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The views and opinions expressed in the Bulletin are solely those of the individual authors, and do not necessarily represent the view of The Royal College of Anaesthetists.

Don’t forget to visit the College website (www.rcoa.ac.uk/news) for the latest news items. You can also download the current and previous issues of the Bulletin (www.rcoa.ac.uk/bulletin).

Editor’s choice

Everest has always been a source of inspiration for speakers and writers. Politicians like Reagan and Thatcher have been unable to resist its allure when making grand statements about achievement, strength and perseverance; these contrast nicely with Edmund Hillary’s laconic first words on returning from the summit: ‘Well George, we finally knocked the bastard off’.

Whilst descending from the summit, members of the Caudwell Xtreme Everest expedition, led by Dr Mike Grocott, took arterial blood gas samples that yielded the lowest measured values of PaO$_2$ ever recorded in non-hibernating mammals. Read Mike’s account of this extraordinary venture, the largest ever high altitude research expedition, in ‘Understanding hypoxia in the critically ill’.

Perseverance has certainly been a feature of our profession’s approach to the safety agenda. In her President’s statement, Judith Hulf describes a recent successful conference, ‘Safety in clinical practice’, held jointly with the Association – an organisation that has promoted an aspect of safety for each of its 75 years since inauguration.

It was teamwork that ultimately ensured the success of Caudwell Xtreme Everest. But in looking back at past intensive care provision, Charles Gillbe and Julian Bion describe how the consultant intensivist was frequently unsupported by any of his colleagues. And teamwork is the key to another major endeavour – Andrew McIndoe and Ed Hammond give an update on: e-Learning Anaesthesia (e-LA), the largest single subject e-learning scheme in the world.

Pain medicine has got off to a good start too, with the formation of a new Faculty this year and 470 approved Foundation Fellows. Doug Justins, the new Dean of the Faculty, describes its scope and progress so far.

Finally, in an extraordinary and heartfelt letter from Singapore, Dr Tan describes his country’s experience of an ‘opt out’ system of organ procurement. Here, hospital staff received verbal abuse and threats of violence from relatives – surely food for thought if we are to consider introducing such a scheme to the UK?

Editor
The autumn at the College and in the President’s office has, as usual, been exceedingly busy. Churchill House is today (mid-November) hosting no less than 11 meetings; David, one of the reception team, tells me that this is a record. Every organisation related to medicine seems to hold its main social event in autumn and this President feels as though she is ‘dining for anaesthesia’; I well understand why Peter Hutton donated a set of bathroom scales to the President’s flat when he was President. The chance to creep away for a week and nibble on lettuce leaves would be welcome.

Safety
Despite such frenetic activity, the late summer and autumn of 2007 have been very positive times for the College. In mid October the College held the ‘Safety in Clinical Practice’ conference jointly with the Association of Anaesthetists. We were honoured by the presence of Her Royal Highness The Princess Royal, our Patron, who spoke to the audience and then listened to Dr Tim Cook presenting the work of the third National Anaesthetic Audit. Her Royal Highness visited the interactive exhibits on the education floors and met with representatives of safety agencies, manufacturers and others. She seemed particularly interested in the ‘SimMan’ demonstration where Professor Dodds played the role of the ‘trainee’ to Dr Clutton-Brock’s ‘trainer’.

I was delighted that Sir Liam Donaldson, the Chief Medical Officer, visited us on the second day. We were able to demonstrate that patient safety is, and has always been, the highest priority for anaesthesia. As they celebrate their 75th anniversary, the Association have produced a poster showing that they have promoted an aspect of safety in every one of those 75 years. This calendar of activity is impressive and should, in my view, be posted on the wall of every anaesthetic department.

Many thanks to all the manufacturers for their sponsorship and to those organisations that participated. Particular thanks must go to Tom Clutton-Brock, Laura Boyd, Charlie McLaughlan and Tara Wilmott and her team for the enormous amount of work that went into setting up this meeting.

The Tooke Report
In early October the findings and recommendations of the Independent Inquiry into Modernising Medical Careers, led by Sir John Tooke, were published. His report, entitled ‘Aspiring to Excellence’, is an exceptionally well written document and I am quite certain that many of you will have taken the time to read it. As you are aware, the College submitted written and oral evidence to the inquiry that did not differ in essence from that submitted by the Association and the Group of Anaesthetists in Training.

The report addresses the issues that the College wished explored in a clear and systematic fashion. Whilst it doesn’t shrink from illuminating clear failures, it does so in a manner that enables the professional bodies concerned to move forwards with defined tasks set. We welcome wholeheartedly the emphasis on a return to flexibility and an aspiration to excellence through competition.

Recently I had the opportunity to speak to the British Association of Indian Anaesthetists and for my talk had cause to look up the dictionary definitions of ‘competence’ (satisfactory) and
‘excellence’ (outstanding). I would say that there is no doubt that we want medicine, and in our case anaesthesia, to be ‘excellent’.

As Sir John Tooke has made clear both in print and verbally, the recommendations of ‘Aspiring to Excellence’ offer a singular opportunity for the medical profession to speak with one voice and to be heard and heeded. However, if we do not seize this chance and expend our energies in disagreement over detail, then we will have lost that opportunity for at least a generation, if not forever. I agree completely with this view, and feel strongly that we owe it to the future of the medical profession and to our patients to get on with the tasks set. We must restore the mutual trust within our profession and its reputation for excellence.

‘Aspiring to Excellence’ offers a route to all the changes that anaesthesia asked for in its submissions to the Inquiry. It presents, yet again, a Herculean task for the Training Department at the College and for training systems and trainers around the country. We will do our best to meet this challenge and I am certain that we shall succeed. We have the opportunity to build a structure for postgraduate training in anaesthesia that is sufficiently flexible to produce anaesthetists with the diverse medical background and anaesthetic expertise that has so enriched our specialty in the past.

Recruitment to anaesthesia in 2008
The recruitment process for 2008 opens on 5 January and so it seems appropriate here to try to give some outline for anaesthesia as we understand it in November 2007. As I write we do not know whether the recommendations of the Tooke report will be adopted.

One of the inevitable consequences of the chaotic recruitment to training posts in 2007 will be that, for the next few years, doctors training in anaesthesia will be following several different pathways. Those appointed to run-through training in 2007 have contracts that will stand; subject to satisfactory assessment, they will progress through training to CCT.

The MMC programme Board for England has made the decision that, for 2008, the recruitment process will be devolved locally to the deaneries. There will be no central computer system. I hope that for anaesthesia the units of application will be deanery based and largely centred on schools, which might make them geographically and logistically manageable. The legal judgement on the position of International Medical Graduates in November means that the number of applicants is likely to be very high.

The Tooke report sets out the principle of ‘core’ training; this was one of the key elements of anaesthesia’s ‘wish list’ in our evidence to the panel. Tooke has recommended that as from 2009, the second Foundation year will be taken into ‘core’ training, thus producing a three year ‘core’ programme. However for 2008, the two year Foundation programme will remain and so ‘core’ training can only be for two years.

Anaesthesia is one of the specialties that has elected to ‘uncouple’. This means that it wishes to have a competitive selection process between specialty training (ST) years 2 and 3, i.e. between ‘core’ and ‘higher specialist’ training. Thus for 2008 we will be recruiting into ‘core’ training of two year duration. If Tooke is adopted then in 2009 we will recruit into a three year ‘core’ programme. It is my fervent wish that all of the posts appointed at ST1 and 2 levels in 2008 and beyond are called ‘core’ training posts and will include all the current ST and FTSTA posts.

We must restore the mutual trust within our profession and its reputation for excellence.

Deans and schools of anaesthesia
Professor Steven Field takes up his post as Chairman of the Royal College of General Practitioners in November. As Postgraduate Dean in the West Midlands, Steve has been our Lead Dean for anaesthesia over the past four years. The College is grateful to him for the time he has devoted to us and for his wise counsel; we thank him and wish him well in his new role. Dr Fiona Moss, Dean in London, has agreed to take on the role of Lead Dean for anaesthesia and also that for the Acute Care Common Stem programme. Fiona is a respiratory physician and so has a considerable insight into the work of anaesthetists. I’d like to welcome Fiona in her new role and to say how much we look forward to working with her.

In London Fiona has also been tasked with setting up specialty training schools. The concept of schools is pretty ‘old hat’ for anaesthesia, though not for many other specialties. Rather than adopt the attitude that we do not want any interference in a system that works, I think we should view the new initiative by Deaneies in a positive light. This is an opportunity to ensure that the governance arrangements for schools are up to current standards and that they are on a firmer financial footing than many
have been in the past. It is only with appropriate funding that schools will be able to continue to deliver good training and provide the information necessary for quality assurance. Many schools struggle because funding has not kept up with their needs. It is also an opportunity for greater co-operative working between the profession and the Deaneries. There is no doubt that the College is uniquely placed to ensure that the mechanism for external specialty specific quality assurance is available to each school of anaesthesia. We have to maintain the closest communication at all times.

ACCEA
The list of national awards was published at the end of October. For anaesthesia, the numbers are even more disappointing than those of previous years, particularly at the level of Bronze awards. This is despite the hard work of the Regional Assessors in soliciting forms and advising their colleagues. There is a will in the ACCEA organisation to increase the profile of anaesthesia and ensure that the specialty reaches the level of awards in line with other specialties. I am afraid that we simply did not have sufficient forms of a high enough standard to achieve this in the 2007 round. I have said before that I do not believe the standard of forms reflects that of the anaesthetists writing them.

Over the next months the College will continue to work with the Association to assist our Fellows and Members in the presentation of their forms and to encourage them. We must not give up. I feel that we need to encourage those applying for local awards as much as, if not more than, those applying at national level. I would urge everyone to read the instructions carefully and to take advice from colleagues; those who hold awards or are experienced with the forms should offer to assist others. During the next few weeks David Whitaker, President of the Association, and I will be considering how we can help further. If you have other ideas then please let both of us know, and I would urge you to start writing the forms for 2009 now so that they are ready to go for the local and national processes. If you don’t produce the forms, we cannot help you or anaesthesia.

By the time this is published, Christmas will be upon us. May I finish by wishing you all ‘season’s greetings’ and offering you and your families my best wishes for a happy and healthy 2008.

Representation for anaesthesia
In November’s edition of the Bulletin I asked for volunteers to indicate their areas of expertise and their willingness to represent the College; we had a number of replies and I do thank the volunteers. If you haven’t yet been asked to help, then please do not think that we are ignoring you. Amanda, my Executive Assistant has your names on file and I am certain we shall call on you in the coming months.

Changes to the FRCA Examinations
Council is considering a number of changes to the FRCA Examinations to comply with PMETB’s conditions for the approval of the College’s CCT assessment systems and to introduce current best practice in those areas where assessment has moved on since the last major change to the FRCA Examinations ten years ago.

The removal of negative mark from the MCQ examinations, with effect from 1 September 2008, was recently announced. Further changes will be publicised via College Tutors and on the Examination pages of the College website as and when they are made. At least 12 months notice will be given of any changes.

PRIMARY MCQ EXAMINATION STANDARDS
The Examinations Committee is concerned at a significant fall in the standard of candidates presenting themselves for the Primary MCQ examination. Since May 2006 the overall pass rate has fallen from 64% to 40% whilst the success rate for first-time candidates has fallen from nearly 60% to 48%. This trend has increased since June 2007. At first the fall was attributed to the uncertainty created by MTAS but that is now behind us and should no longer be used as an excuse for poor performance. Now that eligibility is open to any registered trainee without the previous 12 months time constraint, it is possible that candidates are applying before they are ready. Please take all the steps you can to get the message across to your trainees that the standard of the Primary MCQ will not be lowered. Any potential candidate who cannot score on a test paper 55% with negative marking or 70–75% without negative marking should think twice before applying to sit the examination.
Educating doctors for the future workforce in intensive care medicine

To many of the readership of this article, HBN57 will be a meaningless phrase; those who like doing crosswords may try to relate it to Heinz Beanz Number. More prosaically it is the abbreviation for Health Building Note 57 (Facilities for Critical Care: HBN57: The Stationery Office for NHS Estates) which sets the standards for the contemporary structure of the built environment for critical care facilities. It was published in 2003 and superseded HBN27 (1993) which had been published ten years earlier. Importantly, it eliminates the absolute distinction between level three and level two intensive care in terms of facilities and makes important recommendations as to the physical environment in critical care units.

These include recommendations that will materially affect the dignity and privacy of patients and thus require changes in the operational management of intensive care units; other suggested improvements include increased bed space and storage.

A second but less well known standard document, namely that of ‘Standards for Consultant Staffing of Intensive Care Units’ was launched jointly by the Intensive Care Society and the Intercollegiate Board for Training in Intensive Care Medicine in May 2007. In summary the recommendations were:

- All newly appointed consultants with programmed activities (PAs) in intensive care medicine (ICM) should have acquired Step 1 competencies, or an equivalent level of training.
- All newly appointed consultants with >50% commitment to ICM should have acquired Step 2 competencies, a CCT in ICM, or an equivalent.
- All units must have a minimum of 15 PAs of consultant time totally committed to ICM each week per eight Level 3 beds.
- All consultants providing an ‘on-call’ service to the ICU must have PAs committed to ICM.
- Consultants should not have any other clinical commitment when covering the ICU during daytime hours.
- During working hours the consultant in charge of the ICU should spend the majority of his or her time on the ICU and must always be immediately available on the ICU.
- There must be 24-hour cover of the ICU by a named consultant with appropriate experience and competencies.
- A consultant in ICM must see all admissions to the ICU within 12 hours.
These two documents have between them defined the most optimistic future for the delivery of critical care in the UK for the next decade.

How we were...
The contrast with the ICUs in which the authors were trained could not be greater. These were crowded, noisy, chaotic, frequently poorly managed and had no truck with the concepts of patient dignity or privacy. Their medical staffing comprised one very dedicated consultant, usually an anaesthetist but occasionally a physician, who would frequently be doubly committed to the ICU and the operating room or clinic, and a variety of peripatetic junior staff who might be attached to the ICU for as brief a period as half a day. One-day attachments were the norm. The consultant intensivist was frequently unsupported by any of his colleagues and either remained on-call for the entire year for intensive care patients or relied on the intermittent support of his consultant anaesthetic colleagues whose knowledge of critical care was not necessarily contemporary.

