly directed – although the responsibility for the patient remains with the physician.

Anaesthesiology residents are in clinical training for a minimum of three years, although plenty take extra fellowship opportunities. Nevertheless, it is possible to be out of residency after three years of specialised training. A year of further experience, and success on ‘boards’, equates to a successful transition to independent practice. Residents undertake subspecialty rotations during training with the attending anaesthesiologist only supervising two resident-run rooms at a time. This working practice is intended to provide sufficient oversight for patient care whilst allowing the development of trainee autonomy. Important aspects of the cases are directly supervised, eg induction, reversal, extubation and line placement. Much of the rest of the case is remotely or intermittently observed. Operating room teaching is opportunity driven and needs to be creative for it to happen well. Good residents seem to develop professionally in spite of the system rather than because of it. Having spoken to other academic colleagues across the country, I do not think that circumstances are any different anywhere else. We all aim to practise anaesthesiology to the best of our abilities while we are preparing the next generation as well as we can within the constraints of the system. That is probably not so different from before!
Global Partnerships 2018 in review

Maria Burke, RCoA Global Partnerships Manager

2018 has been another busy year for us in the Global Partnerships team, with many of our initiatives and projects beginning to take shape.

As you will have seen, earlier in the year we undertook a number of membership engagement sessions, which really gave us the opportunity to meet (virtually) with our international members and discuss how the College engages with you, and how we can best support you in your very diverse settings. We found this very useful, and it gave us a real insight into the environments in which you work. We are always keen to receive feedback from you, so if you have any thoughts on what the College does well, or what we might do better, please do get in touch with us, via global@rcoa.ac.uk. We will be taking this work forward in the coming months and will be providing an update as this develops.

We have also continued to see a rise in interest in the Medical Training Initiative, which gives doctors from low- and middle-income countries (LMICs) the opportunity to undertake a training placement for up to 24 months in an NHS hospital, before doctors return to their home country to put into practice what they have learned in their healthcare systems. In total we placed 102 doctors from nine different countries. In this time, we have signed a memorandum of understanding with the World Federation of Societies of Anaesthesiologists (WFSA) to help to increase the number of applications from under-represented countries. We look forward to seeing how this develops in 2019.

We have also seen an increase in the number and diversity of fellowships available to UK anaesthetists in training in LMICs. This is an exciting development as it shows that our anaesthetists in training are showing an interest in global health matters, particularly the workforce and training issues facing global surgery (including anaesthesia) highlighted in the Lancet Commission report published in 2015. The College provides support to anaesthetists in training by approving posts for training (subject to the usual out-of-programme training process), and also through utilising our Remote Educational Supervisor mechanism, which ensures that trainees have a UK contact with whom to discuss any concerns whilst undertaking their placements.

Our projects with Hong Kong and Iceland have also continued to develop. 2018 saw two sittings of the final FRCA examination being undertaken in Hong Kong, and in May, the College provided an external representative to sit on the first anaesthetic annual review of competence progression panels undertaken for acute care common stem trainees in Iceland.

2019 also looks to be an exciting one for the team. As Professor Ellen O’Sullivan mentioned in her introduction, we have two high profile events happening, our Global Anaesthesia: Engaging the Collective event here at the College on Friday 22 March, and our joint conference between the Australian and New Zealand College of Anaesthetists (ANZCA), the Hong Kong College of Anaesthesiologists (HKCA), the College of Anaesthetists of Ireland (CAI) and RCoA, which will be held from 29 April to 3 May 2019 in Kuala Lumpur.

We are also looking to continue our engagement with the College of Anaesthesiologists of East, Central and Southern Africa (CANCSA) along with our other UK and Irish partners, to work with them to continue to develop the College, which will then provide oversight of education and training of the anaesthetic workforce within the region. The WFSA World Anaesthesiology Workforce Map highlights the workforce needs within the region.

Throughout the year, we will also be reviewing the Global Partnerships Strategy and looking to launch version two of this at the start of 2020. Suffice to say we are going to be busy!
Multidisciplinary teams have continued to work together in the UK, improving outcomes and standards of care for their patients who undergo emergency laparotomy surgery.

