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Editor’s choice

Winston Churchill once admitted that although he was always ready to learn, he did not always like being taught. Even if teaching and learning may not always be connected, education is the link throughout this issue.

Education changes behaviour – essential if our services are to avoid stagnation and fossilisation – yet is all too easy to be ground down by the relentless demands of our service commitments. In her President’s statement, Judith Hulf argues that despite these pressures, we need to develop services through teaching, management and research; indeed it is these very activities that define our professionalism.

One disconnect between teaching and learning is in the promotion of awake fiberoptic intubation – ‘widely recommended but infrequently practiced’, lament Kevin Walker and Andrew Smith. And having performed a few and entered them in your logbook, are you securely on track towards revalidation? Not quite, according to Aditi Kelkar and Subbiah Chelliah; in an article on logbooks, they warn that most anaesthetists have lost their data at some point.

From lost data to the new ‘lost tribe’, it is the growth of trust grade doctors that exercises the mind of Ramana Alladi. Trusts may consider this grade a financially attractive option, but Andy Lim and Roger Laishley point out that trust doctors need to maintain their skills and develop professionally too, like all of us, and so need sessional time for this.

Never short of a good ‘put-down’, Churchill described one unfortunate who crossed his path as having ‘all the virtues I dislike and none of the vices I admire’. Might he have also applied this description to Professor George Lloyd, the extraordinary ‘Brummie’ surgeon featured in David Zuck’s ‘As we were’? There’s nothing like the past to put into perspective how much better things are for having moved on.

Churchill knew well what knowledge of the past could achieve. Mischievously he recorded ‘history will be kind to me for I intend to write it’.

Editor
We’ve also formed a number of advisory groups to support projects, which will meet either infrequently or only over a short, focussed period in order to deliver a task.

Difficult though time is for everyone, I do believe that work in the wider NHS to develop the service, be it through teaching, management or research, is important just in the same way that service delivery is important; if we do not continue to push at the boundaries we lack in our duties. This is in equal part what defines us as high quality, medically qualified specialists. We hear much about what defines us as doctors, and I’m sure that our leadership in fields of activity, clinical and otherwise, is what makes us different.

UK harmony and Modernising Medical Careers

Never have leadership and harmony been more needed than during 2007 as we’ve all struggled to maintain the service alongside the recruitment exercise – don’t let us use the MTAS initials ever again! There is now a new Modernising Medical Careers (MMC) Programme Board for England that has been working during the late summer and will continue after the enquiry, led by Sir John Tooke, reports in October. Some of you may well be aghast at this and cry ‘why are we persisting with MMC?’ I would reply that the core principles of MMC have substantial merit; it was the development and method of implementation that failed anaesthesia and many other specialties so miserably.

I have serious regret that the new Programme Board is only for England, and have said so. While I recognise that the four nations may require different processes, I believe that it is imperative that we maintain the consistency and compatibility of postgraduate medical education and training across the United Kingdom, and more particularly, exactly the same professional standards. As a UK wide College we are probably in a stronger position to support this strategy than some others. This is one of the reasons that the College is in the process of setting up a Welsh Advisory Group, in line with those already established in Scotland and Northern Ireland. The two existing groups provide an invaluable link for the College to the Chief Medical Officers (CMOs), the Deans and...
sometimes Ministers so that the specialty can both inform and be informed. This is really important as we try to move forward sensibly and restore some confidence in the postgraduate training system. By the time that this article is published I anticipate that the terms of reference for the new Welsh Advisory Group will have been accepted by Council and its first chairman appointed.

Towards safer sedation
In June we held a multidisciplinary meeting on ‘issues in conscious sedation’. This meeting was initiated by Professor Tony Wildsmith and his report on the meeting has been accepted and welcomed by Council in September and is available on our website (www.rcoa.ac.uk). Further meetings to support the practice of safe conscious sedation are planned as regular though infrequent events, to enable all relevant disciplines to identify where work needs to be done in the future. Although the Royal College of Anaesthetists will continue to lead and co-ordinate this initiative, it will not necessarily lead each work stream. The first two areas of sedation identified for consideration are in emergency medicine and gastro-enterology.

As a result of this meeting and the publication of a report from the Standing Committee on Sedation in Dentistry – ‘Standards for conscious sedation in dentistry: alternative techniques’ – the professional standards directorate at the College has received many enquiries and expressions of interest. I hope that Professor Wildsmith will expand on the work of his group in an article in a future edition of the Bulletin. As Tony Wildsmith has now left Council, Paul Cartwright has taken the lead on sedation but I have no doubt that we shall be looking to Tony for his continuing support for this initiative.

Representation for Anaesthesia
As we set up work streams in sedation and other areas I am constantly asked for experts to represent the College, or rather ‘anaesthesia’ in its widest sense. I’ve spoken before about the need to know who represents us and where, both so that we know and so that we can give credit for the enormous amount of work done by Fellows and Members for anaesthesia. Amanda, my executive assistant, has done sterling work in bringing the ‘register’ of representatives up to date, although it is still far from complete. I’d like to request now that if you are particularly interested in an area of practice and would be willing to offer expert advice, please will you let Amanda know (aregan@rcoa.ac.uk) so that we can have a ‘pool’ of expertise to dip into. We do, of course, receive support and advice from the specialist societies but it would still be good to hear from individuals.

National Anaesthesia Audit
Over the last year many of you have contributed to the response to the RCoA’s third National Anaesthesia Audit on the major complications of spinal and epidural anaesthesia. This project has yet to complete and report but it has been a success because of the efforts of Tim Cook and the Professional Standards Department at the College, and, most particularly, because of the work of ‘local reporters’ and clinicians in providing and collecting the data. Key to the positive outcome of the third audit will be the complementary reporting of incidents through the National Confidential Acute Pain Critical Incident Audit (NCAPCIA) portal, managed by Dr David Councsell. Although the College originally set out to complete only three audit projects, these have proved of such value that a fourth is now in the planning stage. We plan to look at airway management and will work in conjunction with the Difficult Airway Society and with the support of the National Patient Safety Agency (NPSA).

I do believe that work in the wider NHS to develop the service, be it through teaching, management or research, is important just in the same way that service delivery is important.

Critical Incident reporting
Last week the College hosted the first of three meetings with senior executives of the NPSA. It was attended by, amongst others, representatives of the Association of Anaesthetists of Great Britain and Ireland (AAGBI), whose by-line in this, its seventy-fifth anniversary year, is ‘safety’. The aim of this meeting was to establish a clear mechanism for extraction and processing of data relating to anaesthesia from the critical incident reporting system at the NPSA. Some of you will remember the College’s initiative in 2002 that led to our specialty specific critical incident reporting system, the potential of which was never realised, but is a front runner for being linked via a specialty portal to the National Reporting and Learning System (NRLS). Once this or an acceptable alternative is in place we will ask the profession to renew its participation in the NRLS.

The next two meetings, which should have taken place by the time you read this report, are to identify how the AAGBI, the College and its patients’ representatives might work with NPSA to define threats to safety in anaesthetic practice. I welcome the atmosphere in which we can foresee some of these threats being averted.
Revalidation

Finally, I have referred to the revalidation of anaesthetists – and indeed all doctors – before, and over the next months will continue to do so. Since I last wrote I have been asked to lead on this issue in the Academy of Medical Royal Colleges – a role I took over from Professor Allan Templeton, immediate past President of the Royal College of Obstetricians and Gynaecologists, in September. Over the past months, Allan and his team, together with all Colleges, have done much groundwork on some of the assessment tools that might be used in this process, and there is still much to do. Perhaps I might share some of my general and personal thoughts with you before we consult you on specific issues?

Revalidation for the medical profession has been heralded as reassurance for the public, but it cannot be just that. It has to provide professional satisfaction for the doctor so that each individual sees him/herself as part of a continuous process of quality improvement. It must be a continuous process that enables early identification of issues that need not become problems if early remediation is offered. The proposed five year cycle must have no element of ‘judgement day’ about it. As far as possible the tools for assessment must be those used in the everyday working lives of the individual and not those of intimidation. At every stage of development we have to make sure that all parties – doctors, the GMC, NHS employers, the BMA, patient groups, etcetera, etcetera – are ‘on board’, and that we are not developing an unusable white elephant. And finally we must learn the lessons of MTAS and MMC this year and not try to shoe-horn all specialties into one precise process or roll it out as a ‘big bang’. I will do my best and keep you informed.

President’s Award for Undergraduate Research

The Royal College of Anaesthetists is committed to supporting undergraduate medical students with an interest in anaesthesia and related specialities. Accordingly, in partnership with the Anaesthetic Research Society, it has established the President’s Award for Undergraduate Research.

Medical students who have undertaken research projects as part of their training are invited to submit an abstract of their work by Friday November 16, 2007. Applicants (supported by their supervisor) will be invited to display a poster of their work at the meeting of the Anaesthetic Research Society at the Royal College of Anaesthetists on January 14, 2008. The posters will be judged by a panel of experienced researchers and the winner will be presented with the prize at the end of the day.

Applicants should submit their abstracts as described on the Anaesthetic Research Society website: www.ars.ac.uk.

Students and their supervisor will be given free registration for the day of the meeting.

Please contact Professor David Rowbotham (djr8@le.ac.uk) with any queries.
Guest Editorial

Promoting awake fibreoptic intubation

Here’s a conundrum. How can the technique of awake fibreoptic intubation (FOI) be so widely recommended for managing both the expected and unexpectedly difficult airway, and yet be so infrequently practised? How can it be simultaneously advocated as a ‘core skill’ for every anaesthetist to possess, and so often viewed as too time consuming and difficult to use except as a last resort? How can it be widely used in other countries and yet be so out of favour in the UK?

Ideals are like the stars: we never reach them, but like the mariners of the sea, we chart our course by them.

Carl Schurz

Let us lay our idealist cards on the table. We believe that awake fibreoptic intubation should be widely and readily performed. We suggest that it is simple to learn and safe to perform. We also maintain that it should be taught to trainees in anaesthesia, who should be encouraged to use it as a first-choice technique. We would like to think that, by creating a technique for awake FOI that is as simple and foolproof as possible, we can create a ‘virtuous circle’ where increasing confidence leads to further and wider use, and so on. Airway management is our prime professional skill and we think that every anaesthetist should be capable of performing this technique for most indications, and that it should not be regarded as an advanced manoeuvre. In this article we explore the current situation and describe the development of some simple guidelines to try to promote the use of awake FOI in our department.

Published guidelines and existing practice

Let us first examine the background to this rather confusing issue. Awake intubation has long been regarded as an essential technique for many anticipated difficult airway scenarios.¹ The 1996–1997 NCEPOD report recommended that ‘each department should have several anaesthetists trained for and competent at awake fibreoptic intubations’.² The Royal College of Anaesthetists’ competency-based training documents describe awake intubation as an additional desirable skill during years 3–4 of training, which should be further enhanced in later training years.³ Current guidelines vary in the emphasis given to expected and unexpected difficult intubations. Those from the American Society of Anesthesiologists (ASA) include awake FOI both for the anticipated and unanticipated difficult airway⁴ whereas Canadian guidelines⁵ and advice from the UK Difficult Airway Society (DAS) only concentrate on the management of unexpected airway problems.⁶ The DAS does recommend, however, that every department has guidelines for awake FOI.

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So much for what is recommended. What actually happens in practice? There are a number of published surveys, which attest to geographical differences in the use of the technique – for instance, awake FOI seems to be more commonly used in the United States. Leaving aside the problem that survey respondents may not actually do what they say they might do (especially when there is professional peer pressure to publicly favour a particular course of action), it is possible to gain a rough idea of how anaesthetists are likely to approach the technique. Rosenblatt’s 1998 scenario-based survey suggested that 57% of respondents would choose an awake technique for pathology above the vocal cords, 51% with pathology below the cords and 87% in a trauma scenario. A similar Canadian survey revealed a 50:50 split between awake and asleep intubation in those cases where there was pre-operative evidence of difficult intubating conditions, with fibreoptic intubation the preferred primary technique (though direct laryngoscopy was preferred for the urgent obstetric case). In the UK, a survey in the Oxford region showed that in the scenario of a patient being woken after a failed rapid sequence induction by an SHO, only 43% of consultants would use an awake fibreoptic intubation as the first-choice technique. In the group who would not use awake intubation, 76% felt that it was an unpleasant experience for the patient and only 53% felt comfortable with the technique. A survey by Popat in 1999 found that 98.7% would choose awake fibreoptic intubation in an obstetric patient with a known difficult airway and failed regional anaesthesia, though many respondents lacked the experience or confidence to do so.

**Competence, confidence and expertise**

There have been recent UK surveys relating to trainees’ exposure to the technique. McNarry et al found that 60% of final year trainees had failed to reach their set competency level of ten awake intubations. The findings have been echoed in specialist registrars in the North Thames region. A survey comparing airway teaching in Japan with that in the UK found that, whilst almost 100% of tutors in Japan felt that awake intubation should be taught during the first two years of training, in the UK only 50% considered it necessary to include it in the first two years and just over 20% felt it was unnecessary to be included in training at all.

To us, all this reinforces our starting premise at the beginning of this article. Anaesthetists know they ought to practise awake FOI but generally do not. This must relate to lack of experience during training, but there is clearly a gap between deemed competence levels and degree of exposure to awake FOI through current airway training in the UK. Whilst basic fibreoptic skills can be taught using a combination of manikins and teaching aids, and fibreoptic intubation may be practised on anaesthetised patients, there is a lack of exposure to awake techniques. How then do we reconcile the need for anaesthetists – both trainees and established practitioners – to be skilled in the technique with the lack of opportunities for doing so? We feel there are two lines of ‘attack’. The first is to try to understand what discourages anaesthetists from performing awake FOI, and the second is to promote its wider use, both by expanding the range of indications for the technique and by compiling a simple ‘recipe’ for anaesthetists to follow.

**Perceived barriers to awake fibreoptic intubation**

Why then do anaesthetists in the UK not perform many awake FOIs? From published reports and our own experience we suggest that the following factors may be in play.

**Concerns about safety**

Awake FOI in the absence of airway pathology is generally accepted as a procedure with little risk and this perception seems to be supported by published data. Complication rates have been considered in several fibreoptic intubation series and include hyperactive airways due to inadequate topical anaesthesia (4.6%), oversedation with restlessness needing conversion to general anaesthesia (in a US study) and severe nasal bleeding in 1.3%. Case reports have described complete airway obstruction during fibreoptic intubation in patients with evidence of partial obstruction and reports from courses where awake intubation was practised on participants have revealed occasional minor nasal bleeding and possible local anaesthetic toxicity (severe paraesthesiae of the hands). The same authors also report an episode of pyrexia and rigors in an otherwise healthy volunteer, attributed to bacteraemia secondary to nasal instrumentation. However, any discussion of safety has to consider the safety of all the alternatives. Our experience is that the practice of performing a rapid sequence induction and ‘having a quick look’ in a possibly but not definitely difficult intubation is not uncommon. The rapid sequence induction is a technique for managing a patient at risk of regurgitation of gastric contents, not for managing a patient with a potentially difficult airway and we would question the need for this approach when a leisurely, controlled option exists where the patient’s airway cannot become compromised.

**Risk of failure**

Major airway problems (‘can’t intubate, can’t ventilate’) are uncommon in anaesthesia but the consequences can be debilitating or fatal. The incidence of difficult direct laryngoscopy is between 1.5–8.5%, with failed intubation occurring between 0.13–0.3%. Failure
rates following awake FOI are more difficult to define; reports tend to involve fewer patients and may also include a higher proportion of patients with anticipated difficulty. Ovassapian et al. had a failure rate of 1.2% in 423 nasal intubations (418 were awake or lightly sedated).14 Heidegger et al. describe a similar rate of 1.5% failures in 1,612 fibreoptic intubations.15 Once again, we suggest that, although these failures may present the problem of what to do next with the patient’s airway, if the patient remains awake, this decision can be made in a calm and unhurried manner.