Education and training in intensive care in the UK have therefore had to change dramatically to provide a workforce capable of managing patients in the new environment and to an acceptable standard.

...and how we are

Training in intensive care medicine in the UK at present

Nowadays, training in ICM is open to trainees in anaesthesia, acute medical specialties, acute surgical specialties and emergency medicine. As part of the curriculum leading to a CCT in anaesthesia, all anaesthetists undertake nine months training in ICM over periods lasting a minimum of three months each. Historically, the first of these is taken at SHO level and this now equates to ST1/2.

The second stage, which was normally taken in two three-month periods or one six-month period, is (rather confusingly) known as Step 1 training and, when combined with six months in the complementary specialty of medicine, is known as Intermediate level training in ICM. The purpose of Step 1 training is to equip anaesthetists with the skills required to recognise and manage patients with, or at risk of, critical illness until such time as the patient is handed over to an intensivist. Intermediate training, by including a period of acute medicine, enables anaesthetists to develop diagnostic skills which make them more effective members of the intensive care team.

Advanced training in ICM for a further uninterrupted year comprises a minimum of six months in general intensive care and a maximum of six months in specialties. The majority of advanced training posts have now been subsumed into programmes leading to a Certificate of Completion of Training (CCT) in ICM. This may only be acquired jointly with anaesthesia, acute medical specialties, acute surgical specialties and emergency medicine. The necessary components of the curriculum, approved by PMETB in January 2007, are indicated in Table 1 along with the indicative ranges of times. In practice, it is anticipated that most of the indicative ranges will continue in the three- and six-month blocks with the exception of Step 2 training, which must be taken in a continuous block.

Assessing trainees

The new curriculum lays a great deal more emphasis on the generic skills of being a doctor in the NHS. It also has a predefined assessment programme consisting of a test of knowledge and a series of workplace based assessments. The test of knowledge is at the very minimum for the acquisition of the Fellowship or Membership appropriate to the specialty of primary appointment of the trainee, but in the words of PMETB: ‘trainees must be strongly encouraged to sit the Diploma in intensive care medicine administered by the Intercollegiate Board’. In practice this is happening without great encouragement since trainees perceive acquisition of the Diploma as providing a competitive edge at appointments committees. It is also a quality indicator which addresses the concerns raised in the Tooke Report that competence should not be seen as inhibiting aspirations to excellence.

Five further sets of assessments are in use and Table 2 demonstrates the

| Table 1 Indicative training times (in months) for the joint CCT in ICM |
|---------------------------------|--------|--------|--------|
| Preliminary ICM                | 3      | 3      | 3      |
| Complementary anaesthesia      | 4      | 8      | 6      |
| Complementary medicine         | 4      | 8      | 6      |
| Core (Step 1) ICM              | 4      | 8      | 6      |
| Enhanced (Step 2) ICM          | 8      | 18     | 12     |
minimum frequency with which these are required. Mini-clinical evaluation exercise (Mini-CEX), direct observation of procedural skills (DOPS), case-based discussion (CBD) and multi-source feedback (MSF) are known collectively as the ‘Foundation assessments’ since they were first introduced for the Foundation programmes pilot schemes three years ago. In addition, during Step 1 training, each trainee must complete ten expanded case summaries. It is central to the new curricula in all specialties that the tenets of the GMC’s ‘Good Medical Practice’ (GMP) are observed and Table 3 illustrates the domains of GMP covered by each of the Foundation assessments.

Each element of the curriculum may be assessed by one or more of the techniques but it is clearly quite inappropriate to endeavour to assess each element individually.

The European Diploma in Intensive Care (EDIC) is often seen as an alternative to the UK Diploma in Intensive Care Medicine; some trainees prefer this diploma since it does not involve the production of a dissertation. Others find that both will give a competitive edge.

The European position
In 2003 a collaborative group led by the European Society of Intensive Care Medicine (ESICM) initiated the CoBaTriCE project (Competency-based Training in Intensive Care in Europe) to create a common minimum standard of intensive care education applicable to the whole of Europe. The competencies, curriculum and educational resources can be accessed via www.cobatrice.org. Developed using Delphi and Nominal Group consensus techniques, CoBaTriCE has now been adopted by many European countries, as well as Argentina, Chile, Malaysia and Hong Kong, with additional interest from the USA.

Future training...
The Intercollegiate Board is at present preparing a single free-standing CCT in ICM. The objective of this is not to replace the joint CCT in ICM available with other specialties of primary appointment but to allow those who are certain that they wish to become intensivists and do not wish to study anaesthesia or respiratory medicine to obtain sufficient grounding in the underpinning specialties of anaesthesia, surgery and medicine to practise as intensivists in a safe and competent manner. It is anticipated that the programme will last for seven years: the first two or perhaps three, depending on the outcome of the Tooke Report, will be based on the acute care common stem and the remaining five or four years will comprise further training in medicine, surgery, anaesthesia, intensive care medicine, imaging and clinical laboratory sciences.

This competency-based programme will be assessed using the Foundation assessment tools and more expanded case summaries; it will also have a test of knowledge consisting of a Primary examination and the Diploma examination, to be taken in the penultimate year of training. Thus the two streams, the joint CCT and the freestanding CCT in ICM, will both have an identical test of knowledge to assure quality. It is hoped that this programme will be approved by PMETB and will run from 2009 onwards, at first in a few pilot schemes only.

...and staffing requirements
The historic model of a small number of specialists and a similar or larger number of trainees in that specialty is only sustainable if there is progressive growth in the number of specialists or if there is great wastage at trainee level. Neither of these is desirable, or indeed, acceptable. It is also likely for quality assurance purposes that the majority of ICUs in future will have a fully qualified specialist on site day and night, 365 days of the year.

Adequate staffing will require a ratio of trained specialists to trainees of between 4:1 and 6:1, depending on demographic and other factors. For logistical reasons it may well be advisable to incorporate non-medically trained personnel to replace some of the more routine tasks carried out by junior trainees at present. Work is continuing to establish the grade of Critical Care Practitioner, but the precise role and, indeed, the whole shape of the workforce in the critical care unit of the future are uncertain.

Work is continuing to establish the grade of Critical Care Practitioner, but the precise role and, indeed, the whole shape of the workforce in the critical care unit of the future are uncertain.
Table 2 Schedule of assessments for the ICM component of the joint CCT in ICM

<table>
<thead>
<tr>
<th>Programme component</th>
<th>Minimum number of assessments</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary</td>
<td>MSF x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEX x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DOPS x 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBD x 1</td>
<td></td>
</tr>
<tr>
<td>Complementary medicine</td>
<td>MSF x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEX x 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DOPS x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBD x 3</td>
<td></td>
</tr>
<tr>
<td>Complementary anaesthesia</td>
<td>MSF x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEX x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DOPS x 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBD x 1</td>
<td></td>
</tr>
<tr>
<td>Core (Step 1)</td>
<td>MSF x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEX x 2</td>
<td></td>
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<td></td>
<td>DOPS x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBD x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expanded case summaries x 10</td>
<td></td>
</tr>
<tr>
<td>Enhanced (Step 2)</td>
<td>MSF x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEX x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DOPS x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBD x 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diploma in ICM</td>
<td></td>
</tr>
</tbody>
</table>

1 This amounts to a minimum of 37 assessments over an indicative period of 33 months.
2 The number of assessments will be determined by the apparent needs of the trainee using the above numbers as minima.
3 It is anticipated that the majority of trainees will require only the minimum number of assessments to convince the educational supervisor of the trainee’s ability.
4 The assessments are weighted towards the placement being undertaken.
5 The nature of the assessments reflects the increasing importance of the cognitive and social components of practice with progression through training.

Table 3 Relationship of assessments to ‘Good Medical Practice’

<table>
<thead>
<tr>
<th>Good clinical care</th>
<th>✔</th>
<th>✔</th>
<th>✔</th>
<th>✔</th>
<th>✔</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintaining good medical practice</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
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<tr>
<td>Teaching and training, appraising and assessing</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Relationships with patients</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Working with colleagues</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Probity</td>
<td></td>
<td>✔</td>
<td>✔</td>
<td></td>
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<tr>
<td>Health</td>
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</tbody>
</table>

Guest Editorial
The inquisition

I was standing in the witness box of an ornately decorated and grandiose coroner’s court. This was not my preferred way to spend a Tuesday morning on a hot summer’s day. Frankly, I would rather have been at the all day gynaecology list where I was scheduled to be. This was my first experience of giving evidence in (any) court. Hopefully, it will be my last. Most anaesthetists to whom I spoke had little experience in the legal aspects of medicine in which I now found myself entangled, so I thought I might share my experience.

Complicated by complications

Firstly, let me explain that the function of a coroner’s court is to determine the cause and mechanism of a death and not to apportion blame for that death. However, when a junior doctor gives evidence explaining the circumstances that led to the death of their patient, it certainly does not feel like that.

The events that culminated in this scenario occurred almost three years earlier, and I had been dreading the arrival of this day ever since. As a first year specialist registrar in a district general hospital, I found myself working in a busy ITU, where one of the elderly patients was being treated for pneumonia, cardiac failure and sepsis. Frankly, he was not making much forward progress – not an uncommon scenario, I think you will agree. After ten days of invasive ventilation a decision was made to perform an elective percutaneous tracheostomy. As you have probably gathered by now, the procedure did not go as planned and tragically the patient died of haemorrhage during the procedure.

The events of that day were extremely distressing for all the staff involved, but particularly for the family. Their command of English was not good and, therefore, they were understandably confused, upset and angry. A locum ITU consultant had performed the percutaneous tracheostomy procedure, and he has since relocated to the southern hemisphere. My own involvement was as the ‘airway controller’. When I received a letter from the coroner’s office informing me that my attendance was required in court I had rightly guessed that I would probably be the only doctor directly involved in the case available to attend.

Brief encounter

Barring the snippets of knowledge I had gleaned from Perry Mason...
and John Grisham, I realised I knew next to nothing of the maelstrom I was caught up in. I spoke to my friends, family and senior consultant colleagues. Most people, whilst being sympathetic towards my situation, were unable to enlighten me on the workings of the coroner’s court, so I sought out legal advice. I went home and began digging through my correspondence to find out which medico legal agency I had been paying into all of these years. My relief was palpable when I realised my membership was fully up to date. I contacted them and the advice I received was both informative and useful. I was advised to revise the medical statement that I had previously submitted to the coroner’s office. In hindsight I should have sent it to the medico legal agency first. They suggested I should retrieve the notes and discuss the case with the hospital’s legal department. Will the family of the deceased have legal representation at the inquest? If so, then I would certainly need legal representation of my own, as would the hospital involved.

Regarding the inquest itself I was informed the coroner would question me and the family could ‘cross examine me’, but could only ask questions towards finding out what the cause of death was, rather than seeking any blame.

Most of the advice I received seemed to be reassuring. I was told I need not worry – easy for them to say! This makes you think about our patients, the petrified ones in the anaesthetic room. When we tell them everything is going to be fine, do they believe us? Now I knew how they felt. I was guided to ‘just tell the truth, answer the questions directly, but not to elaborate further than the question put to me’. At my request to the hospital, the lead ITU consultant attended the inquest to provide the support that I needed. This at least made me feel I was not alone! Nonetheless, my anxiety continued to grow as I discovered the only other witness present would be the pathologist. Fear of the unknown meant a sleepless night for yours truly before the inquest.

**What do you call an anaesthetist in a suit?**

Putting on my best whistle, last worn at my job interview, I looked at least somewhat respectful and professional for the court. On arrival at the coroner’s court a female representative from the hospital’s legal department met me and escorted me up the imposing marble staircase to the grandiose courtroom. There really was a sense of drama about the proceedings. The coroner would sit high up behind a large bench officiating over the case, with everyone else below him.

I waited nervously outside the courtroom with the ITU consultant and the legal department official in the large grand lobby. I was experiencing similar feelings in my stomach to those I last had outside the Royal College on the day of the vivas. The press reporters were pointed out to me. Doubtless they would be there hoping to get a scoop to take back to the local newspaper. It all seemed a bit out of hand. Also waiting was a medical expert witness who would also be giving evidence to the court.

As the time approached for the inquest to start, the family of the deceased arrived in the lobby. With the grand surroundings, the whiff of lawyers, the starchy suits and the stares from the deceased’s family, I began to feel like I was myself the accused at a murder trial.

The coroner’s officer appeared in the lobby to show us all into the court. The family entered first and sat on one of the front benches that ran at a right angle to the coroners’ bench. The witnesses (including myself) were led in next under the watchful eyes of the family, and sat on the bench directly opposite them. It felt confrontational. Silence fell in the coroner’s court and we were asked to stand as the coroner entered. The case proceeded, with the coroner’s officer introducing us all to the coroner. The first witness called was the pathologist who gave testimony regarding the post mortem. This determined that the cause of death was upper respiratory haemorrhage from the tracheostomy, with contributing factors of aortic stenosis, ischaemic heart disease and sepsis. After his testimony the family were invited to ask questions to the pathologist. Looking somewhat stunned they consulted each other then the eldest son proceeded to ask a question from a prepared list. The first question related to the tracheostomy procedure and did not have any relevance to the post mortem. The coroner pointed this out and directed him to repeat the question to the next witness – me.

The coroner dismissed the pathologist and I was called upon to give testimony. After swearing to tell ‘the truth the whole truth and nothing but the truth…’ (yes this was what I really had to say!), the coroner began his questioning. Firstly, I had to introduce myself and give an account of my medical qualifications and medical experience. Then I was asked how many tracheostomies I had
performed. Although a predictable question, I was a little surprised by it. I had not expected to produce my logbook here, but perhaps it was still fair to ask. I rapidly searched my memory and came up with an estimated figure of 15 tracheostomies, which I hoped the court would think was sufficient experience to make me a credible witness.

Secondly, I was asked to give the medical indications and benefits of percutaneous tracheostomy in the ITU population. It felt like a viva! I delivered a standard FRCA answer, but it was confusing as to whom the answer was meant to be directed – you would hope the coroner would know. The family just looked perplexed and disbelieving.