The 4th NELA report presents data from about 23,929 patients who had their operation between December 2016 and November 2017, and who were looked after by multidisciplinary teams at 179 hospitals in England and Wales. The knowledge from this audit informs areas of care and process that need improvement, and supports shared decision making with patients. Lessons learnt are applicable to the care of these high risk patients wherever they present for surgery, and the challenges in their care may be consistent worldwide.

More patients are now benefitting from preoperative input from consultant surgeons (92 per cent of patients) and anaesthetists (89 per cent). Consultant involvement is more likely if a patient has a higher individual predicted preoperative risk documented. This is important because, as more patients are having their risk considered before surgery, more are potentially benefitting from having consultant involvement in their care. Consultant presence during surgery is at its highest level since NELA started collecting data with anaesthetists present 88 per cent of the time and consultant surgeons 92 per cent.

Morbidity is also an important consideration for patients and clinicians when making decisions about their care. Alongside considering their longer-term chances of surviving surgery, understanding the impact of major emergency surgery on their lifestyles and abilities to carry out their normal daily activities is vital. NELA presents the data on discharge destination after surgery. The cohort that are likely to suffer the biggest change in lifestyle are those who are admitted from their own home but are discharged to residential/nursing homes. This may imply a significant impact on their ability to manage their own activities of daily life and their quality of life.
Key recommendations
There are six overarching key recommendations, each of which has supporting recommendations to guide their implementation:

- improving outcomes and reducing complications
- ensuring all patients receive an assessment of their risk of death
- delivering care within agreed timeframes for all patients
- enabling consultant input in the perioperative period for all high risk patients
- effective multidisciplinary working
- supporting quality improvement.

Encompassing all the recommendations is the importance of reviewing and using local data; sharing it with all stakeholders including the executive team and the clinical staff. Data can inform morbidity and mortality meetings, mortality reviews, identify gaps in care processes, and help teams collaborate with other improvement initiatives. This effective use of data can then support developing clearly defined pathways of care during the perioperative period.

NELA has inspired similar efforts elsewhere. Several other countries have expressed an interest in joining NELA, such as the Channel Isles and the Isle of Man, and colleagues in Australia and New Zealand have established ANZELA-QI (Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement), with 60 hospitals contributing data to the pilot project. We would welcome the opportunity to collaborate with colleagues internationally and spread this improvement work even further afield.

Key results
Since 2013, national 30-day mortality rate has fallen from 11.8% to 9.5%

The number of days a patient spends in hospital has fallen further, to 15.6 days in 2017
Down from 16.6 days in 2016 and 19.2 days in 2013, when NELA began

75% of patients now receive an assessment of risk (up from 71% last year, and 56% in Year 1)

For further information and to download a copy of the Report, please go to:
www.nela.org.uk/Fourth-Patient-Audit-Report
When I started my medical career in Sri Lanka, I knew that I wanted to specialise in anaesthesia.

I was inspired by many great anaesthetists during my medical internship. Five years down the path, I found myself as a senior trainee in anaesthesia, having completed all my exams and training locally and ready to take up a temporary training post overseas, as this is a compulsory component to obtain board certification as a consultant in Sri Lanka. I managed to secure a post in the UK through the College’s Medical Training Initiative (MTI) scheme. This is a very well-structured programme designed for doctors from developing countries.

My main concern when I started applying for posts abroad was whether these would provide good quality training. This was guaranteed under the MTI scheme as MTI doctors receive the same educational opportunities as their UK anaesthetists in training counterparts. As a Sri Lankan postgraduate trainee at the University of Colombo, I had the advantage of having General Medical Council full registration without College sponsorship. I could have therefore taken up a specialty grade job in UK easily, but since these types of jobs are not training posts, I opted to take up an MTI post.

When I started the MTI post in the UK, the biggest challenge that I faced was to get used to a team-based culture as opposed to the doctor-led approach, which I was used to in my country. It took me a little time to incorporate fully into the team and to feel comfortable. Coming from a different country, I had the misconception that the other team members would be watching me and trying to find fault with my performance. However, as I worked within such a diverse environment, I realised that in the NHS it is all about patient care and safety. The biggest plus point for me being an MTI trainee was that I had a dedicated educational supervisor and an excellent College tutor. I could always approach them for work and non-work related advice.