Hurting the patient
Awake FOI is often described as painful or unpleasant for the patient. Indeed, the term ‘awake’ connotes a state of unimpaired consciousness where the hapless patient is fully aware of the procedure and this, coupled with diffidence in the technique, makes anaesthetists reluctant to broach the subject with potentially suitable patients. Of course, adequate topical anaesthesia is the mainstay of the technique, and when this is coupled with appropriate analgesia and sedation, patients usually report it as not uncomfortable and may have little recall of the whole event. This is echoed by personal statements from courses where participants practise on each other. Ovassapian describes a successful training programme for FOI on awake patients following demonstration of fibreoptic skills on a model then demonstrating airway anatomy on asleep consented patients.20 Out of 69 patients, six described the procedure as unpleasant due to pain and only two were dissatisfied. Extra care with sedation may be needed with certain patient groups, such as obstetrics and other scenarios where aspiration is a risk.

Equipment
Whilst most departments now have access to intubating endoscopes, there may be real or perceived barriers to their use. Equipment may be shared with different theatre areas or critical care and may be unfamiliar (especially the video stacks, which are beneficial for teaching). It may be felt that the process of setting up and cleaning equipment is too time consuming or inconvenient to justify choosing the technique.

Complexity
Awake FOI is often seen as a difficult procedure and techniques for topical anaesthesia and sedation have been described in many ways. Techniques vary in complexity – they may rely on navigating the endoscope through the nose (which can be the most difficult part for novices) or mouth, or may include the use of aids such as split Airways. Clearly, the more skill a technique requires, the longer it will take to learn.

Consent
The requirement for specific consent for alternative airway skills remains unclear, especially with regard to training.22 Current guidance from the AAGBI recommends that consent is not necessary if the anaesthetist is skilled in the technique and if it does not significantly differ from the alternative (e.g. direct vs fibreoptic oral intubation).23 It would follow that specific consent should be obtained for novices and if nasal intubation is to be performed solely for training purposes. We would suggest that consent for awake FOI should always be obtained; the options and risks may differ significantly between patients.

Overcoming the barriers
Our first step in trying to achieve these aims was to develop a ‘recipe’ for the technique to make it as simple and straightforward as possible for those who did not use it frequently. We recently wrote departmental guidelines for awake intubation (see Appendix) to include our ‘recipe’ and to provide a basic equipment list. This list would ensure that everything required was readily available, and also...
reduce the time required to set up as anaesthetic assistants would know what would be needed.

There is always a balance in writing guidelines between producing a comprehensive review and a practical guide and we wanted to favour the latter. With many ways in which to achieve adequate airway anaesthesia, some complex, too much choice might appear daunting to inexperienced anaesthetists. The word ‘guideline’ has come to denote a systematic search and collation of processes and interventions from research-based evidence. There is nothing wrong with this evidence-based approach where evidence exists. Where it does not, we need to fall back on what we have always used – the accumulated wisdom and skill born of years of professional practice. This is usually referred to as ‘tacit’ knowledge. Our previous work in Lancaster has highlighted the importance of this knowledge in anaesthetic work. The process of writing the guidelines included a literature search looking for evidence from comparative studies that would allow us to justify our choice of technique but, as expected, we found very little. We did, however, find many narrative accounts and useful tips that we tried to incorporate where they met our purpose. Presenting the guidelines to the department allowed us to collect further tips from colleagues which we were able to include as variants or for use in case of difficulty.

We hope to be able to report on this in the future but, for now, would like to hear how others have tried to tackle this problem. We are aware of the vast experience which exists in this technique and we would be especially pleased to receive practical suggestions from readers to add to our compendium of tips and tricks for making the technique as simple, safe and pleasant for the patient as possible.

References
9 Allan AGL. Reluctance of anaesthetists to perform awake intubation. Anaesthesia 2004;59:413.
Appendix

University Hospitals of Morecambe Bay
Guidelines for Awake Fibreoptic Intubation

These guidelines are to assist in the technique of awake fibreoptic intubation. Consideration must be made in each case about anticipated difficulty of ventilation, intubation and patient co-operation. Consider merits of awake vs asleep technique or surgical technique.

**Indications**
1. Known or anticipated difficult airway.
2. Known/suspected cervical cord trauma or unstable neck (e.g. severe rheumatiod arthritis) and risk of aspiration.
3. Consider in obesity or obstructive sleep apnoea.

**Contraindications**
1. Patient refusal/unco-operative patient.
2. Coagulopathy – nasal route may be difficult.
3. Care with periglottic masses – risk of developing complete airway obstruction or laryngospasm.

**NB** Core recommended technique is in bold italics – other variants are possible.

**Preparation**
1. Anaesthetic room:
   a. Intubating fibreoptic scope (+/- video stack).
   b. Endotracheal tube (ETT): 6.0 reinforced tube, softened in warm water.
   c. Drugs for inducing general anaesthesia when tube successfully in place.
2. Patient:
   a. Explanation of technique and consent.
   b. Consider premedication:
      i. Antisialogue: IM glycopyrrolate 400 mcg 30 mins pre-op.
      ii. Sedative: temazepam 10–20 mg orally.
   c. Identify more patent nostril.

**Procedure**
1. Positioning:
   a. Patient sitting up at 45º with operator facing.
   b. O₂ via nasal sponge in other nostril.
   c. Monitoring: pulse oximetry/ECG/NIBP; capnography ready to attach.
2. Airway preparation:
   a. Nose:
      i. Vasoconstriction/local anaesthesia: cocaine or co-phenylcaine spray.
     ii. Serial dilatation with nasopharyngeal airways and lidocaine gel to at least one size above size of ETT.
   b. Oropharynx: lidocaine spray or gargle.
   c. Larynx:
      i. Spray lignocaine through fibreoptic scope when vocal cords visible (can be via epidural catheter).
      ii. Nebulised lidocaine (can use up to 6 mg/kg 2% lidocaine).
      iii. Transtracheal injection (cricothyroid) 2–3 ml 2% lidocaine.
3. Sedation:
   a. To enable continual verbal contact with patient.
   b. Include hypnosis and opiate for anti-tussive effect, e.g. boluses of midazolam (initially 1–2 mg)/fentanyl (initially 25 mcg).
4. Technique:
   a. ETT mounted onto fibreoptic scope and lubricated.
   b. Fibreoptic scope passed through nose to pharynx under direct vision.
   c. Vocal cords sprayed with lignocaine (can be via epidural catheter).
   d. Fibreoptic scope advanced through vocal cords.
   e. ETT advanced with 90º anticlockwise rotation of tube.
   f. Visually check ETT is in trachea with fibreoptic scope.
   g. Confirm with capnography and induce general anaesthesia.
   h. Leave inflating cuff until very end.

**Hints for difficulties**
1. Ask patient to take deep breaths when tube approaching glottis.
2. If difficulty advancing ETT then try over-rotation (tube rotated 180º anti-clockwise then back to 90º) or 360º rotation.
3. Protrusion of tongue may help if oro-pharynx obstructing view.
4. If difficulty navigating nose, consider using blindly inserted ETT as conduit.

**Equipment checklist**
1. Intubating fibreoptic scope.
2. Size 6.0 reinforced ETT.
3. Nasal airways sizes 5 to 7.
5. Cocaine or co-phenylcaine spray.
6. 4% lidocaine spray.
7. Lidocaine gel.
8. Lidocaine 2% in 5 ml syringe to attach to epidural catheter.
9. Epidural catheter with end trimmed to remove side holes and connector attached.
Logbook keeping among anaesthetists

The Royal College of Anaesthetists recommends that all anaesthetists maintain a logbook in some format. It is a compulsory component of training and assessment for all trainees. Although most anaesthetists maintain some form of a logbook, many seem to experience hardware or software problems at some point.

When one keeps an electronic record of patient data, it is a legal requirement to register with the Data Protection Officer. We do not know how many anaesthetists knowingly or otherwise breach this rule. Trainees take home theatre lists for their logbooks, which can potentially result in a breach of patient confidentiality.

Survey
We conducted a survey on the methods of logbook keeping among all grades of anaesthetists in the University Hospitals of Leicester NHS Trust. Our aims were to find out about logbook keeping practice among all grades and to see if our local practice is in line with national recommendations for data protection.

Similar surveys were published in 1993 and 2000, which primarily focussed on trainee anaesthetists and did not cover aspects of data protection.

We sent a postal questionnaire to all anaesthetists working in the three hospitals in Leicester requesting information about various aspects of logbook keeping. Overall, 146 out of 203 anaesthetists responded – a response rate of 72%.

We divided anaesthetists into four grades:
- consultant (cons)/senior lecturer
- staff and associate specialist (SAS)
- specialist registrar (SpR)/lecturer
- senior house officer (SHO).

What we found
Whilst all trainees and SAS anaesthetists maintain a logbook, only 45% of consultants do so. PC based methods seem to be popular among all (53%) but consultants seem to favour Pocket PC and Palm based systems. 23% of consultants use paper based systems as the sole method, and other grades use them as a backup (see Figure 1).

The RCoA programs are the most commonly used, with 59% using the PC version and 23% using the Handbase version. Consultants and SAS grades favour self devised programs, and some SpRs also use MS Access and Apple MAC programs (see Figure 2).
Most anaesthetists (65%) take operating lists home and enter data daily (16%) or whenever possible (49%).

Lost data
Most anaesthetists have lost their data at some point; 51% have lost it once or twice, and 11% have lost it several times (see Figure 3).

Lost data from PCs is common for all grades of anaesthetists (40% overall). This was due to a failure to back up data in 37% of cases, and battery failure in 24%. Interestingly, none lost data because of loss of equipment (see Figure 4).

We found that anaesthetists often have problems generating reports. Half of the respondents described having problems with the present setup. Most anaesthetists think that the logbook closely reflects the clinical work that they do and most said they would maintain a logbook irrespective of the rules.

Interestingly, while virtually all anaesthetists admit awareness of the Data Protection Act, only 11% are registered with the Data Protection Officer. Many think they do not need to register as their logbooks do not contain any patient identifiable data (see Figure 5).

Why keep a logbook?
The RCoA regards the regular appraisal, assessment and review of trainees as an integral part of postgraduate education. Appraisal is also a non-negotiable requirement for all doctors employed by the NHS. The logbook can be an important source of evidence for both, and is compulsory for trainees at annual review towards their certificate of completion of training (CCT). The various reports generated from the logbook provide a wealth of information and can be used as evidence in assessing an individual trainee’s progress during
training. With the introduction of modular and competency based training, the logbook is becoming increasingly important in comparing quantity and quality of experience amongst trainees and in setting standards about acceptable levels of experience.

The logbook is the key to studying the impact of changes to training – the European Working Time Directive (EWTD) being an example in recent times. Although not essential for Consultant appraisal at present, logbooks might in future provide evidence of continued competency in technical skills and teaching for consultants, with revalidation now under review.

The e-logbook could be incorporated into an e-portfolio in which all grades of anaesthetists could maintain a complete record of their training, experience and achievements, to be used for appraisal, revalidation and even for job applications. Logbooks are here to stay.

Constraints

It is quite clear from this survey that the existing setup of logbook keeping among anaesthetists is far from ideal. We have no reason to believe that the situation in the rest of the country is much different from our trust. There are a number of issues that need to be addressed. Firstly, there is a clear need for a robust, foolproof, user friendly and reliable logbook software. Then there is the issue of potential breach of patient confidentiality when anaesthetists take home the theatre lists. Ideally, any data that can identify a patient should not leave the hospital premises. Many hospitals are now slowly becoming increasingly aware of this problem.

Data protection

Although there is a high level of awareness of the Data Protection Act, there appears to be some confusion about whether one needs to be registered. Most anaesthetists are of the view that if their logbook does not contain patient identifiable characteristics like name, hospital number and birth date, then they do not need to be registered. This is not the case. Anyone who maintains an electronic logbook is a ‘data controller’ and is required by law to register with the Data Protection Officer. The employers’ notification does not cover individual doctors’ computerised logbooks.

Notification is easy and can be done on the web at: www.informationcommissioner.gov.uk.²

It costs £35 per annum (deductible expense) and it might be prudent for anyone who has electronic records to notify. If however, the logbook were in a manual format, notification would not be necessary. The basic principles of patient confidentiality should however be followed. Guidance was provided through a joint statement by the RCoA.
Looking ahead

The RCoA and the AAGBI should take lead in developing such a national online system. This would not only help maintain secure individual records but would also help in comparing training experience in the various schools of anaesthesia in the country and in setting national standards. We just can’t be seen to be having an unreliable outdated system when even the orthopaedic surgeons have a robust online logbook!

Awareness about the Data Protection Act should be a part of the induction process for new trainees. Trainees should also be encouraged to complete their logbooks in the hospital and not take the theatre lists home as they are patient records.

Response from Dr Chris Dodds, Vice President

Thank you for the opportunity to comment on this audit.

The e-logbook must be considered in the wider context of an e-portfolio, which will become increasingly important for all anaesthetists for a range of purposes, including revalidation.

The RCoA is evaluating how we will manage the process of revalidation for anaesthetists in non-training posts at the present time. Part of this will include the requirement to 'positively affirm' that our doctors meet the standards of care defined by the RCoA. One effective part of that process lies in the evidence provided by individual logbooks as part of their portfolio of professional activity. It is hard to see how clinical activity can be confirmed by any other form of evidence.

There is no doubt that this process will be much easier for all if we could provide a safe, secure and foolproof database within the College that allowed all Fellows to maintain their portfolio online. However, none of those descriptors (safe, secure, foolproof) is achievable in absolute terms. Current computing solutions will allow us to get very close though, albeit at considerable expense. We are committed to this development because we believe that such a database is in the interests of all anaesthetists. It will allow us to combine the recording of CPD activity, clinical work and other work for the wider NHS in one easily accessible portal.

Hopefully, once this is realised the problems of data loss and poor interrogation report processes will become of historical interest only.

References

2. www.informationcommissioner.gov.uk
5. www.elogbook.org
Preparing the ground

It was agreed that I would join her on the ward at 1.00 pm to meet with the patients prior to their operations. Subject to their consent, I would ‘sit in’ on their operations, permission already having been obtained from the Medical Director of the hospital.

I approached the afternoon with an open mind and a certain degree of nervousness having not experienced the inside of an operating theatre before – not conscious anyway!

Having seen Dr Cooper in action on a number of committees, I felt sure that her inter-personal skills would be excellent. However, I wanted to observe the relationship of the anaesthetist with the patient from the patient’s perspective, bearing in mind the demands and pressures presented in anaesthetists’ working lives. How did anaesthetists deal with the patient’s individual wants and needs before and after surgery, as well as during it? Was it possible to get the balance right?

The act begins

There were five operations scheduled for the afternoon, but this was reduced to three as one patient did not arrive and the other had their operation cancelled. This must inevitably be frustrating for all concerned but this was not apparent and the afternoon ran like clockwork.

All three patients were in different wards – fitness must be a requirement for all anaesthetists to get to each patient without seeming to be out of breath! All three were having different procedures and were of differing ages but the underlying factor that affected all three was their nervousness of being ‘put to sleep’. One patient when asked: ‘Do you have any questions or concerns?’ replied: ‘Yes, please make sure I come round, I want to wake up and live.’ Her anxiety was very apparent; tears filled her eyes. She really was in a state of terror about the idea of being ‘put to sleep’ and the possibility that she might well not wake up again.

I appreciate that patients will be nervous and the role the anaesthetist plays in allaying any fears. Body language, tone of voice and facial expressions go a long way towards reassuring those patients who really are terrified of the whole process – I include myself in that category.
On reflection
I began the day with an open mind; from my experience (and from the patient’s perspective) the following observations emerged.