The questioning continued with the coroner asking me to describe the procedure and then asking related questions that he thought would clear queries up for the family. Predictably, there were to be some questions from the family, and after 20 long minutes the coroner asked them if they would like to question me. This was the part I had dreaded the most. I felt like a lowly medical student on a grand round, internally praying not to be asked anything. ‘If you knew the operation could kill my father why did you do it?’ asked the daughter. Having been told repeatedly that a coroner’s court did not apportion blame I half expected the coroner to instruct me not to answer the question, but he did not. In attempting to answer the question I found myself using phrases like ‘risk/benefit judgement’ and ‘rare complication that in my (vast!!) experience I had never come across before’. The questioning continued, but I never felt the family fully trusted my answers to their questions.

After my testimony the expert medical witness was called. In this case the term ‘expert’ was not an exaggerated one. His list of qualifications, publications and experience was so impressive I could not comprehend how one person could achieve so much in one sole career. He must have entered university at puberty and never slept since! He answered questions about tracheostomies and reviewed the case notes giving a summary of the patient’s care. He was very supportive of the treatment we gave and when it came to the most important question – ‘Was the operation necessary and performed appropriately and safely?’ – he was able to categorically answer ‘yes’. My heart leapt.

The coroner finished the inquest and addressed the family directly. The family could ‘pursue further action in a different court’ if they wished, but he had no trouble in declaring ‘accidental death’ as the outcome of the inquest. Once again we stood for the coroner as he made his exit. Then I left the court and walked past the family on the staircase, as the local press was interviewing them. They did not appear to wish to discuss anything further with me, and I was happy to leave the building …and never return.

A free piece of legal advice
So what lessons have I learnt from this experience? Well, for starters, be prepared, read all the notes and statements and do some background reading. If you are involved in a case which could entail legal proceedings, prepare immediately. This may save time and heartache in the long run.

Secondly, get good medico legal advice from the start and find out if lawyers are required. Contact the base hospital’s legal department as soon as you can. Have a meeting well in advance of any proceedings. Contact your medical defence as early as possible and remember always to update your details with them – especially as you move up grades! Make enquiries around the hospital, as someone somewhere will have been down this road before. They may not advertise this fact and indeed the memory may be painful for them, but their empathy and advice may help you a lot. Make sure you take a friend, even someone non-medical. Despite not being on trial, it certainly feels like it. Prepare yourself for some archaic buildings and practices. Remember that although intensely unpleasant, it is a necessary part of our professionalism. Finally, never be the only one left in the country to be called to account!
The Patient Liaison Group Debates

Breakout from The High Chaparral

Mrs A Murray, Chairman

Many years ago my young son and I used to watch a late afternoon TV series called ‘The High Chaparral’. This was an early soap, set in a cattle ranch on the US side of the Mexican border, where men were macho and women simpered and swished their skirts a lot (when not having to be rescued by the men).

Everyone was very busy, galloping off to endless parleys concerned with managing the movement of cattle (MMC) or responding, generally with much indiscriminate shooting from the hip, to the latest unacceptable policy for marketing extremely tough beef (you’ve guessed the acronym). There was also a lot of activity around protecting the territory, which involved mending broken fences, diverting water courses and generally fending off attacks from unfriendly external forces.

The funny thing was that we didn’t see much of the cattle. It appeared that the folk of The High Chaparral were so tied up with the daily fight against fearful odds that they seemed to have completely forgotten about the animals which were the reason for running the ranch. The cows barely got a mention, and were usually only seen as a large herd being driven in a cloud of dust from plain to (mended) corral or reclaimed river. Sometimes the odd awkward beast was lassoed and brought in for treatment, which it received with vociferous reluctance – no informed consent or leaflets on ‘Your Branding Explained’ for these poor cows, then. (Or, for that matter, any recourse to the annual General Malefactors Corral).

Last September, when I became Chairman (no political correctness here, but I can assure you that I neither simper nor swish my skirts) of the Patient Liaison Group and was thinking about how the PLG – which apart from me consists of six lay* and six anaesthetist members, including a Vice-President of the College and a representative of the AAGBI – might direct our energies in the coming months, The High Chaparral came to mind.

Beefing about

Like the ranchers, we lay PLG members certainly haven’t been idle. We provide College committees with a lay view, and are not timid about offering criticism along with our support. We conscientiously read the plethora
The Patient Liaison Group Debates

that we would venture forth from the ranch, and we’ve set up a Short Life Working Group (three lay and three anaesthetists) to look at ways and means of liaising at grass roots level and which will report back to the PLG in mid-February. We’d like to reach the sort of people who, like the herds of The High Chaparral, aren’t much in evidence, and maybe don’t even realise that anaesthetists are doctors (as evidenced by Dr Kate McCombe’s article ‘The party planners’ in the July issue).

We provide College committees with a lay view, and are not timid about offering criticism along with our support.

If you have read this, and have any (helpful) suggestions to offer us, we’d appreciate hearing from you ASAP, either by email to plg@rcoa.ac.uk or note sent to me c/o Churchill House. Like me, my lay PLG colleagues replied to the College advertisement because we did have some insight into the work of an anaesthetist, and realise that you are probably the most important person in an operating theatre or ICU as far as our safety and wellbeing are concerned. Whether you are a younger doctor in training, or a more experienced practitioner, will you please send us your ideas for PLG patient liaison at a local level so that we can improve our advice to your College?

*Just in case you have an idle moment when at the computer, if you look at the wonderful new PLG pages on the College website (www.rcoa.ac.uk/index.asp?PageID=807), you will be able to see photographs of all of the members of the PLG. As I’m not exactly a whiz on the computer, it took me ages to discover that by clicking on the pictures you can read 50 (self-written) words about each of us. Maybe this will just confirm your suspicions about the type of people who apply to join the PLG, but then again, maybe not. We are potentially your resource – please use us.

On the range

At the September meeting of the PLG, it was agreed

of consultation documents and recommendations that emanate from the centre (or one of its tentacles), consider the implications from the patient’s perspective, and produce a timely response to either be included in or to separately complement the professional view. We attend relevant national meetings, sit on external working parties and provide feedback and so on, but by and large we have been reacting to external stimuli rather than pro-actively seeking input from the patients we aim to represent. Although we are required to make recommendations to Council on how we can improve communication with patients and improve patient liaison at a local level (in points 1.5 and 1.6 of the PLG’s Terms of Reference), of late we haven’t really been doing much about this, as we’ve been really busy doing other things. Of course, providing a lay perspective at national policy making level is extremely important, but so is listening to our ‘constituency’.

We are aware that it isn’t possible for us as individuals to represent the diverse views of all patients, but hope to be able to speak for their values and interests by drawing on our own experiences, contacts and knowledge. Those of us, who are engaged at a local level with patient and public involvement, know that anaesthesia and critical care (as opposed to pain management) do not have a high public profile, and we are also aware that it is often difficult for patients to separate out anaesthesia-related care from their overall experience. Knowing this, shouldn’t we be trying to do something about it, by gathering information from the hitherto silent (or at any rate unheard at RCoA level) majority of patients?

The Patient Information Unit within the College does a superb job answering queries received by email, letter and occasionally by telephone (1,500 over five years, many of which are from patients). Our own PLG pages on the College website* have also improved our outward communication with ‘savvy’ patients who use the Internet, but we need to consider how we might reach others, and liaise at a local level to enable us to gather the feedback we need in order to make truly informed recommendations to Council. How do we open up channels to listen to the ‘voice’ of the patient who receives care related to anaesthesia or an associated discipline? How can we do this from the viewpoint of our own Terms of Reference without entering the arena occupied by single issue lobby groups and coalitions?

*In case you have an idle moment when at the computer, if you look at the wonderful new PLG pages on the College website (www.rcoa.ac.uk/index.asp?PageID=807), you will be able to see photographs of all of the members of the PLG. As I’m not exactly a whiz on the computer, it took me ages to discover that by clicking on the pictures you can read 50 (self-written) words about each of us. Maybe this will just confirm your suspicions about the type of people who apply to join the PLG, but then again, maybe not. We are potentially your resource – please use us.
SAS doctors without a Certificate of Completion of Training (CCT) are not included in the specialist register. For those of us who are eligible, the Postgraduate Medical Education and Training Board (PMETB) allows an application for a CESR or Certificate of Eligibility for Specialist Registration via Article 14. Remember this is not a CCT, however, and does not allow free employment throughout the European Economic Union. CESR is only a standard of equivalence and not a qualification that is awarded following approved training that meets the minimum standards as laid down by European legislation. It therefore does not fall within European mutual recognition arrangements.

Article 14 applications are submitted to PMETB which checks that the applicant has included all the required evidence and that the chosen referees have submitted complete structured references as laid down in the regulations. Applications are then forwarded to the relevant Medical Royal Colleges for evaluation before being sent back to PMETB for a final decision. There are many people who complain that they are left waiting for months on end for the result of their applications, and wonder why. This process is very time consuming as, at each stage, the application is checked for completeness and accuracy. So it behoves the applicants to try and make life as easy as possible for PMETB and the Colleges by ensuring that their applications are as complete and accurate as possible.

The requirements for applying are clearly stated in the PMETB guidance on their website and this is updated regularly. Section 2.8 of the guidance document for applying for Article 14 also clearly states:

‘It is your responsibility to check regularly on the PMETB website and that of the College, Faculty or Joint Committee for your specialty to make sure that you have seen the most recent information and guidance.’

Reasons for delays in forwarding applications to the College for evaluation are many, but tend to be similar. Usually the delay is because an application is incomplete or because there is no response to a request for a structured reference from a referee. It is your responsibility to ensure that your choice of referees meets the stated requirements. This goes for the whole application too. As an example, the July update states that if you are applying after 1 August 2007, you will have to meet the standards required for a CCT at the time of application.

Your applications are referenced against the CCT standard of the College and there is a specialty specific guidance note on the PMETB website for you to use. This reflects the standards that need to be met against the General Medical Council’s ‘Good Medical Practice’ guide.

Completed applications are forwarded to the Equivalence Committee of the College for evaluation; each application is seen and assessed by at least three members of the Committee. Both Roger Laishley and I sit on the Equivalence Committee, so it is not solely consultants who sit in judgement. I would stress again that the committee members do take this role very seriously and take great pains to assess each application scrupulously and fairly. As a College, we try very hard to ensure that all applications are evaluated, decisions made, and forms returned to PMETB within the time frame specified. Remember, the clock starts when PMETB informs you that your application is complete, and not when you send your application in.

What does all this mean to those of you who are applying through Article 14? It means that you must read all the documentation on the PMETB website very, very carefully. You also need to read the CCT documentation for the College which is all available for download from the College website. You need to do your homework and compare your application evidence against the required standards to see if you stand a chance of gaining a CESR. It is no good applying ‘in hope’ or using the scattergun approach and sending every single piece of evidence you have thinking that it will be enough. If the evidence is not relevant, it won’t count! Above all, don’t rush your application: take your time to fill it in and good luck!

Resources
Caudwell Xtreme Everest:
understanding hypoxia in the critically ill

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Senior Lecturer in Intensive Care Medicine,
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On 23 and 24 May this year five anaesthetists, two GPs and a vascular
surgeon stood on the summit of Mount Everest along with two
cameramen and 15 Sherpas. This is the story of why they were there and
of the Caudwell Xtreme Everest expedition of which they were a part.

Caudwell Extreme Everest (CXE)
climbers on the Hillary Step

The 2007 Caudwell Xtreme Everest
expedition is the largest ever high
altitude research expedition. In April
and May, more than 200 volunteers
trekked to Everest Base Camp as
subjects of an investigational team of
more than 60 doctors and scientists.
Individuals aged 18–73 voluntarily
gave up three weeks of their holidays
to climb on foot to 5,300 m in order
to provide unique and extraordinary
scientific data.

The expedition set out to answer
two questions. First, which adaptive
changes explain alterations in
performance after prolonged
exposure to hypoxia? Functional
capacity is severely limited at altitude
in the face of normal oxygen
content. Sea-level aerobic capacity
does not predict performance at
altitude; indeed, elite high altitude
climbers have a remarkably normal
capacity for oxygen delivery and
consumption (VO\textsubscript{max}). Yet the
classical explanation of adaptation to
prolonged hypoxia (acclimatisation)
is built entirely around factors
relating to the flux of oxygen from
the atmosphere to the tissues. We
sought to understand if alternative
mechanisms at a microcirculatory or
cellular level had a key role. Second,
we sought to understand how
differences in the ability of individuals
to adapt to hypoxia relate to genetic
variations. Most members of the
research team have a background in
critical care and the reason we asked
these questions was to explore how
humans adapt to hypoxia during
critical illness. Heterogeneity of
premorbid state, presenting injury,
evolving critical illness, and complex
interventions are typical of any
group of critically ill patients. This
makes isolating and studying the
effect of a single variable, such as
hypoxia, extraordinarily difficult
– never mind the added complexities
of obtaining consent or assent for
studies in a very vulnerable group of
patients. The alternative approach
that we chose was to study healthy
individuals undergoing a homogeneous environmental hypoxic challenge. Our ultimate hope: to develop novel therapies for critically ill patients so that individuals who adapt poorly to hypoxia can mirror the responses of those who adapt well.

Origins
The expedition is the flagship project of the Centre for Altitude, Space and Extreme Environment Medicine (CASE) at University College London (www.case-medicine.ucl.ac.uk). Set up in 2000, CASE was the brainchild of a small group of young doctors fascinated in equal part by human physiology and adventure in extreme environments. The centre grew in the supportive environment of the successful group of anaesthesia and critical care researchers at University College London (UCL). The idea of an Everest related project was long in gestation. An obvious opportunity to investigate responses to hypoxia from the early days of CASE, the expedition plan grew from discussions in the pub in the late 1990s, into a project framework pulled together in Parisian street cafés by a group attending the 13th World Congress of Anaesthesia in April 2004.