The support and encouragement received by my supervisors and colleagues were instrumental for me to sit the UK final FRCA exam, which was not a priority when I originally planned my MTI training. I would classify passing the FRCA final and becoming a full member of the College as the highest achievement I had during my training in the UK.

When I look back at my two years in the UK, there is a lot that I learnt. I developed my clinical skills and I acquired new soft skills. The NHS has a strong focus on patient communication, teamwork, and the holistic approach to each and every patient to provide a good perioperative care. When it comes to the use of the latest technology and the latest drugs, I had exposure to robotic and laser surgeries, which might take some time to reach my country.

Since I started my career as a consultant in Sri Lanka, I have been able to incorporate the team approach to my colleagues quite successfully, which definitely has shown much better patient outcome and better interaction and satisfaction within the team. The nature of respecting the role played by individuals has infused self-respect and enhanced the commitment of junior team members. My training in the UK has completely remodelled my communication with my patients, which I think is a good example for the new generation of doctors at my workplace. Moreover, the relationships and the ties that I have built during my training in the UK and the link with the College have helped me immensely to be up to date in my practice and when dealing with difficult cases.
The Royal College of Anaesthetists has developed a toolkit that offers patients the information they need to prepare for surgery, including the important steps they can take to improve health and speed up recovery after an operation.

The Fitter Better Sooner toolkit consists of:

- one main leaflet on preparing for surgery
- six specific leaflets on preparing for some of the most common surgical procedures
- an animation which can be shown on tablets, smart phones, laptops and TVs.

You can view the toolkit here: www.rcoa.ac.uk/fitterbettersooner

We have also created printable posters, flyers and stickers to help you signpost patients to the toolkit. The animation can be shown on TVs in waiting areas. You can find all these additional resources and instructions on how to download the animation in MP4 format on our website here: bit.ly/RCoA-FBSresources

Please share this toolkit with colleagues in both primary and secondary care settings.

It has been shown that people who improve their lifestyle in the run up to surgery are much more likely to keep up these changes after surgery.
This event will explore the greatest challenges to universal access to safe anaesthetic and surgical services across the world. Emphasis will be given to the importance of good quality research in the field, and how a systems based approach to the provision of healthcare can have a positive impact on service delivery. In addition, the importance of advocacy and cross specialty working towards shared goals will be explored.

Attendees will gain a better understanding of the challenges faced by multidisciplinary medical teams across the world, particularly in low and middle income countries, and explore how the anaesthetic community, as a collective, can help to overcome these.

This event is open to anyone who has an interest in the provision and delivery of anaesthetic services and a wider interest in global health provision across the world.

Book your place at: www.rcoa.ac.uk/globalanaesthesia
New worlds
Come explore
ANZCA ASM 2019
April 29 – May 3
Kuala Lumpur, Malaysia
asm.anzca.edu.au

Key dates
Abstract submissions open late September 2018
Registration opens late November 2018

Keynote and Invited speakers
Associate Professor Phil Peyton, Australia
Associate Professor Marcus Skinner, Australia
Professor Donal Buggy, Ireland
Dr Mary Cardosa, Malaysia
Dr Shahridan Fathil, Malaysia
Professor Bruce Biccard, South Africa
Baroness Susan Greenfield, United Kingdom
Professor Harriet Hopf, United States
Professor Ellen O’Sullivan, United Kingdom
Associate Professor Chad Brummett, United States
Dr Lawrence Poree, United States
ANAESTHESIA 2019

20–22 May | etc.venues St Paul’s, London

The opioid epidemic: A disaster in waiting?
Dr Cathy Stannard
NHS Gloucestershire CCG

Developmental anaesthetic neurotoxicity
Professor Hugh Hemmings
British Journal of Anaesthesia

The future of anaesthesia
Professor Ramani Moonsinghe
University College London Hospitals

Improving outcomes after emergency laparotomy
Professor Rupert Pearse
Bart’s and the London School of Medicine & Dentistry, Queen Mary

Perioperative anaemia and IV iron
Dr Sonya McKinlay
Glasgow Royal Infirmary

Fitness, exercise and surgery
Professor Denny Levett
University of Southampton and University Hospital Southampton

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