- The anaesthetist plays a crucial role in inspiring confidence in the patient.
- The importance of the ‘team’ in any operation.
- The need for flexibility and adaptability in coping with changes to the list with very little notice.

In response to my original question concerning the balance between the role of a busy anaesthetist and the particular patient’s individual wants and needs I was pleased to note that it is possible to get the balance right. I accept, of course, that this may be easier to answer in the affirmative because the list was reduced from five to three on that particular afternoon. However, as a patient representative I can report my confidence that, despite the pressures faced by an anaesthetist, a patient can be secure in the knowledge that they are in safe hands. Not only will they receive high quality care delivered by trained professionals, but the anaesthetist will also able to address their particular wants and needs in the periods before and after surgery.

Team spirit
Once inside theatre, I was pleased to see that there was very much a ‘team’ spirit having heard mumblings prior to my visit that surgeons are somehow seen as more important than the anaesthetists. The atmosphere was very much one of unity with all the team playing a vital role in patient care. The team (including the surgeon) had the utmost respect for Dr Cooper and the skill involved in performing her role in ensuring the survival of the patient. I suspect that much of this is down to the individual concerned.

The relationship between anaesthetist and patient did not end there as Dr Cooper was on hand to accompany the patients to the recovery room. Back on the ward she was greeted with beaming smiles and effusive thanks from the patients and one in particular apologised for being so nervous prior to the operation.

Dr Cooper was happy to deal with any questions that I may have had during the afternoon including the temperature in theatre and achieving the right balance between the needs of the patient to be kept warm and of those working there to ensure that they are not too hot to perform safely. My thanks go to her for providing me with the opportunity to shadow her for the afternoon.

Body language, tone of voice and facial expressions go a long way towards reassuring those patients who really are terrified of the whole process.
Trust grade doctors
A personal view

Dr R Alladi,
Associate Specialist,
Tameside General Hospital, Ashton under Lyne

During the last few months readers might have noticed a sudden proliferation in the appointments for staff grade and trust grade jobs. I counted not less than 300 posts advertised within the past year.

Why so many?
The overwhelming reason for creating these jobs is to cover service needs in smaller trusts, particularly for out-of-hours work which is expensive to cover using consultants. Besides, junior trainees may not be experienced enough to cover obstetrics units, ITUs and some emergency work. Trust grade doctors and staff grade doctors cover both trainee and consultant sessions routinely depending on their experience. Most of the obstetric units and ITUs in smaller trusts are now manned by staff grade and trust grade doctors.

Foundation trusts have the ability to recruit trust grade doctors to fulfil their obligations without necessarily having to consider overall NHS management manpower planning.

There are a number of reasons why doctors take up these posts. Some doctors fail to climb the MMC ladder and wish to continue working in the specialty. Some have no intention of becoming consultants having embarked on a conventional training path. Other valid reasons are: failure in obtaining the Fellowship; a preference for an alternative work/life balance including part-time working; raising a family; and a desire to remain in one area. Such anaesthetists want career grade posts.

A variable picture
However, the creation of trust grade jobs is not the solution. Trust grade doctors do not officially belong to any established category or section of the workforce. They are not SAS doctors. The main concern is a lack of national guidelines for terms and conditions for most of these jobs. Who will be in charge of their training? Who will regulate them?

There is a tremendous variation in the nature of contracts offered up and down the country. Wise trust grade doctors will read the small print in their contracts and should ask the British Medical Association and the Health and Social Care Authority (HSCA) for advice regarding contractual issues.

Trust grade doctors are vulnerable as they have limited rights and at present no national organisation to support them. Most of them are on short-term contracts, lasting for one year. There is no security of employment and local trust budgets and priorities determine their fate. Their stress is compounded with the current predicted unemployment of large numbers of doctors in the UK and their need to meet financial obligations in terms of mortgages and family needs.
What should be done

In the past these jobs were covered by locums, overseas doctors and SHOs, but not any more. It is high time that the RCoA and the AAGBI considered the plight of trust grade doctors. These doctors will be playing a very significant role in providing anaesthetic services up and down the country and are responsible for the quality of anaesthetic service provided in NHS. Currently they are not included in the teaching programmes. There are no pathways for career progress. Remember, they may be inexperienced and need support and encouragement from national bodies.

How the trust grade might develop

Some sufficiently experienced trust grade doctors could be involved in the teaching and training of trainees. Trust grade doctors should be encouraged to develop specialist interests. Perhaps we might consider reintroducing the old style DA examination to assess basic competence in anaesthetics? This could give them an incentive to study and a qualification for trusts to take into consideration. It is time that trusts, consultants and trainees work together with trust grade doctors as members of the same team, as they already do with SAS doctors.

These views reflect my own personal thoughts and may not reflect those of the RCoA or the AAGBI.
Trust grade doctors
A view from the RCoA SAS Committee

Being granted foundation status by the government changes the relationship a hospital has with its staff and patients. As a foundation trust, the hospital is no longer accountable to the Department of Health but is instead accountable to its membership and a regulator (Monitor). It also has to abide by legally binding contracts with local NHS primary care trusts.

The trust has greater freedom to manage its workforce, its financial priorities and the delivery of healthcare to its patients. It must do this within a framework of external influences that include practice-based commissioning, payment by results, rising healthcare costs and increasing competition between hospitals for the referral of patients, not to mention the ‘loss’ of patients to the independent sector treatment centres.

Not surprisingly, there has been an increasing number of ‘trust grade’ or ‘clinical fellow’ posts being advertised and appointed, that are more financially attractive to an employer. Unlike staff and associate specialist (SAS) posts these are local appointments with local, not national, terms and conditions. As such they are no longer subject to the same rigorous quality assurance that can be had from an appointments committee with College input. Although foundation trusts are not obliged to include College input for consultant appointments either, at present most still appear to be doing so.

Individual considerations
With increasing competition for medical employment, there will be more doctors willing to take up such appointments. The onus will be on the individual concerned to ensure that there are opportunities for professional development embedded into their locally negotiated contract. It is imperative that any doctor considering a trust post clearly understands the role they are being asked to fulfil and insists on appropriate time for personal development.

Indeed, many trust grade contracts will mirror the terms and conditions of national SAS agreements, but the burden to ensure suitability now rests with the individual and the employing trust and not with the nationally agreed terms and conditions to be found in a standard SAS contract.¹

The trust has responsibilities too
Whilst the focus may be on service delivery, the trust still has to comply with good medical practice.² Every doctor, regardless of grade, is required to maintain high professional standards and embedded in this is the need for continuous professional development with life-long education and learning. The forthcoming plans for revalidation and recertification serve to reinforce this requirement.
A trust has a duty of care to ensure that its workforce has opportunities for continued education. Additionally, trusts will wish to invest in the quality of their workforce and, by providing support together with opportunities for development, they will ensure that they are able to provide high standards and excellence in the community.

What about the RCoA?
The SAS Committee of the College is aware of the rise in trust grade appointments and has long been concerned with the rise in non-standard appointments that are outside the nationally recognised frameworks. As befits any professional, maintenance of skills and opportunities for professional development are essential components of any contract, whatever the grade or nomenclature. For many years, we have encouraged all anaesthetists in the UK to attend meetings organised by the College and others for the purposes of continuing medical education.

Although the College has no statutory obligation to ensure standards and training for non-standard posts, we wish to promote and facilitate professional development in all grades of anaesthetists throughout the UK. To this end, we encourage any doctor practising anaesthesia in the UK who is not an NHS appointed consultant to join the College. There are various categories of membership and their requirements are available for viewing on the website. Membership of the College allows access to the support and advice that a recognised Royal Medical College can bring.

In order to meet the revalidation and recertification requirements set out by the GMC, every career grade – whether SAS, trust grade, clinical fellow etc – should have time to undertake clinical governance and personal development embedded in their sessional contract. We suggest that as an absolute minimum this should be one session per week for a full-time contract (or on a pro rata basis for less than full-time).

The College is primarily responsible for training, education and standards in anaesthesia, critical care and pain management, but has no statutory power to enforce any of the issues surrounding study leave and continuing medical education. As these are principally issues to do with terms and conditions, they fall within the remit of the British Medical Association (the medical trade union) and the Association of Anaesthetists of Great Britain and Ireland. This problem does not only affect anaesthetists on non-standard contracts in the UK: it affects all doctors who are appointed to NHS trusts on non-standard contracts.

Some deaneries are now beginning to develop an educational framework to support SAS and other grades of doctors. Such endeavours are to be welcomed and encouraged.

The educational components
The foundation for continuing education is the appraisal process. All doctors, irrespective of nomenclature, should be regularly appraised. This will inform the educational process and provide strategies for personal development.

Additional components include a job plan review and educational activities which may incorporate in-house programmes, regional or national study days, use of study leave and involvement with teaching and training.

In summary
- The future of trust grade and other nationally unrecognised service posts is uncertain.
- The direction of Modernising Medical Careers (MMC) remains to be determined but it is foreseeable that many of these posts will in time be subsumed into the ‘yellow box’ service posts as envisaged by MMC.¹
- The College offers different levels of membership depending on previous experience and training. Consider joining the College as a Member or Associate Member.
- College quality assurance is currently lacking for these posts unless specifically invited by employing trusts.
- Continuing education is a vital component of professional life and is to be encouraged.
- The onus for ensuring appropriate education and training is on the individual. Before accepting such a post it is incumbent on you personally to ensure that this is provided for in your contract.
- Many trusts do indeed include appropriate opportunities but this is not universal, and we advise that these posts are taken up with caution in full knowledge of their benefits and limitations.

References
1 NHS Employers Terms and Conditions of Service version 8, July 2007 (see: www.nhsemployers.org/restricted/downloads/download.asp?ref=464&hash=72ebc8bc76942e03e7d4b482b1781f0&itemtemplate=e_aboutus_3col_aboutus-2028).
3 MMC website interactive diagram of career structure in the NHS (see: www.mmc.nhs.uk/pages/interactive-diagram).
Notice is hereby given that an election to vacancies on the Scottish Board will take place on Monday, 3 December 2007.

Consultant members
Consultant members of the Board are elected by Fellows and Associate Fellows resident in Scotland. The first term of service for the candidate elected to this vacancy is three years and the second term is three years. Four consultant vacancies on the Board will occur in December 2007. These arise from the retirement of Dr John McClure and Dr Paul Wilson, after completing their full terms of office in this capacity, the completion of the first term of office of three years by Dr John Colvin and the resignation of Dr David Brown. Dr Colvin is eligible to stand for a second term of office in this capacity. Those eligible to stand are Fellows by Election, Fellows ad eundem, and Fellows by examination of the College of four or more years’ standing complying with the conditions of the Ordinances and Regulations and who are resident in Scotland.

The names of the eligible Fellows who have given notice that they intend to stand as candidates to fill these vacancies are:

1. **COLVIN** John Russell (Fellow: 1987) Ninewells Hospital and Medical School, Dundee.
   Nominated by: Dr N MacKenzie, Dr G Rodney and Dr S McLeod.

   Nominated by: Dr F Knox, Dr R Stephenson and Dr A J McDiarmid.

   Nominated by: Dr D W Noble, Dr P B Randalls and Dr G Adey.

4. **McLintock** Traven Thomson Christison (Fellow: 1985) Glasgow Royal Infirmary.
   Nominated by: Dr A MacLeod, Dr J L Plenderleith and Dr P A Wilson.

5. **McGRADY** Elizabeth Mary (Fellow: 1985) Glasgow Royal Infirmary.
   Nominated by: Dr J A Patrick, Dr J Kinsella and Dr T McLintock.

6. **HOSIE** Heather Elisabeth (Fellow: 1985) Southern General Hospital, Glasgow.
   Nominated by: Dr D Russell, Dr J M Crawford and Dr P MacKenzie.

7. **FERGUSON** Kathleen (Fellow: 1988) Aberdeen Royal Infirmary.
   Nominated by: Dr M Kumar, Dr A Howter and Dr J MacDonald.

8. **AZIZ** Talat Saeed (Fellow: 1994) Western General Hospital, Edinburgh.
   Nominated by: Dr G Jones, Dr S Rae and Dr D Duncan.

Dr Kate Wilson (Member: 2004) has given notice that she intends to stand for a second term for the Staff and Associate Specialist vacancy. As no other nominations were received by the closing date, no ballot is required. Dr Wilson is therefore returned unopposed, effective Monday, 3 December 2007.

Voting papers were sent by post on Wednesday, 17 October 2007 to the address registered at the College.

The election results will be declared as soon as possible after Monday, 3 December 2007 and will be published on the College website (www.rcoa.ac.uk).
NOVEMBER

- 13 November 2007 (code: C43) RESEARCH METHODOLOGY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £120
  (limited spaces)

- 14 November 2007 (code: C65) AIRWAY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £175
  (£150 for registered trainees)
  (limited spaces)
  Please see page 2347 for details

- 20 November 2007 (code: A12) INTRODUCTION TO TEACHING
  Royal College of Anaesthetists, London
  Registration fee: £180
  (£120 for registered trainees)

- 21–23 November 2007 (code: C11) CURRENT TOPICS MEETING
  INCLUDING SCOTTISH STUDY DAY
  National Museum of Scotland, Edinburgh
  Registration fee: £415 (or £150 per day)
  Please see page 2348 for details

- 28–29 November 2007 (code: C80) TEACHING METHODS WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £350
  (£300 for registered trainees)
  (limited spaces)
  Please see page 2347 for details

DECEMBER

- 4 December 2007 COLLEGE ASSESSORS TRAINING DAY
  The Royal College of Anaesthetists, London
  By invitation only

FEBRUARY

- 1 February 2008 SIXTH FORM OPEN DAY
  The RCoA presents a unique insight into choosing a career in medicine
  and anaesthesia
  The Royal College of Anaesthetists, London
  An invitation will be sent to schools in London. For other interested individuals,
  please contact the Events Department.

- 4–6 February 2008 (code: C68) CURRENT TOPICS MEETING
  The Royal College of Anaesthetists, London
  Registration fee: £415
  Please see page 2351 for details

- 6 February 2008 (code: B53) AIRWAY WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £175
  (£150 for registered trainees)
  (limited spaces)
  Please see page 2349 for details

- 20–21 February 2008 (code: C84) TEACHING METHODS WORKSHOP
  The Royal College of Anaesthetists, London
  Registration fee: £350
  (£300 for registered trainees)
  (limited spaces)
  Please see page 2347 for details

- 25 February–7 March 2008 (code: A82) FINAL FRCA COURSE
  The Royal College of Anaesthetists, London
  Registration fee: £540
  Please see page 2349 for details

MARCH

- 5 March 2008 (code: C96) AIRWAY WORKSHOP – CARDIFF
  Marriott Hotel, Cardiff
  Registration fee: £175
  (£150 for registered trainees)
5 March 2008 (code: D23)
ULTRASOUND WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £200
(£180 for registered trainees)
Please see page 2351 for details

12–13 March 2008 (code: A03)
ANNIVERSARY MEETING
PAIN MEDICINE: ADVANCES IN BASIC SCIENCE AND CLINICAL PRACTICE
Regent’s College Conference Centre, London
Includes the admission of Foundation Members to the Faculty of Pain Medicine (by invitation only)
Registration fee: £375
(£260 for registered trainees)
Please see page 2350 for details

18 March 2008 (code: A93)
CORE TOPIC MEETING:
ANAESTHESIA TODAY, TOMORROW AND THE NEXT DAY
The Royal College of Anaesthetists, London
Registration fee: £220
(£170 for registered trainees)

APRIL

7 April 2008 (code: C19)
AIRWAY DAY: RECENT ADVANCES IN AIRWAY MANAGEMENT
The Royal College of Anaesthetists, London
Registration fee: £210
(£180 for registered trainees)
Please see page 2347 for details

9–10 April 2008 (code: B36)
TEACHING METHODS WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £350
(£300 for registered trainees)
Please see page 2347 for details

11 April 2008
CLINICAL DIRECTORS MEETINGS
A joint meeting with the AAGBI
The Royal College of Anaesthetists, London
By invitation only

14 OR 15 April 2008 (code: C77)
ULTRASOUND – TRAINING THE TRAINERS
The Royal College of Anaesthetists, London
Registration fee: £250 for 1 day
Please register for details on our website

15 April 2008 (code: D04)
ANAESTHETIC EMERGENCIES – Glasgow
The Teacher Building, Glasgow
Registration fee: £220
(£170 for registered trainees)
Please see page 2347 for details

22 April 2008 (code: A74)
AIRWAY MANAGEMENT – TRAINING THE TRAINER
The Royal College of Anaesthetists, London
Registration fee: £175
Please see page 2349 for details

MAY

7 May 2008
DIPLOMATES CEREMONY
Kensington Town Hall, London
By invitation only

9 May 2008 (code: D08)
JOINT SAS REVIEW DAY
The Royal College of Anaesthetists, London
Registration fee: TBC

27 May 2008 (code: C85)
RESEARCH METHODOLOGY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £120
(limited spaces)

REGISTER
for programmes, prices and event codes by submitting a registration form. This can be found when clicking on individual event pages on our website.