CXE follows in a long tradition of Anglophone high altitude research on and around Everest. In 1960–1961 six doctors and scientists overwintered at 5,800 m on a glacier only a few miles from Everest Base Camp. The investigators lived in the eponymous Silver Hut. The Silver Hut team, living much lower than the highest altitude reached by the CXE team, was much more pioneering; it was unknown in 1960 if anyone could survive for so long at this altitude. The result was a vast amount of unique data that rewrote the textbooks of high altitude physiology. Twenty years later in 1981 the American Medical Research Expedition to Everest (AMREE) went higher still and conducted detailed studies on a small group of subjects at Everest Base Camp (5,300 m) and in the Western Cwm (6,300 m). Subsequently some of the team ascended to the summit (8,850 m) and made unique measurements including an extraordinary alveolar gas sample. From these data comes the closest estimate until now of the limits of hypoxia tolerance in humans. Several facts support the idea that the top of the world’s highest mountain is also very close to the limit of human hypoxia tolerance. When Hillary and Tenzing first climbed Everest in 1953, both used supplemental oxygen. A further 25 years passed before the first climbers reached the summit without using supplemental oxygen. Since then only about 100 of the several thousand climbers who have climbed Everest have done so breathing only air. More recently, the UK based Medex research group have taken larger numbers of subjects to the base-camps of several Himalayan peaks conducting several small parallel studies.

The study
The CXE strategy built on elements of all these expeditions and incorporated two distinct research approaches. First, and most importantly, we wanted to study a large population in order to achieve our goal of exploring difference between individuals and pinpointing the genetic correlates of phenotypic responses. Second, we hoped to make unique measurements high on the mountain in order to define better the limits of human tolerance to hypoxia. The primary hypothesis we tested was that differences in performance in hypoxia (at altitude) are due, in part, to factors unrelated to changes in global oxygen delivery. We therefore set out to identify changes in the microcirculation, in tissue oxygenation and in cellular (mitochondrial) ‘metabolic efficiency’ that might explain these observed variations in performance and organ function. The study design involved two complementary groups of subjects. The most valuable data derived from a 200-strong group of trekkers. These subjects allowed us to explore variation in response to hypoxia and test specific hypotheses. Alongside this group of subjects, a smaller sample of 24 climbers and investigators, ‘The Xtreme Team’,
studied themselves. They conducted more invasive and comprehensive studies, higher on the mountain and over a longer period. The aim of this group was to provide the novel ‘edge of the envelope’ physiological data relating to tolerance of profound hypoxia and to redefine the limits of what is measurable at extreme altitude. Meanwhile, at more alpine heights, the Smiths Medical Young Everest Study took the opportunity to acquire unique data on a small group of children aged six to 13 who were already visiting members of the team at the lower laboratories (up to 3,900 m).

A commonly asked question is whether we could have met our research goals by conducting a hypoxia study in a hypobaric chamber. Irrespective of the arguments in the altitude literature about the validity of results from chamber studies, there were several pragmatic reasons. We judged that it would be very difficult to persuade more than 200 people to give up their holidays to sit in a metal box, be experimental subjects for three weeks, and pay for the privilege! Practically, the limited supply of chamber places and higher cost of running such studies ruled out this option.

**Funding and media profile**

From the beginning, we recognised that it would not be possible to finance CXE from conventional biomedical research funding sources. The MRC, Wellcome and the major charities were not going to support the infrastructure cost of conducting research in such a difficult environment. Therefore, we set out to obtain the majority of our funding from commercial sources, specifically targeting pharmaceutical and biomedical device companies who could both readily appreciate the scientific value of the research, as well as recognising the PR and marketing advantages of being associated with the charismatic pull of the Everest name. The inevitable accompaniment of this approach was the need for a substantial and sustained media profile, and this was a primary element of our strategy.

We were fortunate early on to have a handful of ‘angels’ who funded, advised and assisted us with marketing and PR. Together we developed a brochure and staged promotional events. Following a press launch managed by the UCL press office, we were fortunate to be featured on the BBC News at Ten, and national and local radio in the spring of 2005. The result was the commitment of our first major sponsor: BOC Medical (now part of the Linde Group) who provided a substantial grant to underpin the research portfolio. Following our first ‘KnO2wledge: lessons learnt from life at the limits’ conference, BBC Horizon committed to filming a documentary about the expedition. During the summer of 2006, whilst lecturing at the Cheltenham Science Festival, three of the team were approached by the director of an American science centre. Unbelievable as it seemed to them at the time he suggested that MacGillivray Freeman, makers of the blockbusting Everest film in the IMAX format, were looking for a sequel. Three months later, after a trip to Laguna beach to meet the filmmakers, the deal was sealed. In March 2009 ‘Return to Everest’ will be released with Caudwell Xtreme Everest having a featuring role. The final piece of the jigsaw came in equal part due to serendipity and the efforts of ‘Yes Consultancy’ our PR agency. John Caudwell, billionaire entrepreneur and ex-owner of the Phones 4u mobile phone retailer, had signed up as a trekker early in 2006. Over the course of several months John became increasingly engaged with the medical goals of the project and in December of 2006 he donated half a million pounds to support the research. As a result, Xtreme Everest became Caudwell Xtreme Everest, our future was finally secure and John and his brother trekked to Everest Base Camp as two of our subjects.

CXE climbers high on the summit ridge with Lhotse behind
Planning and logistics
Although the Everest expedition was the centrepiece of Caudwell Xtreme Everest there were many other components. The programme of research leading up to Everest had included two previous ascents to extreme altitude (Cho Oyu, 8,201 m, sixth highest mountain in the world) in 2005 and 2006. Along with other field studies and extensive hypobaric and environmental chamber validation work, this allowed us to go to Everest with the confidence that our plans were feasible and our kit reliable. The project has been a massive logistical and organisational challenge. From the earliest days, we were very clear that our priorities were safety and science, with the summit a distant third. The team was divided into specific research, logistical and management groups with identified leaders and a clear brief. Partners with outside expertise, including our basecamp manager who organised logistics, and trekking and climbing support company ‘Jagged Globe’, were invaluable.

The practical obstacles to achieving the research goals were huge. Four substantial physiology laboratories had to be set up in remote, sometimes hostile, environments on the route to Everest Base Camp. Two further substantial laboratories were erected at Camp 2 (6,350 m) and on the South Col (7,950 m). In the end, we shipped more than 26,000 kilograms of equipment to Nepal. More than 400 60-litre plastic barrels, along with more than 100 ‘tough cases’ containing more than a million individually catalogued items, were delivered to the right place at the right time: a logistical tour-de-force. In Nepal we were completely dependent on the Sherpas who became our friends and companions for the three months of the expedition. They helped coordinate transport up to base-camp and were completely responsible for taking expedition and research kit high on the mountain. Above base-camp they are extraordinarily strong and are able to carry big loads high on the mountain; without them, none of the high altitude science would have taken place. At the peak of activity there were more than 60 investigators, 40 Sherpas and a logistical team of five, along with up to 112 trekkers in the field at any one time. Even now, five months after our return from Everest, there are still six team members on the payroll managing data and winding down the expedition machine. Experimental measurements ranged from simple physiological diary data to invasive real-time monitoring of complex cardiorespiratory variables. Transcranial Doppler measurements, near infrared spectroscopy, intra-vital video microscopy and complex neuropsychological test batteries were commonplace. Pre- and post-expedition testing has included structural and functional MRI. Whilst in laboratories back home, we are undertaking everything from simple biochemical tests to light and electron microscopy, functional mitochondrial assessment and proteomic and genomic analyses.

Gastrointestinal tonometry and muscle biopsy studies competed for the position of least popular study amongst the Xtreme Team!

The climb
Everest is a mountain that has claimed more than 200 lives. Minimising the risks associated with climbing the mountain was a key element of CXE planning. The Khumbu Ice-Fall and the final summit ridge are the two principal hazards. The Ice-Fall has a long history of tragic deaths due to the instability of this continually moving river of ice. The summit ridge presents a different problem: the large number of

The expedition set out to answer two questions. First, which adaptive changes explain alterations in performance after prolonged exposure to hypoxia?

Nigel Hart (left) and Mike Grocott on the summit
climbers on Everest means that congestion is a significant risk, with consequent delays and prolonged exposure to hypoxia, extreme cold and high winds. Our plan involved minimising exposure to the Ice-Fall by reducing the frequency and duration of trips through it, and deliberately ‘holding our nerve’ for the summit attempt in order to climb late in the season and reduce the risk of encountering congestion.

We also had the huge advantage of having a climbing support team. Whilst ten of the climbing team had the job of reaching the summit and obtaining the highest measurement of physiological variables, five others were specifically tasked with supporting the research and providing medical and rescue back-up for our team and any other climbers in need. We had anticipated the risk of ‘moral hazard’ that was likely to result from the presence of a large medical team high on the mountain: the possibility that other teams might be tempted to take greater risks in the knowledge that back-up was available. In the event the team were involved with two rescues above the South Col including a well-reported rescue of a young Nepali woman who had been abandoned by her own team.

Ultimately, the summit was reached by two teams over the nights of the 23 and 24 May. These were the last two nights that Everest was climbed from the South this spring. The balance between holding our nerve and missing the window of opportunity had been a fine one. Conditions on the summit proved too cold and windy for safe arterial blood sampling to take place. However, 450 m lower the team were able to obtain four arterial blood samples and one venous control sample. The Sherpas once again demonstrated their astounding prowess when one of them carried the samples from 8,400 m to 6,300 m in less than two hours. A full analysis successfully completed at Camp 2 yielded, to our knowledge, the lowest measured values of PaO₂ ever recorded in non-hibernating mammals.

**Second, we sought to understand how differences in the ability of individuals to adapt to hypoxia relate to genetic variations.**

Amongst the climbers, some have plans for further 8,000 m peaks whilst others will not go back to extreme altitude for many years, if ever. Caudwell Xtreme Everest will, and should, be judged on the value of the science and the translational clinical studies that are to come: on the benefits to patient care that the

**The future**

Back in the UK there are mountains of data to manage and analyse: more than 4,000 diary days amounting to more than a quarter of a million items of data, more than 2,000 exercise tests and 10,000 blood samples. Doing full justice to this resource will keep us busy writing papers for years to come. The aggregated data will allow us to map out the nature and time course of the physiological responses to progressive hypoxia. The genetic data along with information from blood and muscle samples will permit insights into new mechanisms. The goal then is to prove that this approach can lead to innovations in clinical care and ultimately benefit patients.

Since our return the close knit team have gone their separate ways. We have had three weddings and an engagement. Many of the team are back in their regular medical jobs, a handful are heading for medical school, and several are continuing their adventures in science.
team hope will be achieved. We are immensely grateful to our trekkers, Sherpas, sponsors and supporters without whom none of this would have happened. For those directly involved there is the great relief of having the whole team home safe, the satisfaction of a job well done with the scientific goals achieved, and the pleasure of knowing that we have made and nurtured friendships that will last a lifetime.

Acknowledgements
The Caudwell Xtreme Everest team wishes to express their heartfelt thanks to the trekkers and Sherpas who made this study possible. Without the generosity and good humour of our trekkers and the strength and companionship of our Sherpas this experiment simply would not have taken place. We owe them a huge amount.

Caudwell Xtreme Everest (CXE) is a research project co-ordinated by the Centre for Altitude, Space and Extreme Environment Medicine, University College London, UK. The aim of CXE is to conduct research into hypoxia and human performance at high altitude in order to improve understanding of hypoxia in critical illness. Membership, roles, and responsibilities of the CXE Research Group can be found at www.caudwell-xtreme-everest.co.uk/team.

The research was funded from a variety of sources, none of which is public. The entrepreneur John Caudwell, whose name the expedition carries, donated £500,000 specifically to support the research. BOC Medical, now part of the Linde Group, generously supported the research early on and continues to do so. Eli Lilly Critical Care, The London Clinic (a private hospital), Smiths Medical, Deltex Medical and Rolex have also donated money to support the research and logistics. All monies were given as unrestricted grants. Specific research grants were awarded by the Association of Anaesthetists of Great Britain and Ireland, and the UK Intensive Care Foundation. The CXE volunteers who trekked to Everest Base Camp also kindly donated to support the research.

More information
www.caudwell-xtreme-everest.co.uk
www.case-medicine.co.uk
www.ucl.ac.uk/anaesthesia

Resources

STOP PRESS!
Congratulations to Dr Jon Raphael and team at the Dudley Group of Hospitals NHS Trust for winning the Pain Medicine in Anaesthesia Award at the prestigious Hospital Doctor of the Year Awards 2007, held at London’s Hilton Hotel, Park Lane, on 22 November.

Well done also to the runners up, Dr Jeremy Cashman and team from St George’s NHS Trust, London and Dr Barry Newman and team from Poole Hospital NHS Trust.
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 has been 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 2403 for details

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

20–21 February 2008 (code: C84)
TEACHING METHODS WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £350 (limited spaces)
(£300 for registered trainees)
Please see page 2399 for details

25 February–7 March 2008
(code: A82)
FINAL FRCA COURSE
The Royal College of Anaesthetists, London
Registration fee: £540
Please see page 2401 for details

MARCH

5 March 2008 (code: D23)
ULTRASOUND WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £200 (limited spaces)
(£180 for registered trainees)
Please see page 2400 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
Registration fee: £375
(£260 for registered trainees)
Please see page 2402 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 2399 for details

8 April 2008 (code: D39)
RESEARCH METHODOLOGY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £120
(limited spaces)

9–10 April 2008 (code: B36)
TEACHING METHODS WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £350 (limited spaces)
(£300 for registered trainees)
Please see page 2399 for details

Further information – www.rcoa.ac.uk/events
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
Joint meeting with the Intensive Care Society
The Royal College of Anaesthetists, London
Registration fee: £250 for 1 day
Please see below for details (limited spaces)

15 April 2008 (code: D04)
ANAESTHETIC EMERGENCIES – GLASGOW
The Teacher Building, Glasgow
Registration fee: £220
(£170 for registered trainees)
Please see page 2399 for details

17 April 2008 (code: C12)
AIRWAY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £175 (limited spaces)
(£150 for registered trainees)

22 April 2008 (code: A74)
AIRWAY MANAGEMENT – TRAINING THE TRAINER
The Royal College of Anaesthetists, London
Registration fee: £175
Please see page 2401 for details

23 April 2008 (code: D36)
SIMULATION – TRAINING THE TRAINERS
The Royal College of Anaesthetists, London
Registration fee: £250 (limited spaces)
Please see page 2403 for details

MAY

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

9 May 2008 (code: D08)
SAS REVIEW DAY
Joint meeting with the AAGBI
The Royal College of Anaesthetists, London
Registration fee: £120 Members
(£240 non-Members)
Please see page 2400 for details

19 May 2008
CORE TOPIC DAY
The Royal College of Anaesthetists, London
Please register for details on our website

JUNE

4–6 June 2008 (code: A32)
CURRENT TOPICS MEETING - BIRMINGHAM
Birmingham Novotel
Registration fee: £415
Details available on our website

5 June 2008 (code: C81)
AIRWAY WORKSHOP
The Royal College of Anaesthetists, London
Registration fee: £175 (limited spaces)
(£150 for registered trainees)

5–6 June (code: C55)
INTENSIVE CARE MEETING
The Royal College of Anaesthetists, London
Registration fee: £375
(£260 for registered trainees)

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

11–12 June 2008
COLLEGE TUTORS MEETING EDINBURGH
First Assembly Hall, Edinburgh
By invitation only

17 June 2008 (code: C18)
INTRODUCTION TO TEACHING
The Royal College of Anaesthetists, London
Registration fee: £180
(£120 for registered trainees)

*NEW FOR 2008*
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 (code: C77)
The Royal College of Anaesthetists, London
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

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.