NEW EVENT IDEAS
Would you like to organise an event with the RCoA?
If so, please visit our website and click on the new event ideas link (bottom left-hand corner) on the Meetings and Events page to complete a proposal form.

CORE TOPIC DAY – ANAESTHESIA TODAY, TOMORROW AND THE NEXT DAY
18 March 2008 (code: A93)
The Royal College of Anaesthetists, London

- Anaesthetic workforce planning, the national picture
- Anaesthetic workforce planning, a Trust’s perspective
- MMC and run-through training in anaesthesia
- The future of SAS and related grades in anaesthesia
- The Anaesthesia Practitioner programme
- The advanced critical care practitioner programme
- Re-validation

REGISTRATION FEE: £220
(£170 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

Further information – www.rcoa.ac.uk/events
TEACHING METHODS WORKSHOPS
20–21 February 2008 (code: C84)
9–10 April 2008 (code: B36)
The Royal College of Anaesthetists, London

An intensive two day workshop for all grades of anaesthetists, about the teaching techniques that are useful for anaesthetists who plan and participate in education programmes for medical students, anaesthetic trainees and consultants.

Day 1
❖ Introduction: adults as learners
❖ The qualities of teachers and learners
❖ Teaching practical skills
❖ Non technical skills
❖ Drinks reception

Day 2
❖ Small group teaching
❖ What is a small group
❖ Types of small group
❖ Small breakout group work – convergent/ divergent
❖ Group process/difficult personalities
❖ Commissioning and organising a lecture
❖ PowerPoint – the dos and don’ts

REGISTRATION FEE: £350
 (£300 FOR REGISTERED TRAINEES)
APPROVED FOR 10 CPD POINTS

AIRWAY DAY: RECENT ADVANCES IN AIRWAY MANAGEMENT
7 April 2008 (code: C19)
The Royal College of Anaesthetists

A series of lectures and interactive panel discussions covering what’s new in airway management in the UK such as:
❖ Video laryngoscopy
❖ Anticipated and unexpected airway difficulties
❖ Preparing for when things go wrong

You will also get the opportunity to ask any questions you have relating to airway management and have them debated in a supportive and friendly environment.

Comments from previous airway days:
‘Good clear take home messages’
‘It will change my practice’
‘Relevant to my practice’

REGISTRATION FEE: £210
 (£180 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

INTRODUCTION TO TEACHING
20 November 2007 (code: A12)
The Royal College of Anaesthetists, London

A one day meeting for all grades of anaesthetists which is designed to introduce doctors to the skills that are required to facilitate effective teaching and training. Subjects will include:
❖ Introduction, including an introduction to teaching adults.
❖ Teaching for small groups and tutorials.
❖ Teaching and assessing in theatre, including teaching practical skills.
❖ Educational supervisors.
❖ How to give a lecture.
❖ Using PowerPoint effectively

REGISTRATION FEE: £180
 (£120 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

ANAESTHETIC EMERGENCIES
15 April 2008 (code: DO4)
The Teacher Building, Glasgow

This course is suitable for all grades of anaesthetists including Consultants and Trainees.

It is a series of lectures surrounding the emergency situations that anaesthetists encounter, presented by experts in their field. This includes:
❖ Emergency anaesthesia
❖ Resuscitation and the complications of anaesthesia
❖ Critical care issues
❖ Consent in emergency situations
❖ Multiple trauma
❖ New criteria for diagnosing myocardial infarction

REGISTRATION FEE: £220
 (£170 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS
## Current Topics Meeting
### Incorporating the RCoA Scottish Study Day
21–23 November 2007 (code: C11)
at The National Museum of Scotland, Edinburgh

### 21 November 2007
- **Session 1:** Out of the Operating Room
  - Physicians assistants in anaesthesia: Is this the way forward?  
    Professor A Chambers
  - Airway management in the ER  
    Dr D McKeown
- **Session 2:** What every anaesthetist should know about...
  - Cardiac risk and surgery  
    Dr P Henriksen
  - Clots at the bedside  
    Dr A Nimmo
  - Protection of the brain following insult or injury  
    Professor P Andrews
- **Session 3:** What every anaesthetist should know about...
  - Renal medicine: drugs in renal disease  
    Dr C Whitworth
  - Sleep disorders: sleep apnoea and cataplexy  
    Dr T Mackay
  - Fast track bowel surgery  
    Dr S Nimmo

### 22 November 2007
- **Session 1:** Science in clinical practice
  - Sugammadex: pharmacology and clinical application  
    Professor R Mirakhur
  - Hips knees and boomps-a-daisy!  
    Dr D Semple
  - Thrombo-prophylaxis  
    Mr C Howie
- **Session 2:** On the fringe
  - Little white lies? A discussion of the placebo effect  
    Dr A O'Donnell
  - Pills, potions and lotions – herbs and anaesthesia  
    Dr J Hall
- **Session 3:** Creeping developments
  - ‘Kit, kilts and kompliance’ – the role of device regulation in anaesthetic safety  
    Dr T Clutton-Brock
  - What is new in the anaesthetic antenatal clinic?  
    Dr R Burns
  - Mechanisms of chronic pain  
    Dr L Colvin

### 23 November 2007
- **Session 1:** Scottish issues
  - Service and training issues in remote and rural locations  
    Dr P Wilson
  - Transport of the critically ill adult  
    Dr M Fried
- **Session 2:** Is devolution good for healthcare?
  - National Patient Safety Agency/SPSA  
    Professor P Davey
  - NICE/SIGN pronouncements from smoked filled rooms: which good old boys should you believe?  
    Dr P Alston
  - Specialty Training  
    Speaker to be confirmed
- **Session 3:** Training
  - Avoiding the GMC  
    Dr A-M Rollin
  - Training in pain medicine  
    Professor I Power
  - Ultrasound for vessels nerves: scud or cruise?  
    Dr J Barcroft

**REGISTRATION FEE:** £415 (£150 PER DAY)
**APPROVED FOR 5 CPD POINTS PER DAY**

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**A Joint Meeting of the Royal College of Anaesthetists and the Intensive Care Society**

### Ultrasound – Training the Trainers
**Focused Ultrasound Training in Anaesthesia and Intensive Care**
14 April 2008 OR 15 April 2008 at The Royal College of Anaesthetists, London (code: C77)

A one-day comprehensive course designed to empower trainers with the knowledge and practices to manage the delivery of training in vascular access/regional anaesthesia/pleura/lung and focused transthoracic ECHO (TTE).

The course includes small group workshops that enable delegates to use a variety of ultrasound equipment, suitable for consultants and post Fellowship SpRs.

**REGISTRATION FEE:** £250 FOR 1 DAY (INCLUDING COURSE CD-ROM)
**APPROVED FOR 5 CPD POINTS**

Further information – [www.rcoa.ac.uk/events](http://www.rcoa.ac.uk/events)
AIRWAY MANAGEMENT TRAINING THE TRAINER
A ONE-DAY SYMPOSIUM FOR TRAINERS AND COLLEGE TUTORS
22 April 2008 (code: A74)
The Royal College of Anaesthetists, London

This is not an airway workshop. This is a forum to empower trainers with the knowledge and practices to optimise airway training in the face of reduced trainee hours and training opportunities. At a time when airway training is under such pressures, we need to develop radical training methods which optimise every training opportunity to equip our trainees with the appropriate airway management skills. The organisers welcome contribution from all delegates of how they have overcome the challenges or difficulties to airway training in their own hospitals.

Experienced Faculty will cover the following sessions
Basic airway training (ST1 and 2)
Advanced airway training (ST3–7)
The use of airway simulators in everyday practice
Running airway workshops
Livelink for fibreoptic intubations
Teaching fibreoptic intubations on each other
National guidelines, College curriculum, airway competencies
Timetabling ‘airway training blocks’
Advanced airway fellowships – ST6/7

Course Organisers
Dr M T Popat and Dr S W Benham, Consultant Anaesthetists, Oxford Radcliffe Hospitals NHS Trust

REGISTRATION FEE: £175
APPROVED FOR 5 CPD POINTS

AIRWAY WORKSHOPS
LONDON – The Royal College of Anaesthetists
14 November 2007 (code: C65)
LONDON – The Royal College of Anaesthetists
6 February 2008 (code: B53)
CARDIFF – The Marriott Hotel, Cardiff
5 March 2008 (code: C96)

Each day is aimed at consultants who wish to ‘catch-up’ with current practice but is also suitable for trainees who wish to receive or top-up their mannequin experience of valuable airway skills. During each day delegates rotate around all the activities, usually in a group of no more than eight people. The workshops feature the core practical skills that are required by all anaesthetists and concentrates on difficult/failed intubation or ventilation. There are usually one or two interactive case-based discussion sessions.

Workshop organisers are experienced small group teachers.

REGISTRATION FEE: £175
(£150 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

FINAL FRCA COURSE
25 February to 7 March 2008 (code: A82)
The Royal College of Anaesthetists, London

This course is intended for those studying for the Final FRCA exam. The lectures run throughout the day, Monday to Friday and will be delivered by experienced lecturers and examiners. Participants will be entitled to attend four tutorials during the first week. These will run from 25–28 February from 4.30 pm to 6.00 pm. The programme covers various subjects but will include topics such as:

❖ Applied pharmacology in anaesthesia
❖ Management of trauma
❖ Respiratory failure and ventilatory support
❖ Paediatric Anaesthesia
❖ Thoracic anaesthesia
❖ Difficult airway

Comments from previous airway days:
‘Informative lectures. A good insight into the length and breath of the syllabus’.
‘Very useful and informative. Lectures were well organised and presented’.

REGISTRATION FEE: £540
APPROVED FOR 15 CPD POINTS

ULTRASOUND WORKSHOP
5 March 2008 (code: D23)
The Royal College of Anaesthetists, London

With a focus on clinical scenario, group discussion and hands-on skill practice, the ultrasound workshop will cover a number of topics using experienced small group teachers to improve knowledge and competencies in ultrasound guided regional anaesthesia.

REGISTRATION FEE: £200
(£180 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS

Further information – www.rcoa.ac.uk/events
Session 1: Pain – the basics
Pain mechanisms: neurophysiology of nociceptive transmission
Professor A H Dickenson, London

Epidemiology of pain
Professor G MacFarlane, Aberdeen

Session 2: Pain perception
Pain assessment
Professor H Breivik, Oslo
Psychology of pain
Professor S Morley, Leeds

Patrick Wall Lecture: Imaging pain
Professor I Tracey, Oxford

ANNUAL GENERAL MEETING
Session 3: Novel mechanisms
Pain and the immune system
Professor C Stein, Berlin
Ion channels and local anaesthetics
Professor G Strichartz, Boston

Session 4: New treatment strategies
Neuropathic pain – emerging treatments
Dr A Dray, Montreal
The therapeutic potential of cannabis
Professor J Zajicek, Plymouth

RECEPTION FOR ALL PARTICIPANTS

12 March 2008

13 March 2008

Session 5: Pain after surgery
Acute pain management
Professor H McQuay, Oxford
Post surgical pain
Dr W A Macrae, Dundee

Session 6: Cancer pain – mechanisms and management
Cancer Pain – a translational approach
Professor S Fleetwood Walker, Edinburgh
Professor M Fallon, Edinburgh
Interventional techniques for palliative care
Professor A Chambers, Aberdeen

Clover Lecture: Two thousand years of human rights and their impact on medical practice
Professor P Hutton, Birmingham

Session 7: Pain in different settings
Pain in children
Dr S Walker, London
Pain in the elderly
Professor D Weiner, Pittsburgh
Analgesia from a veterinary perspective
Professor P Flecknell, Newcastle

Session 8: The future of pain medicine?
Debate: Pain medicine or pain management?
Professor I Power vs Professor C Main
The Faculty of Pain Medicine
Dr D Justins, London
Admission of Foundation members to the Faculty of Pain Medicine

REGISTRATION FEE: £375
(£260 FOR REGISTERED TRAINEES)
APPROVED FOR 10 CPD POINTS

Further information – www.rcoa.ac.uk/events
## CURRENT TOPICS

**4–6 February 2008 (code: C65)**
The Royal College of Anaesthetists, London

### 4 February 2008
- **College issues: training, revalidation and workforce planning**
  - Dr J Hulf, President, The Royal College of Anaesthetists
- **Understanding evidence-based medicine**
  - Professor H J McQuay, Oxford
- **Stress response to surgery**
  - Professor G Hall, London
- **Current aspects of heart disease in non-cardiac surgery**
  - Dr M Patrick, Manchester
- **Medical management of severe asthma**
  - Speaker to be confirmed
- **Monitoring to improve outcome**
  - Dr D Conway, Manchester
- **Anaesthesia for vascular surgery**
  - Dr P Bayly, Newcastle

### 5 February 2008
- **Paediatric emergencies for the generalist**
  - Speaker to be confirmed
- **Keeping out of trouble in obstetric anaesthesia**
  - Speaker to be confirmed
- **Obesity and anaesthesia**
  - Speaker to be confirmed
- **Intensive care update**
  - Dr P Nightingale, Manchester
- **Upper limb blocks**
  - Dr B Fischer, Redditch
- **Sepsis update**
  - Speaker to be confirmed

### 6 February 2008
- **Advances in chronic pain management**
  - Speaker to be confirmed
- **Acute pain management**
  - Speaker to be confirmed
- **Excessive bleeding in surgical patients: why and what to do?**
  - Dr D Keeling, Oxford
- **Recognition and management of the difficult airway**
  - Dr M Mushambi, Leicester
- **Cardiopulmonary exercise testing**
  - Dr J Wilson, York
- **The surgical patients with stents: how to manage them**
  - Professor P Foex, Oxford
- **Controversies in fluid management**
  - Speaker to be confirmed

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### REGISTRATION FEE: £415

**APPROVED FOR 15 CPD POINTS**

THIS IS A DRAFT PROGRAMME AND THEREFORE SUBJECT TO CHANGE

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### ‘GUYS AND DOLLS’ SIMULATION TRAINING IN ANAESTHESIA AND CRITICAL CARE

The RCoA will be running a number of combined e-learning and one-day, hands-on workshops to be held three times a year. Please register your interest by email at: events@rcoa.ac.uk.

- Introduction to simulation delivered as an e-learning pre-load session undertaken in your own time prior to the workshops
- Simulation for practical procedures hands-on workshop
- High fidelity simulation in anaesthesia hands-on workshop
- High fidelity simulation in critical care hands-on workshop
- Simulation and working as a team hands-on workshop
- Building a business case delivered as an e-learning after-load session undertaken in your own time following the workshops
- Summary Delivered as an e-learning after-load session undertaken in your own time following the workshops

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Further information – www.rcoa.ac.uk/events
Our events are open to all grades of anaesthetists, unless specifically stated otherwise. When an event is full, this will be publicised on the website. To be put on a waiting list, please contact the Events Department on 020 7092 1670. We will then contact you as soon as a place becomes available.

All of our events have CPD approval of five points for a full day and three points for a half day, with the exception of FRCA revision courses, which carry a maximum of 15 points, for non-trainees only.

Lunch is included in the registration fee unless otherwise indicated.

This generic application form is to be used for all events. Further copies of the form are available from the College website.

Booking and payment

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**Cancellation policy**

- Notice of cancellation must be given in writing to the Events Department or by email to: events@rcoa.ac.uk at least ten working days prior to the event to qualify for a refund.
- All refunds are made at the discretion of the College and are subject to the deduction of a £35 administration fee.
- Delegates cancelling less than ten days before the event will not be entitled to a refund.
- The College will accept name changes for attendees, please inform the Events Department at least seven days prior to the event.

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- By cheque. A cheque for £ is enclosed (Sterling cheques should be made payable to ‘The Royal College of Anaesthetists’)
- By credit/debit card. Please debit my card by £ (tick appropriate box): V M I A

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| Card number: |

| Valid from: Expiry Date: Issue number (if applicable) |

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Anaesthesia and surgery in 1910

Dr D Zuck,
History of Anaesthesia Society

Professor George Jordan Lloyd (1854–1913) was a renowned Birmingham surgeon of the old school, a 'Brummie,' a 'character,' who was still spoken about with reverence by profession and public alike long after his death. The following account of the hazards and terrors of general anaesthesia and surgery is extracted from the diary of Marion Burt, a medical student who was a member of his firm. Mr Goodwin was JL's first assistant.

Anaesthetics

The day came when Mr Goodwin beckoned me to the anaesthetic room for instruction in the technique of anaesthesia. Why it was that J.L. preferred to do without the services of the Hospital's official anaesthetist, I could only guess, but it has never ceased to amaze me that he so readily accepted the whole responsibility, not only on behalf of his able H.S., who was in fact capable enough, but also willingly sponsored raw students like ourselves.

The next week I gave the anaesthetic under Mr Goodwin's guidance who was acting as first assistant to J.L. the while. It was the 'rag and bottle' method. Three drop-bottles beside me on the trolley and a metal mask with a covering of gauze over the patient's face. It became difficult at times to know whose instructions to follow. Mr Goodwin would sign to me: 'Take it off', but “Don't you fidget, Mr Goodwin; me an' the Dresser'll look after the patient. I'll see she don't kill 'im. Shove it on, my girl, or e'll vomit in a minute". Violent signs from Mr G. to take it off! Crisis!

“A new anaesthetist, Lloyd?” said an Honorary who had just floated in, half admiring, half condemning the apparently haphazard way (practised only by J.L.) of letting dressers give anaesthetics. “Yes, we try to teach our young people something”. But the dread of it was, in the language of our Chief: ‘the vomiting of the whole damned belly-full of guts out’ just at the critical moment. Then words waxed so fluent as to justify a drop-curtain. Spurred on by this the next thing was “Not breathing? Manipulate 'is head, my child; manipulate 'is head, why don’t yer; that's all 'e wants... Now finish it Goodwin... (and to me) Well, is 'e dead?”... And I went out to put the next patients comfortably under. All went calmly and well until a drawly voice remarked: “Yes, Miss Dresser, in less than two twinks the patient'll be in Paradise... Damn it, girl (voice rising to that shrieky pitch) why don't you take the mask off. You don't seem to know the difference between snoring and dying!” The crisis passed off satisfactorily.
Later on I found that a worse problem was anaesthetics for operations on neck and jaw. He would plant his arms strategically over the mask and face of the patient with forceps and retractors reaching far and wide. I had one hand with which to aim drops of chloroform over the bend in the Surgeon’s elbow or under his armpit whichever his rapid movements permitted at the moment.

“Why don’t yer keep ‘im under, Dresser? What? In yer way am I? Get under there then”. I would have to crouch down with my neck through the angle of his arm. He would not tolerate inhalers. Then, “Take that fool of mask away. A bit of lint!”... Then: “What are you doing with that disgraceful bit of rag? You ought to know better”...

He knew his patients before operation, and with some he made a point of speaking as they were about to be anaesthetised. “Now, look at your doctor and listen: you’re alright. Have faith in yer Doctor. Shut yer eyes and get off to sleep... Deep breath; now another; again (and she was off). See, Dresser, you must talk nicely to them and make them feel safe. You women are more sympathetic and affectionate than we are, but you’ve difficulty in giving confidence -- and less in obtaining confidence”. “Take her in. What idiot introduced these anaesthetic trolleys with all their fancy fiddles! Don’t want ’em. Two bits of lint and two bottles with slit corks are all the paraphernalia wanted for any anaesthetic”. He would have nothing to do with gags or tongue forceps but putting a stitch through the tongue was an exceptional sign of dire distress, manipulation of the head being of prime importance.

“Don’t you worry about the pulse AS LONG AS he breathes and has a fair colour... He’s pale. He sweats. Don’t like it. Lower the head... Don’t lose your heads, now. Damn it, you chaps, can’t any of you give a hand? (the operating table sticks as it is being lowered)... No! Get away with yer oxygen. Tie up the foot, Goodwin... Hot towels... Strychnine? Oh yes if it amuses yer... Now then; that’s better. Quick’s the word now...” And all went well with the patient henceforth.

One day, during a cleft palate operation the boy stopped breathing. “He’s bad” (this was an ‘in extremis’ formula). J.L hung the boy over the table and pumped air in and out of him by bringing his weight down on the ribs. The boy revived and prospered. “He was bad, very bad; but I knew we could get him back. There’s a look in the eyes, hard to describe, which tells you when it’s all up. You may go on pumping an’ whatnot till midnight but you’ll never bring ’em back. Yes, I’ve had fifteen anaesthetic deaths in my time. Fifteen! If they knew that, they wouldn’t be quite so ready to come to me”. But we thought that the number, compared with the critical nature of many of those he handled, was not so shocking. “Ah, Dresser, they wouldn’t look at it that way. And it’s a drawback of a surgical career that one is bound to make disastrous mistakes. It’s not very soothing to the conscience to know that if it weren’t for you someone might be alive now.”

An operative death

Another hectic business was gall-stone removal. Theatre Sister was on his right, I on his left, Mr Goodwin opposite, Miss H. giving the anaesthetic. Pulling one retractor away with the gall bladder while the other was hooked under the costal margin, my exacting chief would exhort: “Up with it; pull it up to the roof! Damn it! What a kid you are!” Fortunately, at that moment, knowing what the strain of the continuous up-drag on both hands was like, and at risk of unlimited oaths, the H.S. quietly exchanged hands with me for a time. The case, the only one I ever saw ‘go wrong’, was a woman of thirty eight. Many stones were removed from her gall bladder and one from the common duct. The gall bladder was hardened and going on for malignancy. It was excised but the woman died next day from shock and capillary bleeding.

“PM. done was it? No great haemorrhage, I hope? Ah, capillary. You gave her calcium lactate in advance. I’ve no faith in it, but it is as well to have given it. Shock. That’s what it was. She was a frail little woman. I might have known better than to excise. That killed her. Oh, yes it did. Undoubtedly: undoubtedly!... And all those kiddies, too”. It was quaint to hear the fatherly tones of the young H.S. (an FRCS of twenty five) trying to smooth out his Chief’s remorse, and ask how, in view of its malignant aspect, he could have done otherwise than excise the gall bladder, and how fit her general condition had been for it.

But our ‘firm’ did not hear the last of that tragedy for weeks. He would harp on his failures, and he used to recall the case of a child of six with acute meningism. Was it meningitis? Or pneumonia? Or appendical [sic]? Everything pointed to the first. She died that night and the post mortem showed suppurative peritonitis. “A common belly full of pus!! (his contempt for himself seemed boundless) Oh, it’s all very well you young people trying to make excuses for me but it’s about time I could diagnose which quarter is at fault. Thirty years at it; and can’t diagnose a common belly full of pus!”

Thoracotomy

Quite the most impressive thing we ever saw was the removal of a sarcoma of the chest wall over the pericardium. The previous day he told us all with unfeigned contempt how it was insisted that intrathoracic surgery must be done in a room where the air pressure could be mechanically graduated. All such elaboration was ‘mere fiddle-faddle’.
would do it with a siphon bottle. “A gallon lotion bottle and some rubber tubing, Goodwin. Now don’t you see how it’ll act?” bringing out an envelope and scribbling an explanatory diagram. Operating the next day he carved away the ribs and chest wall over the heart. As the thoracic cavity was opened the lung collapsed with a swish; the patient snored horribly and became livid as a plum: “Keep ‘im well under Miss. And ‘ere Dresser come ‘ee here: ‘ave you ever seen the human heart beating before? (holding the lung aside) See how the contraction begins in the great vessels and spreads down like a force pump. Look you: how full the right ventricle is over there. Now you can understand what I mean when I say that 70% of anaesthetic deaths result from over distension of that right ventricle beyond its recoiling point. When any muscle is stretched beyond that point it’ll never contract again.”

The growth and tags were finally eradicated and the wound closed, except for a tube, with a flap... “Now then, for the siphon!” An on-looking surgeon remarked: “I don’t see how you’ll get that lung fully expanded again”. “Oh, don’t yer: you wait. Start the siphon Sister.” The air gurgled out of the pleural cavity till there was no more to come, and a last stitch sealed it up. The patient made an uneventful recovery, leaving hospital the next day without a set back. Whether he ever had a recurrence I have not heard.

Gastric surgery
Of all the ‘ops’ the one I found most intriguing was that of gastro-jejunostomy, though it was one during which we invariably suffered a bad time. The rapidity, accuracy and ease with which he accurately stitched together the severed intestinal ends made us stand ‘lost in admiration’. “There, Dresser, do you think you could sew that up any better?”

Jaw cancer
Those which seemed to me the most ghastly to witness were for cancer of the jaw. He would chisel out almost the whole of the maxilla till the eyeball sagged into a bloody cavern continuous with the mouth and seeming to reach round to the back of the neck. Then he stuffed it full of soap [sic] and sewed the mess up into a face again: and next day we would see the patient sitting up and talking. We watched the progress from day to day with amazement which fortunately the patient did not share.

Cleft palate
Cleft palates, although pretty, were abominations. Junkers [sic], tongue spoons, head holding etc called forth thunder storms! “Now, Dresser, are you going to manage the tongue or the head?” I took the head — a more strenuous task than might be imagined by one who has never knelt on a tiled floor and taken a dangling head in unsupported hands for the best part of an hour. But I was favoured that day; “Now, give the Dresser a cushion to say ‘er prayers on... That’s it. Stick yer elbows on my thighs and support the head SO... No, I must have it so as the light shines on the uvula... That’s exactly it. Don’t you let it slip an inch. Now let me steady my arm on your shoulder... Getting tired Dresser? No? Then you must be in good practice at saying yer prayers”.

Relationships
The effects of the torrential abuse which not one of the team escaped had diverse reactions. Some were paralysed by it, some reduced to tears or fumbling confusion, others to sulks or even suppressed laughter. Notably, Mr Goodwin, whom, when next to me, I could sometimes feel jerking gently with controlled giggles while curses were hurled at his head. This an occasion for special rejoicing for us dressers who well knew that no one was held in higher estimation by our Chief than he was. Only the Theatre Sister remained completely immune, supremely capable and unmoved throughout.

She was an intimate of the Lloyd family. “Sister, how’s that? (having artistically completed a most intricate operation) Old Lloyd, ‘e’s getting past it, that’s what my colleagues say”. (And changing voice to squeaky levity) “There ain’t much old Lloyd don’t see, is there Sister? Oh, I saw the minute my House Surgeon fell in love. ‘E don’t go racing off to Kidderminster in the drenching rain on ‘is new motor bike for nothing”.

It is on the record that ‘the Prophet’ (second surgeon at the Hospital) was assisting him at a private op. of some severity one day. “Lloyd”, he said “I think we’d better ask the aid of the Almighty before beginning”. “No, we don’t want no unqualified assistance here” was the flash-back repartee.

More surgery
To return to our scenes in the operating theatre: “Now, where’s my big retractor, Goodwin? Asleep, are yer?” As Sister passed over the instrument it touched my face. The H.S. gave out an exclamation of annoyance, handing it over to the nurse by the sterilizer with “Sterilize it...
quick. Give it HERE! What’s the matter with yer? Touched ’er face, did it? Well, there’s nothing very dreadful growing on the Dresser’s face. In with it. None o’ yer fancy coccodoodles growing there, are there, Dresser?” Poor Mr Goodwin’s aseptic soul withered within him. I watched the case anxiously afterwards, but he thrived.

Some felt that there was something uncanny in J.L.’s ‘luck’. “See, I tell them to heal, and they heal”; he laughed with the air of a conjurer. He always professed a belief in wart charmers. On the ward the talk turned to hypnotism of which he was an advocate. He not infrequently used it on bad subjects for anaesthesia, so that they ‘went off’ with only a few drops to start. O’Brian held that he hypnotised all his patients. Certainly, as he stepped into the ward the worst of them looked hopeful and a new outlook and pluck seemed to come to them on listening to his: “Have patience; it’s a long job, but you’re better and we shall make old bones of yer yet”. O’Brian said his popularity was due to this kind of influence.

Comment
The conditions described may well be unbelievable to the present generation, but will bring back memories to anyone of pre-1945 vintage, because certain things had changed little some 30 years later. The chloroform and ether drop bottles were still in use, and I myself (DZ) was surgical dresser in 1942 to a chief cast very much in the Jordan Lloyd mould. Jordan Lloyd’s daughter, Dorothy, became a distinguished protein chemist, making several fundamental discoveries, and has a number of entries on the web. The diarist, Marion Burt, qualified in 1915, took the DPH, and spent most of her working life in the Birmingham Schools Medical Service.

Acknowledgement
A much fuller version of the diary was published in two parts in the 2006 and 2007 issues of Aesculapius, the Journal of the University of Birmingham Medical and Dental Graduates (Sands Cox) Society. We are indebted to the Editor, Dr R F Fletcher, for permission to publish these extracts.
Anaesthetists and the Mental Capacity Act – why it matters

The Mental Capacity Act 2005† provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It clarifies who can take decisions in which situations, and enables people to plan ahead for a time when they may lose capacity. It enshrines in statute current best practice and common law principles concerning individuals who lack mental capacity and those who take decisions on their behalf. It replaces earlier statutory schemes for enduring powers of attorney and Court of Protection receivers with reformed and updated schemes.

The Act applies to individuals who are 16 years of age or older and who are in England or Wales, and came into effect in full in October 2007. Scotland has its own legislation, the Adults with Incapacity Act 2000, which contains similar principles. Northern Ireland currently has no similar legislation, and common law applies. The Mental Capacity Act relates to the management of property and financial affairs, as well as healthcare and personal welfare matters. In relation to healthcare, there are a number of situations in which the Act will influence management of patients by surgeons and anaesthetists, in both the operating theatre and the Intensive Care Unit. It sets out in detail the manner in which lack of capacity should be assessed, and for the first time enables other people to provide or refuse consent on behalf of an incapacitated adult.

The Act is underpinned by five key principles.

■ Every adult has the right to make his or her own decisions and must be assumed to have the capacity to do so unless proved otherwise.

■ An individual must be given all appropriate help in understanding what is proposed before it is concluded that he cannot make a competent decision.

■ Individuals must retain the right to make what may be seen to be eccentric or unwise decisions.

■ Any decision made on behalf of individuals without capacity must be in their best interests.

■ Anything done for an individual without capacity should be the least restrictive of his basic rights and freedoms.