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

Delegates will also receive one to one feedback on their presentation skills and style.

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:

- Complications associated with airway management
  Dr T Cook, Bath
- Moving on from Macintosh laryngoscopy
  Dr R Mihai, Oxford
- Fibreoptic intubation made easier
  Dr S Scott, Oxford
- Extubation matters
  Dr A Diba, East Grinstead
- Training in basic airway skills
  Dr M Stacey, Cardiff
- Responsive Contingency Planning
  Dr S Darshane, Prescot
- The i-gel and other second generation supraglottic airways
  Dr C Seller, Bath

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

**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

Further information – www.rcoa.ac.uk/events
SAS REVIEW DAY 2008
A JOINT MEETING WITH THE AAGBI
9 May 2008 (code: D08)
The Royal College of Anaesthetists, London

This year’s programme is looking at new anaesthetic techniques and awareness and will include the following topics:

‘TIVA or not (to) TIVA that is the question’
Dr C Rowlands, Bradford

BIS monitoring – or how to avoid awareness in one easy lesson
Speaker to be confirmed

Desflurane – wonder drug or cash cow?
Dr P Rüther, Salford

Cardiopulmonary resuscitation – what’s new and in fashion?
Dr J Nolan, Bath

GMC – revalidation and recertification – who, what, why, when and how?
Speaker to be confirmed

PMETB and the SAS doctor – ‘for us or against us?’
Speaker to be confirmed

Q&A Session to include BMA, AAGBI, RCoA, PMETB
(RCoA – Dr A Lim/AAGBI – Dr R Alladi)

REGISTRATION FEE: £120 MEMBERS (£240 NON-MEMBERS)

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

This workshop is aimed at Anaesthetists wanting to update themselves with ultrasound equipment and its use for guided regional anaesthesia.

The day will focus largely on clinical scenarios, group discussions run by experienced lectures and faculty members. Morning presentations will consist of topics such as:

- Ultrasound basics.
- Sonoantomy upper and lower limb nerves.
- Approaches to upper and lower limb nerves.
- Miscellaneous blocks.

The afternoon session will involve rotating through a variety of stations. These stations will include the opportunity to:

- Practice nerve localisation techniques using ultrasound on volunteers.
- Practice probing/needling using specially developed phantoms.

These rotations will be done in small groups giving the chance for all to practice and to improve their knowledge and competencies in ultrasound guided anaesthesia.

The event will be sponsored by two large equipment companies.

Comments from previous workshops:

‘An excellent practical session with a good introduction to ultrasound in regional anaesthesia’
‘Very useful, really stimulating’.

REGISTRATION FEE: £200 (£180 FOR REGISTERED TRAINEES)
APPROVED FOR 5 CPD POINTS
LIMITED AVAILABILITY
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
Advanced airway training
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

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

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.

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 and 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 breadth of the syllabus’.
‘Very useful and informative. Lectures were well organised and presented’.

REGISTRATION FEE: £540
APPROVED FOR 15 CPD POINTS

INTRODUCTION TO TEACHING
The Royal College of Anaesthetists, London
17 June 2008 (code: C18)

This one day meeting for all grades is designed to introduce the first stage of the Anaesthetist as Educator Programme.

Participants will be introduced to the concepts and skills that are required to facilitate effective teaching and learning in clinical practice. Subjects will include:

- An introduction to educational theory and adult learning.
- How to create a positive educational environment.
- How to teach in theatre (one-to-one).
- How to be a clinical or educational supervisor.
- How to approach the trainee in difficulty.
- How to use Workplace based assessments.
- How to give a lecture and use PowerPoint effectively.

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

Further information – www.rcoa.ac.uk/events
12 March 2008
Session 1: Pain – the basics
CHAIR: DR L COLVIN
Pain mechanisms: neurophysiology of nociceptive transmission
Professor A H Dickenson, London
Epidemiology of pain
Professor G MacFarlane, Aberdeen
Session 2: Pain perception
CHAIR: DR D JUSTINS
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
CHAIR: DR D LAMBERT
Pain and the immune system
Professor C Stein, Berlin
Ion channels and local anaesthetics
Professor G Strichartz, Boston
Session 4: New treatment strategies
CHAIR: DR J HUNTER
Neuropathic pain – emerging treatments
Dr A Dray, Montreal
The therapeutic potential of cannabis
Professor J Zajicek, Plymouth
RECEPTION FOR ALL PARTICIPANTS

13 March 2008
Session 5: Pain after surgery
CHAIR: PROFESSOR I POWER
Acute pain management
Professor H McQuay, Oxford
Post surgical pain
Dr W A Macrae, Dundee
Session 6: Cancer pain – mechanisms and management
CHAIR: DR K SIMPSON
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
CHAIR: DR C REILLY
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?
CHAIR: PROFESSOR D ROWBOTHAM
Debate: Pain medicine or pain management?
Professor I Power, Edinburgh vs Professor C Main, Salford
The Faculty of Pain Medicine
Dr D Justins, London
Admission of Foundation Fellows of the Faculty of Pain Medicine
RECEPTION TO CELEBRATE THE FOUNDATION OF THE FACULTY OF PAIN MEDICINE
(By invitation only)
## CURRENT TOPICS

**4–6 February 2008 (code: C68)**
The Royal College of Anaesthetists, London

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<th>4 February 2008</th>
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| **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  
Dr G Brear, Manchester  
Monitoring to improve outcome  
Dr D Conway, Manchester  
Anaesthesia for vascular surgery  
Dr P Bayly, Newcastle | **Advances in chronic pain management**  
Dr L Colvin, Edinburgh  
**Burns and anaesthesia**  
Dr D Knights, Birmingham  
**Obesity and anaesthesia**  
Professor A Chambers, Aberdeen  
**Intensive care update**  
Dr P Nightingale, Manchester  
**Upper limb blocks**  
Dr B Fischer, Redditch  
**Sepsis update**  
Dr A McCluskey, Stockport | **Paediatric emergencies for the generalist**  
Dr I Walker, London  
Keeping out of trouble in obstetric anaesthesia  
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  
Professor M Mythen, London |

**REGISTRATION FEE:** £415  
**APPROVED FOR 15 CPD POINTS**  
**THIS PROGRAMME IS SUBJECT TO CHANGE**

### *NEW FOR 2008*

**SIMULATION – TRAINING THE TRAINERS**

23 April 2008 (code: D36)  
The Royal College of Anaesthetists, London

The RCoA are running a new course for 2008, the course is intended for Consultant Anaesthetists interested in how to deliver simulation training. You will receive an introduction to simulation training delivered as an e-learning ‘pre-load’ session undertaken in your own time prior to the workshops. This will be followed by a one day hands on workshop course at the College, to include:

- Simulation for practical procedures.
- High fidelity simulation in anaesthesia.
- High fidelity simulation in critical care.
- Simulation and teamwork.

Finally an ‘afterload’ session will be delivered by e-learning to include building a business case, plus a summary of the course.

**REGISTRATION FEE:** £250  
**LIMITED AVAILABILITY**

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.

Bookings will be accepted on a first come first served basis. Bookings will not be accepted unless the appropriate fee and application form are received together. Please also ensure that the application form shows the event code, title and date.

Please note that places are not reserved until payment is received.

Confirmation of a place will be sent to you within 14 days of payment being received. If you do not receive this, please contact the Events Department.

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 an 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.

Payment details

- 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):

Please use BLOCK CAPITALS.

Cardholder’s name: ___________ Card number: ___________

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

Card Security Code: ___________ OR ___________ Signature: ___________
Conscious sedation for dentistry: an update

Many detailed recommendations were made, but their essence was that the standards of care in general dental practice (GDP) should be those which had long pertained in hospital. Nevertheless, major adverse events, virtually all involving avoidable factors, continued to be reported by an increasingly strident media. Fifty years before, an occasional death might not have caused headlines nationwide, but this was not the case at the end of the 20th century. The result was a review by the Department of Health (DH) and the publication of ‘A conscious decision’ which, in effect, banned general anaesthesia from its very birthplace, dental practice.

The report also promoted the wider use of conscious sedation in the management of dental phobia, although it was recognised that its standards also needed to be high to ensure patient safety. This, and other matters related to the use of sedation in medical practice, prompted the Academy of Medical Royal Colleges and their Faculties to commission a report (Safe sedation practice) from this College. In terms of clinical care this advocated nothing which had not been said before, but it did introduce new recommendations regarding the framework within which sedation is used by non-anaesthetists for diagnostic and therapeutic procedures. Most of these requirements relate to hospital practice so the reader is referred to the report for details, but one aspect common to all specialties is that the relevant organisations (i.e. Colleges, Faculties and Societies) should define appropriate techniques for their areas of practice and the training requirements needed for them.

In dentistry this led the DH’s Standing Dental Advisory Committee (SDAC) to instruct an Expert Working Group to produce a report, published in 2003, setting out these requirements for the ‘standard’ techniques of conscious sedation for dentistry: IV
benzodiazepines (normally midazolam) for adults, and inhalation of nitrous oxide/oxygen mixtures for adults and children, both methods involving titration of dose to a recognised end-point.4 Some believe that these are all that is required in the GDP setting, but there are three issues (all relating to developments in practice) which have emerged and support the need for further advice being made available. It is argued that:

1 intranasal midazolam is a useful method which could be considered ‘standard’ even though titration of dose is not possible

2 some patients require more than the ‘standard’ techniques, but can be managed safely away from the hospital setting

3 more complex techniques (involving polypharmacy and/or drugs normally used in general anaesthesia) have been developed in response to point 2 and some guidance framework is better than none.

Each of these points, particularly the third, is controversial, so their consideration, let alone acceptance, must be undertaken with great caution. Initially, the SDAC established a second Expert Working Group to consider such matters, but changes in the commissioning of dental sedation by the DH5 meant that no report was published. The work passed to the Standing Committee on Sedation for Dentistry, a group led by this College and the Faculty of Dental Surgery (RCSEng). A report has been produced,6 and its recommendations are summarised below.

Standards for conscious sedation in dentistry: alternative techniques

The new report extends, but does not replace, existing guidance and states quite clearly that the definition of conscious sedation is retained and supported:

A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely.

The report recognises that there is ongoing concern about safety and quality standards in the provision of dental sedation7 and that there are continuing difficulties in patients gaining access to appropriate services for pain and anxiety control. Thus the argument that some of these problems may be overcome by the careful implementation of other techniques of sedation is accepted, but with emphasis that the issue is not just about the drug regimen employed (often the only focus of attention), but the whole package of care delivered to the patient. The report defines exactly what techniques are included within the terms ‘standard’ and ‘alternative’, and makes both general and specific recommendations to ensure patient safety with the latter.

Standard techniques

- IV sedation using midazolam alone.
- Inhalational sedation using nitrous oxide/oxygen.

Alternative techniques

- Oral/intranasal benzodiazepine, but only within a strictly defined protocol which requires specific training and competence in IV sedation, especially venous access.

General recommendations

- Assure compliance with guidance.
- Introduce a robust system for assessment of the quality and safety standards of all NHS and independent clinical teams matched to the type of service provided.
- Develop a network of integrated referral centres (dental anxiety management services) providing an extended range of techniques improving service to patients while achieving revenue savings.
- Establish such centres on the basis of a local needs assessment.
- Develop and continuously update guidance on the quality standards required of such centres.
- Take advantage of the
opportunities presented by the new centres to link teaching, training and research to service provision.

Specific recommendations
Space here precludes a full account of the specific requirements, but a summary can be given under the three broad headings in the document.

1 Environment and patient selection. As well as meeting the requirements of dental practice each component of the premises (waiting room, surgery, recovery area) must be appropriate to the sedation technique(s) used. The staff and equipment available must meet the needs of both the technique (including monitoring) and its possible complications, and clear limits are placed on what the operator/sedationist can use. Patient selection should involve dental, psychological, medical and social assessment, be undertaken in advance of actual treatment and include a valid consent process.

2 Qualifications and training. It is made clear that the provision of dental sedation requires specific training and supervised experience as practitioners progress to the use of more complex techniques. There is, as yet, no mandatory postgraduate qualification, but a range of relevant qualifications (e.g. at Diploma or MSc level) is considered highly desirable.

3 Experience and CPD. Even before starting to train in the use of an alternative technique, practitioners must have documented experience of the relevant standard technique(s) (a minimum of 100 cases over two years) and four years postgraduate experience.

Appendices to the report provide documentation for checking that the requirements have been met in individual practices.

Key points: for anaesthetists and dentists
From the perspective of this College the key point in the report is that it is quite explicit that it applies to both medical and dental graduates.

Dental sedation should only be delivered by those who are trained, quite specifically, in its use.

Conscious sedation for dentistry is very different from the sedation which anaesthetists often deliver in the operating theatre or intensive care unit. There, all the facilities for the provision of general anaesthesia are available so ‘sedation’ to the point where the patient becomes unresponsive is acceptable, often desirable.

In the dental practice setting the situation is very different, and the component of the definition of conscious sedation which refers to a ‘margin of safety wide enough to render loss of consciousness unlikely’ must be kept constantly in mind.

Conscious sedation is a technique for dealing with dental phobia; it is not an alternative to effective local anaesthesia or good behavioural management; neither is it an excuse for something more like total IV anaesthesia given in the isolated setting of a dental surgery with the aim of producing rapid patient throughput.