†www.opsi.gov.uk/acts/acts2005/20050009.htm
‡The individual may, of course, be female. The term ‘he’ is used only for the purpose of brevity.

Professor Alan R Aitkenhead,
Division of Anaesthesia and Intensive Care,
University of Nottingham
Assessing lack of capacity

An individual lacks capacity in relation to a matter if, at the time, he is unable to make a decision for himself because of an impairment of, or a disturbance in, the functioning of the mind or brain making him unable:

- to understand the information relevant to the decision
- to retain that information
- to use or weigh that information as part of the process of making the decision, or
- to communicate the decision, whether by talking, by using sign language or by any other means.

An individual is not to be regarded as unable to understand information if he is able to understand an explanation of it in a way that is appropriate to the circumstances, using, if necessary, simple language, visual aids or any other means. The fact that an individual is able to retain information for only a short period of time does not prevent him from being regarded as able to make a decision. The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or the other, or of failing to make a decision. A lack of capacity cannot be presumed merely by reference to an individual’s age, appearance, the presence of a specific disease or diagnosis, or any aspect of behaviour which might lead others to make unjustified assumptions about capacity.

Best interests

If an individual lacks capacity, the person who determines what is in his best interests must take into account a number of factors.

- How likely is it that the individual will at some future time have capacity and, if so, when is that likely to be?
- If possible, the individual should participate in decision-making as far as he is able.
- Consideration must be given, as far as is reasonably ascertainable, to the individual’s past and present wishes and feelings (and in particular any relevant written statement made when he had capacity), the beliefs and values that would be likely to influence his decision if he had capacity and other factors that he would be likely to consider if he was able to do so.
- If it is practicable and appropriate to consult them, views should be obtained from anyone named by the individual as someone to be consulted, anyone engaged in caring for the individual or interested in his welfare, anyone with lasting power of attorney (see below) and any deputy appointed for the person by the Court.
- If the decision relates to life-sustaining treatment, the person must not, in considering whether the treatment is in the best interests of the individual, be motivated by a desire to bring about his death.

Acts in connection with care or treatment

Provided that a person reasonably believes that an individual lacks capacity and that it will be in the individual’s best interests for a particular decision to be made, the person does not incur any liability which he would not have incurred if the individual had the capacity to consent and had consented. This does not alter civil or criminal liability for negligence, and does not apply if an advance directive exists and is relevant.

Lasting power of attorney (LPA)

An LPA is a legal document in which an individual (the donor), who must be at least 18 years of age and have capacity, confers on another person, the donee (who must also be at least 18 years of age), authority to make decisions in circumstances in which the individual no longer has capacity. An individual can appoint more than one donee, and may appoint them to act jointly or to act in respect of some matters only (e.g. one donee might be appointed to look after financial matters, and another to deal with healthcare decisions).

An LPA does not authorise the donee to perform any act which is intended to restrain the donor. Restraint is defined as the use or threat of force if an incapacitated individual resists, and any restriction of liberty or movement whether or not the individual resists. Restraint is permitted only if the donee reasonably believes that it is necessary to prevent harm, and if the restraint is proportionate to the likelihood and seriousness of the harm. The authority does not extend to making decisions if the donor regains capacity, is overruled by relevant advance directives but does extend to giving or refusing consent to the carrying out or continuation of treatment by a healthcare worker. However, the LPA does not authorise the giving or refusing of consent to life-sustaining treatment unless there is express provision to that effect in the document.

The Court of Protection and deputies

The Court of Protection is a new, specialist court which has jurisdiction to deal with decision-making for adults who lack capacity. It may sit on any day at any time, and at any place in England or Wales. In relation to its jurisdiction, it has the same powers, rights, privileges and authority as the High Court. Applications to determine whether a proposed action is lawful (e.g. withdrawal of nutrition and hydration of patients in a permanent vegetative state) will now be dealt with by the Court of Protection. Other cases may be referred there if there...
are ethical dilemmas in untested areas or conflicts between healthcare professionals and family members.

The Court of Protection may appoint a deputy if no LPA exists. The deputy has the powers of a donee under an LPA, except that the deputy cannot refuse consent to the carrying out or continuation of life-sustaining treatment, and can authorise restraint only if authorised to do so by the Court (in addition to the restrictions placed on donees).

The Public Guardian
The new post of Public Guardian is appointed by the Lord Chancellor. His functions are, among others, to establish and maintain registers of LPAs and of orders appointing deputies. His actions will be overseen by a Public Guardian Board.

Advance decisions
An advance decision is a decision made by a person of 18 years of age or more, who has the capacity to do so, that if, at a later time – in circumstances which can be specified – he lacks capacity to consent to the carrying out or continuation of treatment, the treatment is not to be carried out or continued. An advance decision does not affect the liability of a person for carrying out or continuing treatment unless the decision is, at the material time, valid and applicable to the treatment. An advance decision is not valid if the individual has withdrawn the decision at a time when he had capacity to do so, or, under an LPA, has conferred authority on a donee to give or refuse consent to the treatment to which the advance decision relates, or if, at the material time, the individual has capacity to give or refuse consent.

An advance decision is not applicable to the treatment in question if that treatment is not that which is specified in the advance decision, or if there are reasonable grounds for believing that circumstances exist which the individual did not anticipate at the time of the advance decision and which would have affected his decision if he had anticipated them. It is not applicable to life-sustaining treatment unless the decision is verified by a statement to the effect that it is to apply to an individual who lacks capacity but has nobody to speak for him. The IMCA makes representations about the individual’s wishes, feelings, beliefs and values and brings to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the individual lacking capacity if necessary. NHS trusts are required to make provision for appointment of an IMCA for an incapacitated patient who has no family members, carers or close friends.

The Act will influence management of patients by anaesthetists in both the operating theatre and the Intensive Care Unit

Research
Research involving an individual who lacks capacity may be lawfully carried out if a Research Ethics Committee agrees that the research is safe, relates to the person’s condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the individual that outweighs any risk, or, if it is to derive new scientific knowledge, it must be of minimal risk to the individual and be carried out with minimal intrusion or interference with their rights. Carers or nominated third parties must be consulted and agree that the individual would want to join an approved research project. If the individual shows any signs of resistance or indicates in any way that he does not wish to take part, he must be withdrawn from the project immediately.

Additional provisions
The Act includes two additional provisions to protect vulnerable individuals.

An independent mental capacity advocate (IMCA) is a person appointed to support treatment even if life is at risk, which must be signed and witnessed. However, with these caveats, an advance decision which is valid and which relates to the treatment in question must be respected.

Implications for anaesthetists
In a dire emergency, it is still reasonable, in a patient who, after careful consideration, is considered to lack capacity to consent to or refuse treatment, to provide life-saving treatment which is considered to be in the patient’s best interests. In patients who require management in an intensive care unit, or those who are considered to lack capacity to consent to elective or semi-elective surgery, steps must be taken to involve the patient’s carers to establish whether a valid LPA or advance directive exists, or whether a deputy has been appointed by the Court; if not, then it is necessary to involve an IMCA before proceeding with treatment. Only life-saving emergency treatment may be given without IMCA representation unless a valid LPA or advance directive exists.
Simulation and assessment
The initial assessment of competency in anaesthesia

Dr Caroline Whymark,
Consultant Anaesthetist
and College Tutor,
Crosshouse Hospital,
Kilmarnock

Ms Julie Hannah,
Resuscitation Officer,
Crosshouse Hospital,
Kilmarnock

Simulation is now well established as a means of training medical students and postgraduate doctors, including anaesthetists. Recently, simulation has been further explored as an assessment tool in anaesthesia and there is now a simulation station included in the OSCE part of the Primary FRCA.

It is well documented that training on a simulator improves performance and retention of skills when compared to traditional teaching methods but the evidence supporting its use in assessment is less clear. As clinical experience is diminished, reliable and robust means of both training and assessment must evolve. Assessment of competence is becoming more and more important to ensure standards are maintained, as training time and clinical exposure are reduced.

We have developed and introduced a simulated failed intubation scenario using SimMan 2 and have used it successfully to assess our new-start senior house officers (SHOs) performing this drill during their initial assessment of competency after three months of anaesthetic experience.

Here we discuss the benefits, difficulties and practicalities of the project and consider how to further use and improve the role of simulation in our specialty.

Background
Our hospital purchased a Laerdal SimMan 2 in 2005. This is an intermediate fidelity or instructor driven integrated simulator. The purchase was funded jointly from the undergraduate training budget and Additional Contribution to Training (ACT), and was sanctioned by the local medical education committee. Provision was also made to employ a Resuscitation Officer who would be responsible for the development of simulation training across the Ayrshire & Arran Hospitals Division.

This appointment was intended to ensure that the full potential of SimMan was utilised and to prevent it being used only as a (very expensive) resuscitation manikin or left unused in a cupboard – which has happened in other centres.

It was anticipated that SimMan would play a pivotal role in meeting the learning needs of undergraduates and postgraduate doctors within Ayrshire & Arran. A positive change to undergraduate training was confirmed through feedback from student evaluations and we are now striving to enhance the local training for junior doctors in a similar fashion.

Using SimMan for assessing anaesthetists
There are many benefits to having and using a simulator. These include practice and repetition of skills and drills and exposure to rarely occurring and/or emergency events. The simulator is a
valuable asset for teaching and assessing core competencies. However, simulation alone cannot be responsible for high-stakes assessments. The unpredictability of true patients is lacking, and scenarios are not usually allowed to progress to ‘patient death’. We do not know if performance on the simulator accurately predicts clinical competence and it does not test vigilance. Nevertheless, we decided to use our SimMan to carry out one aspect of the initial assessment of competency.

The SHO initial assessment of competency is perhaps the most important assessment of a new trainee’s ability. It is usually carried out after three months of teaching and training with level 1 (immediate) supervision prior to the trainee commencing on-call duties. The assessment should comprise a consensus view of the trainers. There are five components to the assessment:

- pre-operative assessment
- administering general anaesthesia for ASA I and II patients with both spontaneous respiration and mechanical ventilation
- cardio-pulmonary resuscitation
- clinical judgement, attitudes and behaviour
- performing a rapid sequence induction and failed intubation drill.

It is for this last component of the assessment that we felt simulation could add to the overall judgement of a trainee’s ability.

While a rapid sequence induction may be regularly carried out and assessed in the course of normal clinical practice, this is not the case for the failed intubation drill. The opportunity may not arise and it would be unethical to orchestrate one solely for the purpose of assessment.

Traditionally in our department, the failed intubation drill has been tested using a manikin. This is a low fidelity part task trainer. While useful in some respects, there is a definite lack of realism to many aspects of the experience. A more realistic simulated environment means the assessment reflects the challenges which occur in clinical practice more closely. As well as technical performance, behavioural attributes such as communication and interaction with other personnel in a stressful situation are also evident when utilising a higher fidelity simulator.

We had five ‘new start’ trainees in August 2006 and decided to use SimMan 2 to assess them performing the failed intubation drill at three months.

**Setting up the programme**

Previously, our SimMan had been used for sick patient scenarios with the focus on learning as opposed to assessment. Scenarios used for training have a degree of flexibility during programming, building and running, depending on the individual learner’s actions or omissions. In contrast, for the SHO assessment we felt it was fundamental to provide a robust scenario with realistic patient parameters that could be reproduced for each candidate. This meant that for every action undertaken by the SHO a predetermined change would occur in SimMan’s vital signs. For example, effective airway management and ventilation would result in increased oxygen saturation and apnoea would occur following induction of anaesthesia. For the programming to be successful it was vital to anticipate both the desired and non-desirable actions which may occur during a failed intubation, particularly should any of the candidates fail to run the drill as per protocol.

To develop a new programme for SimMan we established the expected actions and relevant parameter changes which would occur and the scenario was built realistically around these foundations. We included baseline parameters for heart rate, blood pressure and oxygen saturation, as well as the changes to these vital signs in response to the physiological stresses of induction, apnoea, laryngoscopy and intubation or failure to intubate. Capnography appropriate to adequacy of ventilation both before and after induction was included. Oxygen saturation was programmed to reflect pre-oxygenation, and the absence of ongoing oxygenation as failed intubation was declared and subsequently managed.

The success of simulation training is partly dependent on the environment and equipment replicating real life as closely as possible. Maximal educational benefit is achieved when the environment and equipment are familiar and readily available. It follows that this should also apply to assessments, and to replicate the physical environment of a failed intubation situation we took SimMan into the anaesthetic room. This was the first time SimMan had been used outside the postgraduate centre or resuscitation training room. The realism of the assessment was significantly increased for the trainees as it occurred in their normal work environment, and SimMan was on a patient trolley and attached to a familiar monitor. The trainees used a Bain co-axial breathing system attached to the anaesthetic machine as is the normal set-up in our department.

Whilst the physical environment is fundamental to simulation, other factors play important roles. It is beneficial to include team members who would ordinarily work together. We created a realistic skill mix by having one of our anaesthetic nurses act in her usual role assisting the SHO anaesthetists during the scenario.
On the day

Once SimMan was set up, monitoring was established and the airway equipment and anaesthetic machine were prepared as usual. We did a practice run of the scenario to allow everyone a chance to practise their role. Before the assessment began the trainees were introduced to SimMan and were allowed to familiarise themselves with its workings. At this time the airway was left without any modification to allow the trainees to practise mask ventilation, insertion of a laryngeal mask and intubation. For the assessment the trainees were brought back to the anaesthetic room one at a time. Before entering the room they were told they had to anaesthetise the patient who had an acute abdomen and to interact with SimMan as they would with any other patient. They were asked to discuss the drugs and doses they would use. Each trainee was given the same scenario and kept segregated from those still to have their assessment. In the anaesthetic room they were observed by two consultant anaesthetists (marking independently) and were assisted by the anaesthetic nurse.

SimMan 2 has many facilities to make intubation difficult. These include trismus, fixed neck, tongue swelling and laryngospasm. While running the scenario we chose to activate limited neck movement and tongue swelling. We felt this was most appropriate for what we were trying to achieve as it produced an airway which the trainees were able to ventilate and perform laryngoscopy on but which they were unable to intubate. All trainees completed the assessment satisfactorily.

Practical difficulties

We encountered very few difficulties considering these assessments were the first time the scenario had been run in real time. One trainee did manage to intubate the patient and we had to improvise by allowing oxygen saturation to continue to fall until he was obliged to remove the endotracheal tube and was instructed to proceed as for failed intubation. During programming we had omitted to activate the capnography trace during the pre-oxygenation phase of the scenario. This was an oversight. If queried by the trainees before induction, they were informed that the equipment was recalibrating at this time and were requested to continue. Fortunately, the capnography trace worked appropriately throughout the remainder of the scenario. This problem will be simple to address for the next time. The exercise was very labour intensive, particularly for the resuscitation team who set up and ran SimMan 2 in a new environment. This was worthwhile as we had five trainees who required assessment. It may be less practical, however, to set up for only one or two trainees, although we may find that with practice we become more efficient at the process.

Feedback

The feedback from the five trainees was informal and entirely subjective. All reported finding the experience incredibly life like and very stressful. Indeed, some had displayed shaking hands, pallor and sweating as the scenario progressed! They reported feeling very well prepared to deal with the situation should it arise in clinical practice although we have no objective evidence that this is indeed the case. We were pleasantly surprised to learn that the anaesthetic nurse had found the experience extremely valuable. Having been through the same scenario several times she felt the repetition had reinforced her knowledge and made her response to the situation more automated as the morning progressed. This has made us aware of a potentially large area in which to develop training using simulation for other members of the theatre, recovery and labour suite teams.

All reported finding the experience incredibly life like and very stressful. Indeed, some had displayed shaking hands, pallor and sweating as the scenario progressed!

Future

The role of simulation can and will increase in the current climate of training and assessment. We are currently modifying the programme for failed intubation drill to improve it in time for our new start anaesthetists in August 2007 who are sitting their initial assessment of competency later this year. We have the facility to use a webcam during simulations. One area for development is to use the webcam to record the trainees in action. This would allow the trainees to view their performances retrospectively, and to reflect on the experience. This is recognised as being a powerful feed-back tool. With our undergraduate training programme well established we are now working towards expanding SimMan to train personnel in other disciplines. Initially, we are developing a rolling multidisciplinary programme targeting Foundation Year 1 and 2 doctors and Hospital at Night practitioners. In addition to acute care skills, our programme will incorporate communication and team working skills. Simulation is likely to play a larger part in the assessment of competence in the years to come. We were fortunate to have secured funding to establish a purpose built simulation training laboratory within
our hospital, and this is almost complete and will be ready for use in the near future.

Summary
We have found using a simulator a great success in replicating a true to life failed intubation scenario and have used it successfully to carry out the initial assessment of competency in our new trainees. The experience has given us lots of ideas about how to further utilise SimMan in view of the reduced clinical experience and increasingly competency-based training programme that concerns the trainees of today.

References

At a meeting of Council on Wednesday, 19 September 2007, the following were admitted/re-admitted (re-appointments are marked with an asterisk):

Regional Advisers
There were no appointments or re-appointments this month

Deputy Regional Advisers
North Thames Central
Dr Indu Sockalingham, Lister Hospital (in succession to Dr Regina M Milaszkiewicz)
Dr Richard J Marks, Royal Free Hospital (in succession to Dr Colin I Beard)

College Tutors
Anglia
*Dr P E Hodgson, Norfolk and Norwich Hospital

Northern
Dr P Mowbray, University Hospital of North Durham (in succession to Dr P A McBride)
*Dr J J Fraser, Cumberland Infirmary

Yorkshire
Dr C L Hildyard, Dewsbury District Hospital (in succession to Dr T R Riad Henein)

Northern Ireland
Dr A M Chisakuta, Royal Belfast Hospital for Sick Children (in succession to Dr B V McCloskey)

North of Scotland
Dr K S Canavan-Holliday, Raigmore Hospital, Inverness (in succession to Dr C A Lee)

West of Scotland
Dr B M Miles, Stobhill Hospital, Glasgow (in succession to Dr D S Ure)

South West Peninsula
Dr Q J W Milner, Royal Devon and Exeter Hospital (second Tutorship)

Severn
Dr S Karadia, Cheltenham General Hospital (in succession to Dr S G O Rees)

South Thames East
Dr D Leschinskiy, Queen Elizabeth Hospital, Woolwich (in succession to Dr S M Robertson)
Dr M P Sinden, Kent & Sussex Hospital, Tunbridge Wells (in succession to Dr C H Taylor)

South Thames West
*Dr M Baruya, Mayday University Hospital

Nottingham & Mid Trent
Dr G O’Dwyer, Lincoln County Hospital (in succession to Dr A S Wolverson)

Wales
*Dr R H Walpole, Royal Gwent Hospital

West Midlands North
Dr P V Lalitha Vedham, North Staffordshire Hospital (in succession to Dr S J Mills)
The following recommendations were made to PMETB for approval, that **Certificates of Completion of Training** be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. The doctors whose names are marked with an asterisk have been recommended for a dual CCT in Anaesthetics and ICM.

**Bart's & The London**
- Dr Julia Susan Hadley *
- Dr Hemlata Ganapathy
- Dr Uta Monika Maria Bellin
- Dr Andrew Sean Michael Hopson
- Dr Dharini Sadanand Chitre

**Imperial School**
- Dr Madhusudhan Mali
- Dr Nadeem Murtaza Sabir

**North Central London**
- Dr Devendra Gobind Mahtani
- Dr Narasimha Prasad Vyakarnam
- Dr David Anthony Walker

**South Eastern School**
- Dr Paul Graham Hayden *
- Dr Ademayo Nojeem Adefewa
- Dr Santanu Mukhopadhyay
- Dr Michelle Leemans
- Dr James Alistair Barron
- Dr Andrew Orlando Wade *
- Dr Ziga Petrovic

**St George's School**
- Dr Andrew Gunatilleke

**Leicester**
- Dr Matthew Dolling *

**Mersey**
- Dr Syed Ayaz Lutfi Sulaiman
- Dr Lyndsay Susan Cheater

**Nottingham**
- Dr Jonathan Andrew Davies

**North West**
- Dr Thomas Hooson Owen *
- Dr Nicholas Henry Fraser
- Dr John Fraser Dougal Atkinson *

**Northern Schools**
- Dr Matthew John Haggett

**Oxford School**
- Dr Paul David Harris
- Dr Richard James Barnes

**Bristol**
- Dr Andrew Robin James Tillyard *

**South West**
- Dr Subhassish Duttagupta
- Dr Gillain Lindsay Ansell

**Sheffield**
- Dr Fareda Mohammed
- Dr Arshad Ghor
- Dr Johann Karl Scicluna
- Dr Kim Erica Russom
- Dr Ophillia Ziwenga

**Wales**
- Dr Doddamanegowda Benkappa Chetan
- Dr Sai Gopal *
- Dr Aida Mary Nadra
- Dr Paulo Francesco Giuseppe Antoniazzi

**West Midlands Schools**
- Dr Kodaganallur Parthasarathi Krishnan
- Dr Heather Jane Black
- Dr Anand Arora
- Dr Karuppudayar Sankar
- Dr Ravi Hebbali
- Dr Barbara Ochnio
- Dr Pushpalatha Linga Nathan

**Yorkshire Schools**
- Dr James Dominic Atkinson
- Dr Louise Barnes

**Tri-Services**
- Dr Glanville Owen Rhys Thomas

**East of Scotland**
- Dr Andrew Nelson Crockett

**West of Scotland**
- Dr Alasdair William Hay *
- Dr Calum Robert King Grant
- Dr Jonathan McHugh
- Dr Martin Francis McCormick
- Dr Linda Margaret Warnock

**Northern Ireland**
- Dr Gareth John Allen
- Dr Claire Ann Jamison

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**College Assessors/Scottish Panellists Day**

4 December 2007

All College Assessors/Scottish Panellists, please make a note in your diary that there will be an inaugural event for College Assessors/Scottish Panellists to attend on 4th December 2007 to debate current and future issues directly affecting your role.

More information will follow by email. If you are unsure whether Anita Mattis, AAC Administrator, has your correct email address, please forward your details to collegeassessors@rcoa.ac.uk.
No laughing matter

A recent Australian study\(^1\) has increased concerns over the safety of the use of nitrous oxide for prolonged surgery.

Nitrous oxide has been used as an anaesthetic since the late 18th century, and the side effects of the drug have been known for some time. Short term administration can cause postoperative nausea and vomiting, whilst prolonged administration may interfere with cellular synthesis of DNA due to an interaction with vitamin B12 and folate metabolism. This can affect the bone marrow and the central nervous system.

In the UK, approximately 6 million anaesthetics are given every year, with a significant proportion including the use of nitrous oxide as a supplement. With the advent of newer anaesthetic drugs and techniques including total intravenous anaesthesia (TIVA), use of the drug in the UK is now declining.

The Australian study suggests that there may be benefits in eliminating the use of nitrous oxide in patients having major surgery. However, it is not clear from the study whether or not the benefits were due to the elimination of nitrous oxide or the use of high concentrations of oxygen. The possible beneficial effect of high concentrations of oxygen during and after anaesthesia on wound healing and infection is controversial, and must be separated from the known side effects of nitrous oxide. High concentrations of oxygen can sometimes be harmful, particularly in babies.

With the publication of the article, the use of nitrous oxide will undoubtedly diminish further. However, further studies will be needed to ensure that the higher concentrations of any alternative agents, used in place of nitrous oxide, will be as safe for patients as the use of nitrous oxide has proved for over one hundred years.


Non-invasive ventilation

Increasingly, non-invasive ventilation (NIV) is being considered as the first choice as ventilatory therapy for the treatment of exacerbations of Chronic Obstructive Pulmonary Disease (COPD). This support is often given outside the ITU environment, sometimes without anaesthetic or critical care involvement, but providing sufficient resources for it is proving difficult. There is also evidence that patients with COPD who would benefit from invasive ventilation are not receiving this intervention despite predicted survival rates in excess of 50%.

Non-invasive and invasive ventilation for COPD patients raise both generic and specific issues. Access to intensive care remains a problem for all chronic diseases likely to be complicated by an acute deterioration. One major issue for intensive care medicine and anaesthesia is that non-invasive ventilatory support is often a prelude to invasive ventilation, and could result in delayed referral to intensive care.

Identifying the patient’s wishes beforehand, and educating staff in clinical management and outcomes, are important areas for development. The National Service Framework (NSF) for COPD wishes to improve matters and is seeking the views of a number of involved organisations, including the RCoA and the Intensive Care Society. Careful planning between all the involved bodies will be necessary to avoid any disconnection in planning future services.

Liver disease

The Department of Health (DH) has become increasingly concerned about the rising incidence of liver disease in the UK. The Chief Medical Officer originally highlighted the problem in his 2001 and 2002 annual reports, and a subsequent DH internal scoping review considered the impact of liver disease on the population and provided a broad assessment of liver services provided by the NHS.

It would appear that the prevalence and mortality are increasing at a faster rate than in other comparable European countries, with liver services generally insufficiently established to meet the consequent demands.

Preliminary work to pull together a fuller picture of liver disease and its causes has begun, with the formation of an expert group chaired by Professor Ian Gilmore (Royal College of Physicians) and a research team under Professor Eileen Kaner (Newcastle University). They are inviting contributions from a broad range of organisations. Hopefully their findings will aid an understanding of the problem and guide Ministers towards possible solutions.
Consultant job prospects following specialist training
Bulletin 45; Sept 2007: 2280–2282

Drs Asif and Crowley are to be congratulated on their detailed analysis of advertised consultant anaesthetist posts and their conclusions are cause for concern. I have been collecting this information since 1999, although not donning my anorak on a Friday evening to count the numbers as some have alleged! I am reassured that my data are remarkably close to those of Asif and Crowley although the news is very disheartening. In the categories that they have chosen to report I have recorded a total of 2,715 advertised posts (compared with 2,760 in their study) and data in the bar chart below are remarkably similar to theirs.

The authors make no mention of the potential inaccuracies of collecting data in this way. The good practice guidance of the NHS (appointment of consultants) regulations, updated in January 2005, requires a minimum of two advertisements, at least one of which must appear in a printed journal. It is not uncommon for the same advertisement to appear twice in the classified section of the British Medical Journal separated by a few weeks or more. It can be difficult to identify these and sometimes it is not always clear whether the advertisement is describing the same job or a different one. It is impossible to be sure whether an advertised post has been filled and, if not, whether the same post was re-advertised a few months later. Some advertisements do not specify the number of posts available. The conclusion is that the number of available consultant anaesthetic posts may be significantly less than the number of advertised posts. Although not affecting overall numbers of advertised posts, the categorisation of a post can also be difficult if, for example, there are sessions in cardiac and general surgery.

Despite these problems the authors have highlighted a downward trend in the number of advertised consultant anaesthetic posts — and I am afraid that my data support this. Estimates of the award of around 500 certificates of completion of training per year for the next few years are deeply concerning (Dr A Tomlinson, College Tutors Meeting, Cambridge, July 2007). A national strategy for workforce planning is urgently required but this cannot occur in isolation. There has to be an open and honest debate about how acute services should be provided and not whether but how they should be reconfigured. Unfortunately, this is not a vote winner! Within the specialty of anaesthetics and critical care, we need to decide whether to provide a consultant delivered or consultant led service and we also need to plan for the European Working Time Directive, which many trusts seem to be ignoring. I know that College representatives have been working for many years with the Department of Health to smooth out the peaks and troughs in workforce requirements but this is an almost impossible task; politicians avoid confronting such uncomfortable but important matters.

Dr P Spargo, Consultant Anaesthetist, Southampton

Annual comparison of total number of advertised consultant posts (by specialty) 2002–2006
Dr Asif and Dr Crowley have missed one factor in their article, perhaps because they wished to avoid the issue.

It is well known that most of the consultant posts that had been vacant for number of years due to the shortage of CCT holders have been filled by the doctors from new member countries of EEC during the last few years. Had this not happened, there would still have been more vacancies than the yearly output of British CCT holders, at least for a few more years.

They also suggest that the supply of specialists can be controlled by controlling the training numbers. Reducing the training numbers in NHS would only reduce the number of eligible British trained candidates for the number of jobs available. It would not stop any eligible EEC candidate applying. This factor is not taken in to account in the demand and supply equation in the job market.

Declaration of interest: I am a CCT holder without a permanent position.

Reply from Dr Asif and Dr Crowley
Thank you for your letter in response to our article. Our aim was not to analyse the demand for these posts and no reference has been made to applicants or the country of origin of any applicant for any of these 2,760 posts. The issue of EEC trained anaesthetists applying for consultant jobs has not been avoided but was simply not an objective in this study.

In our discussion we refer to the market forces of supply and demand; our article analysed supply rather than demand. In the current competitive consultant job market, NHS Trusts are looking for the highest quality applicants and competition is high. Some EEC trained CCT holders may be eligible to apply for advertised posts. Whether Trusts appoint them or UK trained applicants holding a CCT remains an issue for the individual trusts involved and not the authors of this article. We wish you luck in your quest for a substantive consultant appointment.

Dr Mark Crowley, Consultant Anaesthetist, Oxford Radcliffe NHS Trust
Dr P Asif, Specialist Registrar, Warwick Hospital

Informing patients: a ‘must’ not a ‘maybe’
Bulletin 44; July 2007: 2233-2235

I wonder how many of those who read Madeleine Wang’s article describing her ‘bit of a scrap’ with a surgeon who disagreed with the need to inform patients of the risk of inadvertent peri-operative hypothermia were on the side of the surgeon? I know from discussions in the coffee room that I am not the only one, and I do not know of anyone who actually does inform the patient of this risk.

I was recently informed by email that our new anaesthetic record will have a tick box to record that we have ‘discussed all material risks’ with the patient. But what can this mean? The verb used is “discussed”, so it is clearly not sufficient to have told the patient there are risks, or to have asked them if they have any questions, or even to have listed all possible complications. We know there are complications of which the patients are unaware, but we cannot know which of these may be of interest to the patient.

To ‘discuss all material risks’ with the patient can only mean we have to list all possible complications and discuss each one. It would seem not to matter whether or not the patients are interested – they must be discussed.

I realise some may view this as apostasy, but I suggest this course of action is:

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References

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In this article Drs Asif and Crowley make a fundamental error. They state ‘the BMJ’s classified job section claims to have 100% coverage of advertisements for all consultant posts.’ This is incorrect. Foundation trusts are not obliged to advertise in printed journals and may confine their advertisements to their own websites. Recently, a foundation trust advertised a post on its website during a holiday month. The closing date was six days after appearing on the website and the interview date was ten days after closing. I do not know if this was an isolated example or whether there are other similar instances. If it is happening elsewhere then it would reduce the reliability of the figures and might explain the apparent fall in advertised posts. It could also explain the reduction in posts with a sub-specialty interest as these may well be the sort of posts that are advertised in a limited manner.

If, with the increase in numbers of foundation trusts, this manner of advertising becomes commonplace, potential applicants would need some kind of search facility to scan these websites as one cannot expect to consult all hospital websites on a weekly basis.

Dr M Pegg, Consultant Anaesthetist, London
1 Impossible
No anaesthetist can have a complete knowledge of all side effects and complications reported of any given technique and of all drugs that may be used, not even for a standard general anaesthetic. Until a recent case report in Anaesthesia,1 I had never heard of the Takotsubo syndrome, and nor had anyone else I know. (I have not met anyone who claims to know of it since this article, but that is a different matter!) If patients want general information, then it could be argued that nowadays, with internet access, it is their responsibility to find out, and I will answer queries and supply information pertinent to the local circumstances, e.g. my own success rates at this particular procedure.