The standard techniques of conscious sedation are approved and have excellent safety records. Everything else, including intranasal midazolam, is an ‘off label’ indication for the drugs, and the implications of this must be recognised.

The safety of any technique is questionable when published series describe patient numbers measured in tens rather than hundreds, or report SpO\textsubscript{2} levels below 90%.

Conscious sedation for dentistry is very different from the sedation which anaesthetists often deliver in the operating theatre or intensive care unit.

Finally
A small number of practitioners ignored professional advice about standards of general anaesthesia in dental practice, with the result that it was banned. If even one aspect of this latest professional advice on conscious dental sedation is ignored, the result could be the same.

References
1 Standards and guidelines for general anaesthesia for dentistry. RCoA, 1999.
Foundation Fellowship

The initial response to the formation of the Faculty was extremely encouraging and more than 500 applications for Foundation Fellowship of the Faculty were received by the closing date in July 2007. The overall calibre of the applications was extremely high and the large number of anaesthetists who applied to join provided further strong justification for the establishment of the Faculty.

Because of the massive administrative load engendered by the large number of applications, the names of the 470 successful Foundation Fellows did not receive formal approval until the meeting of the Faculty Board in October 2007. The delay was a minor irritant, but the award of Foundation Fellowships was an important, one-off event so great care was taken with the selection process.

Only Fellows of the RCoA who were in good standing with the College and who fulfilled other requirements were eligible to apply for Foundation Fellowship. This category of Fellowship is now closed forever. Foundation Fellows are advised that no-one is entitled to use the post-nominals (FFPMRCA) until approval to do this has been granted to the Royal College of Anaesthetists by the Privy Council. Thereafter, the continued use of the post-nominals is contingent upon the Fellow remaining in good standing with the Faculty and the College.

Around 50 applications for Foundation Fellowship were received from anaesthetists who were only involved with acute pain. The need for inclusiveness of acute pain anaesthetists had been one of the principles agreed for Foundation Fellowship. It was acknowledged that, once the period of entry to Foundation Fellowship had closed, all future applicants would have to meet the full criteria for Fellowship as defined in the Faculty Regulations and that this will require competency.
in the broader aspects of pain medicine rather than just post-operative pain. It is hoped that many of the acute pain anaesthetists who have joined the Faculty will be enabled to broaden the scope of their practice, particularly with respect to their involvement in the training of future pain doctors. Only time will tell whether Membership of the Faculty will continue to be attractive to anaesthetists whose only pain commitment is to acute pain, and the Board welcomes suggestions as to how this can be achieved.

Applications for other categories of Fellowship and Membership

To avoid any conflict or confusion, the Board decided to delay the opening of other categories of Fellowship or Membership until after the Foundation Fellowships had been approved and finalised. The details of the other routes of entry to Fellowship and Membership, together with the methods of application, will be published on the Faculty section of the College website from time to time. The Board regrets the delay that this has caused for potential applicants. Anaesthetists who practise pain medicine in the UK and who are not Fellows of the Royal College of Anaesthetists (including colleagues whose qualifications were gained in other countries of the European community) will have an opportunity to apply to these other categories.

The Regulations allow for the award of Fellowship to doctors from other medical specialties as well, and already there have been enquiries from general practice, palliative medicine and neurology. Doctors who trained in other specialties will not possess the same competencies as anaesthetists who practise pain medicine. Great care will be required in the assessment of the ‘equivalence’ of the relevant training and experience of the different groups, but the Faculty of Pain Medicine in Australia and New Zealand has benefitted from its multi-speciality membership so potentially there is much to be gained.

Advanced training in pain medicine

A prime function of the Faculty is to develop further the schemes for advanced training in pain medicine. For the foreseeable future, advanced training in pain medicine will continue to be assessed against the criteria for competency-based training as published in the current version of CCT in Anaesthesia (see the RCoA website). The Board is not considering any major changes in the immediate future other than those relating to the assessment process itself. Ample notice will be given of any changes and new requirements will not be imposed retrospectively.

So far as gaining entry to the Fellowship of the Faculty is concerned, there will be a uniform standard applied to all applicants for Fellowship by assessment. The route of entry may vary depending on whether the applicant has, for example, already completed advanced training, is currently undertaking advanced training, or is not scheduled to commence advanced training for a year or more. There will be a transitional period before the final route of entry is adopted, so current trainees involved in advanced pain medicine training at present will not be disadvantaged. All applicants will, however, have to provide evidence that they have achieved the required competencies and undertaken the required training based on the published criteria. Comprehensive details of any new requirements for advanced training will be made available as soon as the Faculty Board has agreed the details.

Overseas training in pain medicine

Questions relating to overseas training in pain medicine continue to cause problems for trainees, and the situation may become even more complicated. It is clear that overseas training in pain medicine should be assessed against the criteria for competency-based training as published in the CCT in Anaesthesia. There cannot be a separate standard.

Trainees who are planning to undertake overseas training in pain medicine must obtain prospective approval from the regional advisor in pain medicine and/or the Faculty and they must have the overseas training and assessment fully recorded and documented. This will need to be arranged well in advance, so early discussions with the regional advisor in pain medicine and the local Deanery are advised. Applicants who have undertaken some of their pain medicine training overseas will have to provide evidence that they have achieved the required competencies and undertaken the required training. In addition, they must fulfil any other requirements prescribed by the local Deanery and by the RCoA.

Please note that there may be significant changes made to the way in which overseas training is recognised, so it is absolutely essential for trainees to check the very latest pronouncements from PMETB and the RCoA. This final point cannot be emphasised too strongly.
Assessment for advanced training in pain medicine

A very comprehensive scheme for the assessment of advanced training in pain medicine is undergoing field trials in a number of centres. If the trials are successful, it should be ready to be ‘rolled out’ very soon across the whole of the UK. The assessment scheme for advanced training in pain medicine will employ a range of well validated assessment tools including: DOPS (directly observed procedural skills), Mini-CEX (mini-clinical evaluation exercise), CbD (case-based discussion), MSF (multi-source feedback) and written case reports. The Faculty will be issuing instructions about the use of each of these assessment tools in relation to pain medicine, but in the meantime generic information and guidance about assessment can be obtained from the Modernising Medical Careers website. Very soon trainees will be assessed by these techniques throughout the entire period of anaesthesia training.

Logbooks

For the time being the Board has decided to delay the adoption or recommendation of any specific logbook on a national basis. It is recognised that excellent examples have been developed in some regions and it is hoped that information about these logbooks can be shared between centres. The logbook question will be kept under review and reconsidered once all aspects of advanced training and assessment have been updated. Plans for the adoption of a general, national e-portfolio have to be considered as well. Trainees are strongly advised to keep a logbook of some description because this is an important part of the evidence required to assess the adequacy of their training.

Criteria for units offering advanced training in pain medicine

There have been a number of questions about the criteria for units offering advanced training in pain medicine. In May 1999 the College published a document ‘Criteria for pain management units seeking approval from the RCoA for the sub-specialty training of anaesthetists in pain management’. This document is being reviewed by the Board and a new version will be issued in due course. Please note that the concept of the College in the past, or the Faculty nowadays, approving posts for pain training is no longer valid. The revised version of this document will be used by the regional advisors to assist in assessing the suitability of any institution to provide some or all of a period of advanced training in pain medicine. At present there are no such things as ‘nationally approved’ posts in pain medicine. Trainees should discuss issues about the suitability of units for advanced training with their regional advisor in pain medicine.

Anaesthetists who seek to retrain in pain medicine after obtaining CCT

The Faculty has received a number of enquiries from anaesthetists in established career posts (consultant and SAS doctors) who are seeking to retrain in pain medicine. Similar questions have been received at the College for many years, long before the Faculty was established. There are two separate issues.

Firstly, there is the issue of how such doctors gain appropriate training to make them competent for the work that they are going to undertake in the field of pain medicine. They might be seeking to gain expertise in a relatively focused aspect of pain medicine or they might be seeking comprehensive training in all aspects. Ultimately, they will have to (a) satisfy themselves that they are competent for the tasks they propose to undertake (see GMC ‘Duties of a Doctor’) and (b) satisfy their clinical director that they are competent in the aspects of pain management covered by their job plan. Their competency should be assessed against the criteria for competency-based training as published in the CCT in Anaesthesia. This document describes the outcome competencies for someone who has successfully completed advanced training in pain management and is the standard against which someone seeking a new career post in pain medicine should be judged.

The second, quite separate issue relates to the eligibility of anaesthetists who undertake retraining in pain medicine to apply for Fellowship or Membership of the Faculty of Pain Medicine. These doctors will have to fulfil the criteria as described in the Faculty Regulations for the relevant category of Fellowship or Membership. For example, if they seek to apply for Fellowship by assessment, then the standard that will be applied will be the same as for all other applicants for Fellowship by assessment and they will be assessed against the criteria for competency-based training as published in the CCT in Anaesthesia. There can be no shortcuts or different standards.
Regional advisors in pain medicine

The Faculty of Pain Medicine has taken over responsibility for the appointment and re-appointment of regional advisors in pain medicine (formerly pain management). The Faculty will be revising the document on the roles and responsibilities of regional advisors in pain medicine and an updated document will be posted on the website in due course. Last year the College extended the first terms of all the regional advisors in pain management until after the Faculty of Pain Medicine had been established. The Board is now reviewing all the appointments and the process will be administered from the Faculty.

The next steps

A lay representative, Kate Rivett, nominated by the RCoA Patient Liaison Group has joined the Faculty Board, and very soon a trainee representative will be recruited from the Trainee Advisory Group that is being established by the College. The Board is examining the ways in which the Faculty can provide support and value for its Fellows and Members, and welcomes suggestions and observations from them.

On 12 and 13 March 2008 there will be a Joint Anniversary Meeting on the topic ‘Pain medicine: advances in basic science and clinical practice’. This meeting is being organised by the British Journal of Anaesthesia and the RCoA and will be held in London. The final session, on 13 March, will include a brief ceremony of admission for all Fellows of the Faculty, followed by a reception.

The Faculty is looking to become active and influential in a wide range of spheres but, first and foremost, the Faculty must ensure that training in pain medicine is delivered to the highest possible standard throughout the whole training programme for anaesthetists and, most especially, for those trainees who undertake advanced training in pain medicine. It is, after all, the Faculty of Pain Medicine of the Royal College of Anaesthetists.

Contact information for the Faculty

A new administrative officer has been appointed for the Faculty and the contact details are:

Ms Ruth Farmer
Administrative Officer
Faculty of Pain Medicine
The Royal College of Anaesthetists

tel 020 7092 1726
email pain@rcoa.ac.uk

Book and journal donation programme for Iraq

Donations needed – please help

The need for medical publications in the Baghdad region of Iraq remains largely unmet. Clinics and hospitals are very short on modern books and recent journals. Iraqi medical training and practice are modern although severely strapped for resources. Their needs are for contemporary publications, both texts and journals. The Iraqi Ministry of Health has requested that donated text editions have publication dates no earlier than 2000 or, for journals, nothing published prior to 2002.

If you are able to help, please contact Dr David Gifford at dgifford@hot.rr.com for up-to-date information about how and where to send donated medical publications and medically related materials.
The Chairman’s introduction returned to the issue of the location of meetings. He reminded members of the results of the postal survey – a clear majority favoured all meetings being held in the College but a significant number of members favoured holding some meetings away from London. He invited suggestions from the floor, and Birmingham, Liverpool and Bristol were nominated as possible locations. The Chairman determined to investigate these possibilities further and, if sufficient numbers continued to support the idea, he would arrange a meeting away from London before the end of his term of office.

The President had sent her apologies for being unable to attend the meeting, and a warm welcome was extended to Vice-President Professor Chris Dodds and Council member Dr David Greaves who had kindly agreed to address the College news and the anaesthesia practitioner topics respectively.

Professor Dodds outlined two major challenges to the profession since the last SFC meeting – the fall-out from the chaos of the Medical Training Application Service (MTAS) as part of the Modernising Medical Careers (MMC) process, and the development of re-validation. An independent review panel, under the chairmanship of Sir John Tooke, had been set up by the Secretary of State to review and advise on the entire MMC process. Input from the Royal Colleges and other key bodies had been sought, and the panel’s interim report had been released a few days before the SFC meeting. It was comforting, but hardly surprising, to note from the report that proposals for postgraduate training included a return to the concept of a period of ‘core’ training after which there would be competitive entry into ‘higher specialist training’. However, some marked differences from what we remembered were highlighted, and these will need to be worked through in some detail – in particular the relative rigidity of core training programmes, the ability for informed choice during ‘Foundation’ posts, and the SAS grades becoming trust registrars.

The re-validation process starts in earnest in 2009 and we were pleased to hear that our President had been asked by the Academy of Royal Medical Colleges to be their lead for revalidation in the UK. It comprises two interlinked processes – relicensing (being recognised as a doctor) and recertification (maintaining that doctor on the specialist register). The former will cycle every five years and depend upon an individual’s performance against the six domains in the GMC’s ‘Good Medical Practice’ documentation. The latter entails three processes, each in a variable state of preparation, involving the doctor, the department, and finally the College.

‘Anaesthesia practitioners’ have been an interesting though contentious topic for some time, and Dr Greaves adopted a novel approach in dealing with this subject in limited time. He asked for questions at the outset rather than the end of his session, and limited the scope of these to seven headings. Members managed relatively few questions – perhaps we had difficulty in remembering the headings! The training courses produced 30 anaesthesia practitioners this year and are destined to continue, but the roll-out in the future will be determined to a large extent by trusts’ enthusiasm. It came as no surprise that the majority of current anaesthesia practitioners are drawn from the nursing ranks, but of particular interest was Dr Greaves’ observation that they do not always produce the ideal trainee, given the variability of their knowledge of basic sciences. This can lead to difficulties in determining the level at which to pitch ‘on the job’ tuition for them during their training. Difficulties in the nature and extent
of supervision were discussed. Whilst the view still holds that anaesthesia practitioners can be of valuable service as part of a medical team, much will depend on the strict criteria under which they function. From the questions, at least, one sensed that the jury is still out.

The guest lecture was provided by Mr John Avery, Master of Wines, Chairman of Avery Wines Ltd, and past Master of the Vintners Company, who gave an interesting and entertaining talk on ‘Life with wine’. He began with an historical account of the links between Bordeaux and England dating from the 12th century, the association of Bristol with wine from the 17th century and the development of Avery Wines Ltd from the late 18th century to its current status of an international wine trading company – a period of seven family generations. A more personal account of his career and lifestyle followed, accompanied by many amusing anecdotes drawn from his experiences of international travel as a wine judge, and satisfying the viniferous needs of some Downing Street personalities, Inns of Court and celebrity artists, not to mention some of Bristol’s hospital consultants!

The meeting concluded over lunch and, whilst it might have been coincidence, the standard of wine served on this occasion was noticeably up a notch or two!

Advance notice!

The next meeting of the SFC will be held at the College on 22 May 2008, when the guest speaker will be Professor Cedric Prys-Roberts, emeritus Professor, Sir Humphry Davy Department of Anaesthesia, Bristol.

AS WE WERE...

In 1851 Lord Campbell, Chief Justice of the Court of the Queen’s Bench, proposed an Act for the Prevention of Crime that specifically targeted the possession or use of chloroform for criminal purposes, the penalty being transportation to Australia. John Snow thought the proposed measure was unfair and unnecessary, being based on a misunderstanding of the action of chloroform, and campaigned against it.

‘In two recent cases of robbery it has been asserted that chloroform was used to render the victims insensible; and although no real evidence has appeared of such having been the fact, yet the statement has gained great publicity through the newspapers, and the sentences on the prisoners have apparently been rendered more severe by the allegation. It can readily be shown that if thieves and prostitutes were to resort to the use of chloroform in the public streets, in the manner alleged, the attempt would only lead to their instant detection on the spot. The sensation of pungency in the nostrils and throat that is cause by this agent, when its vapour is in sufficient quantity to produce any effect on the sensorium, is so strong and peculiar that no person can take a single inspiration without being aware that he is inhaling something very unusual. Chloroform, in fact, can never be administered without the consent of the party taking it, unless by main force, which has to be used in the case of children who are not old enough to be reasoned into taking it. If a child be asleep when the process of inhalation is commenced, it nearly always awakes before being made insensible, however gently the vapour may be insinuated. As breathing is perfectly under the control of the will, a person would, on finding such a strange attempt being made on him in the public street, instantly hold his breath, and use all his powers of resistance to repel the assault.’

The author of the very successful holiday-reading blockbuster, the ‘gloriously intelligent’ ...‘richly motivated’ ...‘psychoanalytical’ ...‘fascinating historical thriller’ ‘The Interpretation of Murder’, in which chloroform is used with criminal intent, is obviously unacquainted with either its use and effects or the writings of John Snow. Also, his use of the word ‘anaesthesiology’ is anachronistic; it was not current in the United States or elsewhere in 1909. Nevertheless, the book is entertaining, with Freud and his disciples providing comic relief in the role of the rude mechanicals.

References

Dr David Zuck
The History of Anaesthesia Society
When I was a registrar in the mid 1990s, I can remember a novice SHO confidently asserting that he would like to attempt Part 1 of the then 3-part FRCA examination before he had completed his first three months of supervised training. This caused uproar. The consultants within the department were clearly divided in their opinions as to whether the notion should be supported or indeed allowed, on the grounds that the trainee was still very inexperienced in the actual practice of anaesthesia. The issue raised debates about the need for a balanced approach to the acquisition of theoretical knowledge and practical clinical experience.

Last year the Royal College of Anaesthetists relaxed its regulations governing the time when trainees are considered eligible to sit the FRCA examination.¹ The 12-month training requirement was removed for eligibility to sit the Primary OSCE and SOEs, and the 30-month training requirement was removed for eligibility to sit the Final FRCA examination. Although it is recommended that trainees complete at least half of their basic level training first, it is possible for trainees to enter for the Multiple Choice Examination (MCQ) as soon as they have passed the Initial Assessment of Competency (MCQ) as long as they have completed the 30-month training requirement. This caused uproar. The consultants within the department were clearly divided in their opinions as to whether the notion should be supported or indeed allowed, on the grounds that the trainee was still very inexperienced in the actual practice of anaesthesia. The issue raised debates about the need for a balanced approach to the acquisition of theoretical knowledge and practical clinical experience.

The e-Learning Anaesthesia project (www.e-LA.org.uk) is an educational initiative that has been undertaken jointly by the Royal College of Anaesthetists and the Department of Health. The primary aim of the project is to support delivery of the ST1/2 curriculum and associated training. The curriculum has been organised into six educational blocks (Figure 1) that are designed to accompany clinical units of training from the first three months of supernumerary attachment to the level of competence previously associated with the certificate of completion of SHO training. A seventh block, comprising basic science elements, underpins the other six blocks and covers knowledge that complements the more clinical aspects.

All ST1 trainees who register with the College for training in 2008 will be able to access the e-LA programme as they progress through their first two years of training. It will provide structured theoretical knowledge to accompany the practical aspects of clinical training and, perhaps most importantly, a guide to the standard of knowledge required at Primary FRCA level.

This web-based system provides access for all UK anaesthetists to on-line tutorials that will support the FRCA curriculum for trainees, whilst simultaneously providing an interactive CPD library for accredited specialists. Approximately one thousand 20-minute tutorials or ‘e-sessions’ have been carefully selected to cover aspects of the curriculum known to present conceptual difficulties to candidates. The e-sessions themselves are designed around a common format. Objectives are defined at the outset and are explored in a manner that encourages the user to interact with the computer to explore the topic.

To accommodate different levels of pre-existing knowledge, information is presented both in depth and in note form. Diagrams and graphs can be animated or constructed in a structured fashion, as one might expect of an able candidate presenting material across the examination table in the Primary FRCA. Understanding and retention of the material presented in these sessions is then tested by numerous self-assessment knowledge checks. ‘e-Learning Anaesthesia’ is intended to complement existing learning resources, but production of the material in the form of interactive sessions will help to demonstrate the breadth and standard of knowledge required of the FRCA examination in a style that enhances conceptual understanding of the underlying principles.

Figure 1 Block structure for the e-LA curriculum

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<tr>
<th>BLOCK 1</th>
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<th>BLOCK 3</th>
<th>BLOCK 4</th>
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<th>BLOCK 6</th>
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<tbody>
<tr>
<td>An introduction to clinical anaesthesia</td>
<td>Consolidating basic clinical practice</td>
<td>Introduction to critical care</td>
<td>Principles of obstetric, paediatric and geriatric anaesthesia</td>
<td>Regional anaesthesia and pain management</td>
<td>Critical incident case scenarios and examination practice</td>
</tr>
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<tr>
<th>BLOCK 7</th>
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<tr>
<td>Basic sciences: anatomy, physiology, pharmacology, physics/clinical measurement, equipment</td>
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</tbody>
</table>
Q: Who can use e-Learning Anaesthesia?
A: This educational resource is accessible to all UK anaesthetists: trainees; consultants; SAS grades; and acute common stem trainees. Generic elements of the e-LA project will also be made available to other acute medical specialties and foundation doctors.

Q: How do I gain access to e-LA?
A: Go to the portal website (www.e-LA.org.uk) to apply for a username and password. You will need to know your GMC number and College reference number. Trainees who have not yet registered with the College can still apply for a username, but will need to complete a College registration form as well.

Q: When will e-Learning Anaesthesia be fully active?
A: There are already fully functional pharmacology sessions loaded onto the Learning Management System (LMS) for demonstration purposes. The e-session syllabus has been defined and a list of the proposed 950 sessions can now be downloaded in pdf format. Complete topics will be rolled-out over the next 18 months with the entire curriculum available from 2009.

Q: Is this just an expensive on-line textbook?
A: e-LA is not simply a textbook. Complex concepts are explored and carefully assembled using frame-by-frame animations to illustrate the underlying points. In terms of style, editors and authors have striven to create sessions that present the best factual elements of an expert lecture or book article but maintain the interactive benefits of a face-to-face tutorial. Sessions are carefully cross-referenced and presented in a format that encourages reflective learning with numerous self-assessment exercises. Some of these exercises provide additional feedback at key stages by allowing the trainee to compare their own self-assessment score with an average score of all other trainees who have sat that assessment at an equivalent stage of training. The LMS keeps track of an individual’s progress through the curriculum, and offers access to archives of support and reference material published by scientific journals.

Q: Isn’t this just for trainees?
A: No, the curriculum covers the knowledge base required for the Primary FRCA but will form an invaluable CPD resource for career grade anaesthetists. The content of sessions within a clinical or basic science block will provide consultants with background material to underpin clinical tutorials and in-theatre teaching.

e-Learning Anaesthesia went live in January 2008. It is one of the most exciting and significant educational developments that the College has ever undertaken. Please take the time to peruse the demonstration sessions that are now available at www.e-LA.org.uk.

Dr Andrew McIndoe
Dr Ed Hammond
Joint Project Leads

PS In case you were wondering, the novice SHO described at the beginning of this article was allowed to sit the Part 1 examination early and passed on his first attempt. Furthermore, he went on to pass the Part 2 examination three months later!

Reference
1 Primary and Final FRCA Examination Regulations. RCoA, April 2007.
Council report

At a meeting of Council on Wednesday, 17 October 2007, Dr M Manji (Birmingham) was presented with the Payne-Stafford-Tan Award.

Dr Manji, Consultant at the University Hospital Birmingham, has made major contributions to patient care by means of his innovative approach to diagnosis and treatment, and his research into mechanisms of multiple organ failure. His interpersonal and management skills have achieved a constructive reorganisation of services, and his leadership of clinical audit together with his application of computer skills led to the development of electronic prescribing in a practical and practicable manner. He has published over 20 peer-reviewed high quality research papers and many chapters in books. Of particular note, he was awarded the Roche Diagnostics Young Scientist of the Year in 2002 for his presentation on microalbuminuria as a predictor of outcomes in intensive care.

Dr Manji’s exceptional teaching skills are also much in demand. He contributes significantly to undergraduate teaching in anaesthesia and critical care and is a great enthusiast, encouraging promising students to join our specialty. He is a first class bedside doctor and, as one of the most outstanding people of his generation in our specialty, is an ideal role model for junior colleagues. For these demonstrations of excellence he is a worthy recipient of the Payne-Stafford-Tan award.

Dr Griselda Cooper

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

The following appointments/re-appointments were approved (re-appointments are marked with an asterisk):

Deputy Regional Advisers
Oxford
*Dr O J Dyar, John Radcliffe Hospital

North Thames East
*Dr J J Durkan, Broomfield Hospital

West of Scotland
Dr E M McGrady, Glasgow Royal Infirmary
Dr R J Chestnut, Crosshouse Hospital (from November 2007)

Tri Services
Dr D J Birt, Derriford Hospital, Plymouth

College Tutors
Anglia
Dr N A Barber, Addenbrookes Hospital (in succession to Dr J A Pickett)

Oxford
Dr D M A Choi, Churchill Hospital

Yorkshire
*Dr G J Oldroyd, Bradford Teaching Hospitals NHS Foundation

North Thames Central
Dr A Patel, Royal National Throat, Nose and Ear Hospital (third term)
Dr S A Chieveley-Williams, Middlesex Hospital (in succession to Dr R M H Bell)

Mersey
Dr S M Gilby, Cardiothoracic Centre (until February 2010)

North West
Dr P Ruether, Hope Hospital (second Tutorship)

West of Scotland
Dr D A Varveris, Southern General Hospital (in succession to Dr I T Davidson)

Wessex
Dr H A Swales, Southampton University Hospitals Trust (in succession to Dr C A Marshall)
Dr J H Cranshaw, Poole and Bournemouth Hospitals (second Tutorship)

Severn
Dr R E Spencer, Frenchay Hospital (in succession to Dr M Gregory)

South Thames West
Dr H G Wakeling, Worthing and Southlands Hospital (in succession to Dr S Panayiotou)

Nottingham and Mid Trent
*Dr S H Kiani, South Derbyshire Acute Hospital
West Midlands North
Dr A A M Taylor, Stafford District Hospital (third term)

At a meeting of Council on Wednesday, 21 November 2007, the following appointments/re-appointments were approved (re-appointments are marked with an asterisk):

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

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

College Tutors
Yorkshire
Dr R Kandasamy, Huddersfield Royal Infirmary (in succession to Dr J Nunez)
Dr G Thomas, Scunthorpe General Hospital (in succession to Dr J Tobias)

North West
*Dr S Thornton, Royal Bolton Hospital

West of Scotland
Dr L Donaldson, Glasgow Royal Infirmary (in succession to Dr E M McGraday)

South Thames (West)
Dr C Carey, Princess Royal Hospital

Wales
Dr S Rassam, University Hospital of Wales (in succession to Dr R Collis)

Anglia
*Dr M T Memon, Hinchingbrooke Hospital

West Midlands (North)
Dr E Carver, Birmingham Children’s Hospital (in succession to Dr A J Moriarty) (from February 2008)

West Midlands (South)
Dr A Wright, Warwick Hospital, Coventry

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 joint CCT in Anaesthesia and Intensive Care Medicine.

Anglia
Dr Prakash Dattatraya Bhagwat

Imperial School
Dr Keri Jane Ashpole
Dr Mary Clare Hennebry
Dr Seetharama Dinesh
Dr Anne Garner

North Central London
Dr Denise Joyce Lim
Dr Dean Allan James Frear
Dr Christopher John Taylor
Dr Sandra Jacqueline Wylie
Dr James William Holding
Dr Aparna Prabhau
Dr Markandu Sathialingam
Dr Paul MacKenzie Downie*

Leicester
Dr Intazar Bashir
Dr David Christopher Bouch*
Dr Emma Elizabeth Fiona Helm

Mersey
Dr Sarah Louise Martin Mitchell
Dr Caroline Carmel Anne Smyth
Dr Graham Colin Kemp

Nottingham
Dr Amelia Banks

North West
Dr Irfan Ashraf Chaudry*
Dr Sharmistha Saha*

Northern Schools
Dr Alan Christopher Sweeney*
Dr Sridharan Suresh
Dr Nicola Victoria Cree

Bristol
Dr Guy Matthew Jordan*
Dr Douglas Craig Mein
Dr Aidan John Marsh*
Dr James William Armstrong
Dr Murli Krishna

South West
Dr Gavin Charles Werrett
Dr Michael Richard Duffy*
Dr Jane Eleanor Bellamy

Sheffield
Dr Christina Schneider-Smith
Dr Emma Jane Elizabeth Maloney

Wessex
Dr Jennifer Kim McLachlan
Dr Kate Elizabeth Paterson

Tri-Services
Dr Michael Ingram
Dr James Joseph Kevin McNicholas*

North of Scotland
Dr Paul Andrew Holder*

South East of Scotland
Dr Jonathan Peter Aldridge*
Dr Suzanne Claire Krosnar
Dr Kenneth James Kerr

West of Scotland
Dr Andrew James Cadamy*
Dr Rose McRobert
Dr Alison Jane Campbell*
Opportunities in undergraduate training

Hywel Jones makes a timely case for the greater involvement of anaesthetists in undergraduate training. There is, of course, much that individual anaesthetists and individual trust directorates can contribute in this area. Here I make a few suggestions.