2 Impractical
If this policy is carried out, pre-operative visits would last 30–45 minutes, and theatre throughput would be severely reduced. If there were to be a complete discussion of the relative advantages and disadvantages of a tracheal tube vs a LMA, this alone could last easily more than 15 minutes – Brimacombe’s book on the LMA is over 600 pages.

Do our managers really want us to do this and to renegotiate our job plans because we now have to spend 30–45 minutes per patient on a pre-operative visit? Of course not – they want us to carry on as normal but pretend to do something different, so they can pretend to believe us.

3 Not required
How many patients want to be presented with a complete meta-analysis of every possible complication by their anaesthetist whom they have met a few hours before surgery?

Medicine could learn much from prospect theory, a discipline from economics that examines how individuals manage risk and uncertainty.2 Solutions Individuals presented with identical problems alter their decisions according to the context in which the problem is framed. Ask a question like ‘...do you want to know everything that could happen?’ of three different groups – a group of healthy people obtained at random, a group of patients who have suffered a medical mishap and are taking legal action, and a group of patients a few hours before surgery – and I suspect you will obtain a different pattern of answers from each of these dissimilar groups. Clearly, what happens in law courts is of relevance, but may not be a good guide to what is the right thing to do in normal circumstances. I always tell patients that there are many other complications that have been reported over the years and ask if they want to discuss these. No-one in over 20 years has ever taken me up on this, but clearly this is now substandard practice.

4 A flawed and ill-defined concept
When you ask advocates of the ‘tell all’ philosophy what is meant by ‘all material risks’, you obtain no clear answer. Generally, they retreat from the definition that it means ‘all risks’, but are unable to give a clear definition of what is ‘material’, and we are left with a number of dilemmas for which there is no answer.

What should you tell patients about complications that are rare and of which there is considerable uncertainty? The Takotsubo syndrome, referred to earlier, is an acute stress induced left ventricular dysfunction that can occur during general anaesthesia, and occurs mainly, but not exclusively, in Japanese females. There is some uncertainty about the exact nature of the syndrome or even if it exists as a distinct entity. Even if you knew of its existence, should everyone be warned of this syndrome, or only women, or only Japanese women? Should the patients be told it might not actually exist at all?

What should you tell them about complications that have occurred only once?

What about complications that have not yet occurred? Some complications will be sufficiently rare not to have occurred yet. Logically, we should warn the patients there might be complications about which we can tell them nothing because they may be the first to experience them.

Should they be warned of the possibility of hospital fires (if the theatre fills with smoke, we may have to evacuate theatres and leave them there!), pipeline misconnections, power failure, and of events that the insurance industry would call ‘Acts of God’?

I think that ‘discussed all material risks’ is such a vague and slippery concept that it almost devoid of any useful meaning.

Dr I Kestin, Consultant Anaesthetist, Glasgow

References

Mrs Wang has done an excellent job describing the current perspectives on paternalism and autonomy within the clinical arena, and the information needs of the patient which allow full autonomy. However, I can’t help but feel that these two concepts describe extremes of ethical behaviour, neither of which is fully applicable to the normal day-to-day patient interactions that occur.

The anaesthetist–patient relationship is unique. In few other medical situations does a doctor seek advice and input from a patient, and then completely remove their autonomy, only to return it
again once the job is done. As such, any autonomy is dynamic throughout a short, but intense relationship.

A patient needs to be rational and in control, in combination with being fully informed, to be autonomous. The provision of information is perhaps the easiest of these three elements and, in my opinion, this is generally done comprehensively and thoroughly. Rationality and control constitute more of a problem. The majority of anaesthetist–patient interactions occur either the night before, or on the morning of a planned anaesthetic. Rationality is altered by anxiety and fear; fear of anaesthesia, the unknown, loss of control and of the doctor or hospital. Control is disrupted by a strange location, lack of privacy, and absence of a usual support network, and is influenced by predetermined ideas, previous experience and baseline knowledge. How then can we apply the theory of autonomy to the majority of our patient group to whom all of these factors apply in varying degrees?

Along with full autonomy must go responsibility: for the extent of understanding the information offered, for seeking clarification, and for the ultimate decision made on the basis of this. What more can a pre-operative visit offer, if it is not the opportunity for the patient to ask questions and clarify any confusion or concern they might have? If we are truly applying autonomy, then our patients need to accept this responsibility and not seek to alter the situation retrospectively.

I agree with the principle of respecting the patient’s autonomy as far as any of our patients are truly autonomous. I feel that an approach balancing autonomy with paternalism, combining the best available evidence with the views and wishes of the patient and the beliefs and experiences of the doctor, is more likely to achieve a satisfactory outcome for all involved than the burdening of every patient with over-information and unrequested responsibility. In my opinion, all anaesthetists need to provide the appropriate information for the patient in front of them.

Dr J Stimpson, SpR Anaesthesia, Peterborough

Mentoring for self development

*Bulletin 44; July 2007:2225–2228*

The guest editorial on mentoring was interesting.

Anaesthetists, though part of a team, frequently work alone. Our conduct often sets the tone of an operating list, and most of us put on a good show.

Consultants can easily slip into a clinical groove over a period of time. Commitments and a busy workload could result in a missed opportunity to develop professionally in the broader sense, despite individuals fulfilling continuing medical education requirements depending on their interest.

The development of consultants is not a high priority for hospital management or the human resource departments, especially where it comes to service specialties such as anaesthesia. Over a period of time individual anaesthetists may therefore feel a sense of under-achievement.

Furthermore, if unfortunately there is a breakdown in the working relationship with a surgical colleague, this can cause great difficulty at work. Private practice can also interfere with open communication with colleagues.

A good appraisal process can help address some of the issues but appraisal is done only once a year and is moving from being formative to a summative process.

Mentoring could clarify the individual’s departmental role and prevent many problems. Finding a mentor may not always be easy, but it would help address many of the above issues and may lead us to a more fulfilling career.

Dr M Shah, Consultant Anaesthetist, Leeds

The party planners

*Bulletin 44; July 2007:2230–2231*

I read with interest and dismay Dr K McCombe’s article on the public perception of anaesthetists, further reiterated by the survey results of Dr M Wee and Dr S Mathieu in their letter in the September Bulletin (*Bulletin 45; September 2007:2314–2315*).

It’s a blow to the integrity of our profession that, despite the increasing role of anaesthetists in acute illness, intensive care, peri-operative care, and acute and chronic pain in the last decade, nearly 60% of patients were unaware if anaesthetists were qualified doctors and the majority considered us to be ‘technicians’. I agree that this perception needs to be engineered in a positive direction, perhaps towards anaesthetists being placed on the same pedestal as specialist physicians.

I believe that the following actions could contribute towards improving matters.

1. Spending some quality time with elective patients pre-operatively (possibly on the day before operation) or at pre-assessment clinics, introducing ourselves as doctors (rather than anaesthetists), discussing issues around pre- and post-operative care and advising on improving overall health.

2. Making regular post-operative visits and showing compassion and care
regarding post-operative issues. This will remind the patient of our wider role relating to surgery and recovery and will foster an appreciation of our role as doctor/anaesthetist.

3 The College could play a great role in increasing the exposure of undergraduates to anaesthesia and critical care in their curriculum training, as it will help to raise our profile with the younger generation and the community around them.

I can assure you that these suggestions work as I have known of anaesthetists who follow them and who have overheard or received messages from patients via ward staff – ‘Oh, that’s a nice doctor, isn’t he?’

Dr R Harish, Consultant Anaesthetist, Swansea

***

Thanks to Dr McCombe for her work into how anaesthetists are viewed by the public. I read with interest her views on how we can raise our profile. These included increasing our presence on television, National Anaesthesia Day, using patient leaflets and promoting our profession at an undergraduate level.

I propose a further way that could be used to raise our profile as a medical profession. This can be done during our routine pre-operative anaesthetic consultation.

This time should not only be used for clinical assessment and to plan the anaesthetic management with the patient, but could also be used for patient education. This education should be seen as part of the process of obtaining informed consent prior to anaesthesia.

Patients should know that their anaesthetic is to be given by a medically qualified specialist. They should know who we are, how we got there, what we plan to do to them and why. If they require further information and explanation, these should be provided in a timely manner with the details documented in the patient record.\(^1\) Patients should know that we are to be their advocate while they are anaesthetised – vigilant, dealing with problems that may arise, and never leaving their side until we have safely returned them to consciousness. Before I hear you cry that no time is made available for this extensive consultation, I remind you that it is our duty to provide good communication and sufficient information tailored to the needs, circumstances and wishes of the individual patient.\(^2,3\) Once this has been done, patient understanding and informed consent will follow.

Through this process, we will be able to change the public’s perception of us, one at a time and will gain their respect and trust. This will ultimately lead to better communication and the improved care that we strive to deliver.

‘Change in all things is sweet’

_Aristotle_

Dr N Christelis, Consultant Anaesthetist, Melbourne, Australia

References
3 Good Medical Practice. _GMC_, 2006.
The Royal College of Anaesthetists’ Bulletin is published bi-monthly and distributed to over 13,500 anaesthetists worldwide, the vast majority being in the UK. Being so widely distributed, it is obviously seen by many other professionals who work alongside anaesthetists.

Advertisements for courses and meetings from anaesthetic societies, or those organisations that are of interest to anaesthetists, are accepted with prior approval of the Editor or Editorial Board. Each advert is generally placed to the rear of the Bulletin amongst the other notices.

Text and any image, logo or crest should be submitted to Mrs Mandie Kelly or Mrs Edwina Jones by email (bulletin@rcoa.ac.uk). Please ensure that images are at least 300dpi in resolution and are sent as a separate file (rather than embedded within a Word document) which will ensure higher quality. Preferable formats are TIFF, JPEG, EPS or high-quality PDF.

The size of the advert is to some extent dictated by content and the layout of all adverts will be in keeping with the Bulletin style and design. Please note that we do not use loose inserts in any issue and cannot supply the names and addresses of our members for marketing or commercial purposes.

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PAYNE-STAFFORD-TAN
AN AWARD FOR CLINICAL EXCELLENCE

This award was established through the generosity of an American friend of the College, Mr Norman Knight. The aim is to mark excellence in clinical practice, teaching or research in anaesthesia, critical care or pain management. The award is open to any Fellow or Member of the College, and comprises a grant (to a maximum of £1,000) to be used for educational purposes such as attendance at a major conference or the purchase of educational materials. The recipient will be expected to provide a short report outlining how the funds have been used.

Nominations are now invited for the 2008 award, and must be made by a Fellow or Member of the College on behalf of another. The nomination should be in the form of a letter outlining the particular merits of the individual nominated, and should be accompanied by a full curriculum vitae. Nominations should be addressed to Professor D J Rowbotham, Chairman of the Academic and Research Committee at the College, before the closing date of Friday, 11 January 2008.
The Mersey Viva Weekend Series

The Aim of the Viva Weekend Courses is to Suffuse the Candidates with so much Exposure to the Viva Challenge that, on the day, they will be Immune to the Stress & Stupidity Which so often & unnecessarily Leads to Disaster

Final Fellowship Examination
2.00 pm Friday 30th November – 4.00 pm Sunday 2nd December

FINAL FRCA VIVA WEEKEND

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Primary Fellowship Examination
2.00 pm Friday 28th – 4.00 pm Sunday 30th December

PRIMARY FRCA VIVA WEEKEND

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POSTSCRIPT

Best viva result to date – 86%    Worst viva result to date – 79%
The Mersey Primary OSCE/Oral course
14.00 Friday 4th – 16.00 Friday 11th January 2008

OSCE/Orals Course 21st – 28th September

“Excellent course, very well organised”
“Thank you very much, well organised as always.”
“An excellent course. Good variation of activities during the day and flexibility of study time.”
“Helpful, friendly Faculty. Formal and informal at appropriate times.”
“Viva roundabout useful as were the silent osce etc. Master classes all very good.”
“Good course. Enjoyed and feel that I have learnt a lot.”
“Felt that this course was quite intensive and just what was needed to get candidates in the right mode for the exam. Facilities were excellent and the food facilities were fantastic.”
“Personally, I think it’s an amazing course. I can more than confident of passing the OSCE now.”
“Good. Focused. Useful viva/OSCE practice.”
“Put under pressure from the start. No shying away” approach – great!”
“Covered all worrying sections of exams. I feel prepared now and am aware of my weaknesses.”
“Really appreciate input from guest examiners and actors- very professional/constructive criticism. Interactive, stressful, no opportunity to shy away – exactly what I needed.”
“Learned more and progressed more this week than thought possible. Helpful faculty. A lot of my many concerns covered in this course. Many thanks.”
“Worth the time and money.”
“Finished 10 times more fine tuning than I could have done alone at home.”

“Best as ever. Thank you.”
“Very happy with the course overall, especially with the formal OSCE and viva.”
“Everyone was very helpful. Will definitely recommend the course to others.”
“It was a very excellent course indeed.”
“I have benefited a lot from this course. I have become more confident and my stress level has gone down while I face examiners!”
“Indeed I enjoyed this week long course very much...”
“Well done to All! Thank you.”
“Registrars and course organisers were extremely helpful. They were very good. Thank you.”
“Mike (On-Going Refreshments) had arranged everything for us very well. Thank you.”
“The course is worth the time and money. I am now more confident and more aware of how the OSCE and Viva work.”
“I think that the final set of ‘intelligence’ papers should be presented to us slightly earlier and then we have a little more time to go through it.”
“One examiner in viva (Friday) was very tough – had terrible facial expression and was almost violent in her verbal responses – she needs help!”
“Excellent preparation.”
“The course was brilliant!”
“I believe you have achieved your aim to create stress. I feel rubbish but much happier about the exam.”
“Dr Gray needs to chill out.**

MENU

Viva Presentation Skills
Machine Checking
Critical Incidents
OSCE Slide Show

Base of Skull
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Very Hard Work But Greatly Enjoyed & Well Worth It

*Dr Gray is now too old to “chill out” whatever that might mean
Deaths
It is with regret that the College records the deaths of the Fellows listed below.
Dr Yeshwant Bhojraj, Bombay
Dr Richard S W Bruce, Australia
Dr Louis Hamilton, Derbyshire
Dr Louis Khan, Middlesex
Dr Robert E Loder, Devon
Dr Peter Pyle, Shaftesbury
Dr Geoffrey Way, Surrey
The College is able to receive brief obituaries (of no more than 500 words), with a photo if desired, of Fellows, Members or Trainees.
The obituaries will be published on the College website for a period of three months, after which they will be moved to a permanent archive. Please email your text and any photo to website@rcoa.ac.uk.

Appointment of Fellows to
consultant and similar posts
The College congratulates the following Fellows on their consultant appointments:
Dr Fazil M Ashiq, Basildon Hospital, Essex
Dr John Barnes, Trafford General Hospital, Manchester
Dr Joseph J Carter, Queen Elizabeth Hospital, King’s Lynn
Dr Tim Murphy, Freeman Hospital, Newcastle-upon-Tyne
Dr John S Muthiah, Dumfries and Galloway Royal Infirmary
Dr Aidan J O’Donnell, St John’s Hospital, Livingston
Dr Nicholas J Pickstock, Lancashire Teaching Hospitals NHS Trust
Dr John L Pike, Pinderfields Hospital, Mid Yorkshire NHS Trust
Dr Khaled A Razouk, Wishaw General Hospital
Dr Dhandapani Sethuraman, Royal Liverpool University Hospital
Dr Claire E Waters, Whipps Cross Hospital, London

Apology
We apologise to Dr Jayesh Menon, recently appointed Consultant at Stepping Hill Hospital, Stockport, for listing his name incorrectly in the September issue.

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