- Seize chances for opportunistic teaching. Engage that surgical student in conversation, and discuss broader issues of patient management.
- Offer to give teaching sessions. Cover subjects such as analgesia, fluid balance, preoperative assessment – the usual suspects. Contact the organiser of undergraduate teaching in your trust. Senior trainees will enjoy these opportunities, and consultants may choose to use their sessions for supporting professional activities (SPAs) in this way. Depending on the local system, it may even attract more money under SIFT (Service Increment for Teaching) for your directorate.

- Remember your talents in the areas of applied physiology and pharmacology. Medical students are notoriously unfamiliar with basic sciences, but explore how much they really know, and give them a framework. Relish the dawn of enlightenment as the autonomic nervous system finally makes some sense.

- If the Council of our College wishes to raise the profile of anaesthesia amongst undergraduates, then we will all need to do more than teach venous cannulation and airway maintenance (important though these skills are). Students need to be shown that anaesthetists are committed clinicians who work from an intellectually sound evidence base in both basic and clinical sciences, and manage at the same time to be a reasonably cheerful bunch of colleagues.

So, whatever type of hospital you work in, hunt those students out and enjoy getting stuck into your favourite topic.

Dr M Heining, Consultant Anaesthetist and Assistant Clinical Sub-Dean, Nottingham

Informing patients

Dr Hill’s concern that the current process of obtaining consent for organ donation is inadequate merited a more considered reply. The available evidence suggests the transplant programme could adopt a policy of informed consent without losing many potential donors. My own experience suggests that the wishes of many donors are vetoed by the relatives: losses which might be counterbalanced if informed consent had prompted discussion within the family.

What is the risk if we are too coy? Public confidence depends mostly on sentiment, not logic, and could so easily be lost if media coverage became critical. Consider the influence of the BBC’s ‘Transplants: are the donors really dead?’ in 1980, or more recently, coverage of the MMR vaccine and Alder Hey ‘scandals’. Parallels with the term ‘retained tissue’ seem pertinent. Our attempts to spare the distress of relatives by using a euphemism when obtaining consent for autopsy only resulted in much greater distress once the raw details became news, with some families so disturbed they organised a second or even third funeral service.

The media achieve balance not by considering the weight of evidence but by giving equal airtime to both sides. Those who advise the government can expect the invitation to participate in media coverage and their strategy must be to preserve public support on the presumption that the news media are not automatically supportive. Dr Hill’s concerns should already have been addressed. Merely rubbing the opposition will guarantee ‘Panorama’ taking the series to 2–0.

Dr G C Fisher, Consultant Anaesthetist, Dudley
Ministerial Task Force on Organ Donation

Bulletin 45;September 2007:2305–2307

May I be allowed to share my country’s experience with respect to organ procurement. As it is an ‘opt-out’ system, there are issues unique to such a system.

In Singapore, the Human Organ Transplant Act (HOTA) allows for the kidneys to be removed, in the event of death due to accidents, for the purpose of transplantation. The Act applies to all non-Muslim Singapore citizens and permanent residents between the ages of 21 and 60 years, who will have priority in receiving a cadaveric kidney if they need one. However, they can also opt out of HOTA if they do not wish to donate their organs when they die. The act was amended in January 2004 to allow more Singaporeans to benefit from other cadaveric organs, and now includes liver, heart and cornea. It now applies beyond deaths due to accidents to all causes of death, and also regulates living donor organ transplantation.

Since the enactment of the Amendment Bill, the pool of potential donors has increased quite dramatically. There are now more organs and more types of organs at issue and hence more potential beneficiaries. Medical staff have the frontline duty to ‘capture’ these opportunities. Those of us working in the neurointensive care units feel the impact deeply because of the many patients who present here with catastrophic intracranial bleeds, many whom are young and otherwise relatively healthy.

Despite official media publicity surrounding the enactment of HOTA, there is still much incomprehension and misunderstanding amongst medical staff, let alone the lay public. For many, especially the elderly, perhaps because of cultural and religious reasons, organ procurement is unnatural and being in the presence of a warm, apparently breathing and heart beating patient, it is simply beyond the relatives’ belief that their loved one will be carted away and ‘cut up to have their organs removed’ despite sincere and repeated assurances that the patient is indeed brain dead.

On several occasions, not unexpectedly, emotions have run high and hospital security have to intervene to escort patients to the operating room for organ harvesting.

Compounding all these issues, organ procurement in the presence of brain death is time sensitive. There can only be hope and prayers for a miracle; what relatives ask for is time, and they are outraged that such a simple request cannot be accommodated.

Needless to say, medical and nursing staff have had to put up with verbal abuse, mental distress and threats of bodily harm.

Along the way, scenarios and situations crop up and many doctors have to cope with difficult ethical decisions, always conscious of being liable for professional misconduct if a potential organ donor is ‘lost’ or incorrectly handled. Does one tell the distressed relatives that their loved one is being admitted to ICU purely for cardiorespiratory support in preparation of enactment of HOTA, when the best option in another place and time would be to let the patient pass off with dignity in the light of medical futility? If we do, and the family refuses admission, what happens next? But how can we not tell them?

What if relatives insist on withdrawal of treatment in a clinically brain dead patient while medical staff are correcting laboratory results in preparation of formal brainstem death tests? Does the State rather than the family now own the patient? We now face a new dimension of ethical issues and there are no easy answers.

Dr T K Tan, Consultant Anaesthetist, Singapore General Hospital

resus:station

A redesign of the resuscitation trolley

Bulletin 45;September 2007:2301–2304

It was informative to read about work being done to solve a perennial problem faced when responding to ‘crash’ calls anywhere, and about the novel approach and progress of the project. I hope a ‘complete success’ rejoinder will follow in due course.

Though not directly relevant to the core of the article, I could not help having an uneasy feeling about the accompanying figure ‘Example snapshot of roles in a resuscitation scenario’. What concerned me was the position of a nurse at the head end. In a climate of decreasing importance attributed to A&B in the ABC scheme of things as evidenced by the change in ALS guidelines and the move by some trusts and anaesthetic directorates to withdraw anaesthetic cover to crash teams, this figure in the RCoA Bulletin may be considered an endorsement.

Between the two skills of external cardiac compressions and airway maintenance with ventilation, I don’t suppose there will be much argument...
as to which one is the more difficult to achieve (and easier to lose through lack of practice), and so needs ‘skilled hands’. Though there are many skilled non-medical staff fully equipped to do this, as a general rule it may be better to encourage medical staff to carry this out.

Dr S Paul, Specialist Registrar, Leicester

EWTD directive 2009 – a wake up call!

Bulletin 45; September 2007: 2288–2290

In order to achieve a 56-hour working week for trainees, many anaesthetic departments have adopted shift rotas. However, when the 48-hour week is introduced in August 2009, these rotas will often not have enough trainees to support training and daytime and out-of-hours service requirements. Some departments have tried expanding non-consultant grade posts to enlarge these rotas, but as many posts cannot currently be filled, this is unlikely to be a viable option for many hospitals.

Anaesthetic departments in some hospitals with a low out-of-hours workload have implemented ‘on-call from home’ rotas to cover their night and weekend work. The New Deal allows junior ‘on-call’ rotas to include an average of 72 hours of duty (i.e. being available) per week, including up to 48 hours working (i.e. being in the hospital). These rotas are effective for training as they reduce night-time working and enhance daytime activity.

Some areas of practice require an anaesthetist to be immediately available 24 hours per day (e.g. intensive care and the labour ward) and these will require shift rotas. Other areas have long periods of low activity (e.g. the operating theatre) and an ‘on-call’ rota is an ideal way of covering these when they are quiet, although a shift system will often be required to provide cover until midnight.

A hybrid rota, with both a shift and an ‘on-call’ component, is an option many hospitals may find useful in achieving a balanced working and training pattern within an average 48-hour week. It allows a department to maximise daytime training opportunities by reducing the time trainees spend in hospital at night. If an emergency theatre case occurs at night the department can escalate cover with both trainees and consultants, providing the ‘on-call’ trainee with consultant supervised experience of night-time emergency work and giving the consultant an extra pair of hands for complex emergency cases. The ‘on-call’ trainee can also provide night cover for sickness in the shift systems. A hybrid system also introduces trainees to the working pattern in which they are likely to work as consultants.

An algorithm for preparing a hybrid rota is given on the RCoA website at: www.rcoa.ac.uk/ewtd.

Dr A England, Consultant Anaesthetist, Royal Free Hospital, London

Simulation and assessment

Bulletin 46; November 2007: 2360–2362

My first encounter with a simulator was during the recent Primary FRCA OSCE exam. As the authors write, it creates a realistic scenario according to my very limited experience. I would like to make a couple of points regarding the use of simulation for assessing novice anaesthetic trainees.

Simulators are an ideal way to assess the failed intubation drill as a part of the initial assessment of competency for novice trainees. Theoretical knowledge alone is not enough for novice trainees to be able to perform when they face real intense situations such as failed intubation. Such situations are quite rare, and as the saying goes, ‘practice makes perfect’. Trainees, when exposed several times to such scenarios created by these simulators, will become more confident in dealing with them when they actually occur.

The other issue that needs to be addressed here is the challenge of implementing such systems in every single hospital, especially when the NHS is facing a severe financial crisis. Furthermore, simulation requires extra manpower with appropriate training to ensure they are used most efficiently in the long run.

Despite all the obstacles and difficulties, simulators still make an excellent tool for both training and assessment in the present day competence based training.

Dr P K B C Raju, Specialist Registrar, Perth Royal Infirmary

The party planners

Bulletin 46; November 2007: 2369–2370

Whilst Dr R Harish’s ideas to improve the profile of anaesthetists are good ones, and I follow most of them already, he is wrong to refer to anaesthesia as ‘our specialty’. Anaesthesia ‘our specialty’, maybe, but medicine is our profession, his and mine: to suggest anything else runs precisely the risk he wishes to avoid.

Dr C P H Heneghan, Consultant Anaesthetist, Abergavenny and Member of Council
EWTD concerns

From 2009, hospitals will be required to ensure that trainees work an average of no more than 48 hours per week. However, a recent RCoA survey of College Tutors has demonstrated that many hospitals are unprepared to meet the 2009 EWTD targets.

The survey, organised by Dr Anne Thornberry, specifically tried to identify how many hospitals:
- met the EWTD hours targets for 2007 and 2009
- managed an average three teaching lists a week for their anaesthetic rotas
- ensured no more than three consecutive nights on-call.

Despite only a 40% response rate, the results were worrying. Of those that replied, currently only 34% of hospitals reach all three targets for the 2007 EWTD hours requirements, and only 11% of hospitals meet all targets for 2009. Furthermore, several hospitals proposed to meet the 2009 target by reducing training time further. and 22% of hospitals reported they planned to employ more staff grade or trust grade posts.

As it is unlikely that there would be sufficient suitable applicants available for this to be a realistic option, other strategies to help cope with these challenges will be required. One possibility is the use of hybrid rotas, as described by Dr England on the College website at: www.rcoa.ac.uk/ewtd.

Listening to trainees

The President of the RCoA has been concerned about the availability of accurate information from trainees to inform College matters. The College has good links with trainees – two trainee representatives are on Council, together with a representative from the Group of Anaesthetists in Training (GAT). There are also extensive trainee connections through every College Tutor and Regional Adviser. Nevertheless issues such as MTAS recruitment emphasise why it is essential to have an up-to-date understanding of the experiences of trainees. The changing face of undergraduate and postgraduate education, coupled with the shifting demography and subspecialty interests of trainees, mean there is an array of opinion to which the College needs to listen.

Accordingly, the College is setting up a Trainees’ Advisory Group (TAG) to exist primarily as a focus group for the College. Regional Advisers are nominating trainees who they believe to be in a good position to advise the College. We are aiming to be inclusive: less than full time, academic, military trainees and those with an interest in pain, etc. We are also recruiting very junior trainees who are often under-represented in medical politics, and medical students and foundation doctors to aid the College in increasing its profile amongst potential trainees. Geographical representation is a priority to ensure that all home nations and major regions of England are covered.

This group will be up and running by January 2008 and will cut its teeth on upcoming issues such as the new round of recruitment, the Faculty of Pain Medicine, and revalidation.

Re-use of intravenous infusion equipment

We have become aware of recent audit data indicating that some anaesthetists are re-using drug infusion syringes and administration sets for subsequent patients. This practice ignores existing published guidance from the Association of Anaesthetists of Great Britain and Ireland, which states ‘All infusions, administration sets or items in contact with the vascular system... are for single patient use’. Similar statements are made by individual manufacturers of drugs and disposable equipment.

Although we are not aware of any published complications arising as a result of such practice, the possible consequences of cross contamination are potentially very severe. In the absence of any evidence as to the safety or otherwise of changing or re-using individual components of infusion systems, it is the view of the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain and Ireland and the UK Society for Intravenous Anaesthesia that drugs and disposables for total intravenous anaesthesia (TIVA) should be strictly single patient use.

References


Appointment of Members, Associate Members and Associate Fellows

The College congratulates the following who have now been admitted accordingly:

**Associate Fellows**

**October 2007**
- Dr Subrahmanyam Radhakrishna
- Dr Nazar Jumaa Murad
- Dr Akshat Rashmikant Shah

**November 2007**
- Dr Catherine Angela O’Dwyer
- Dr Andrzej Leszek Wlaszczyk

**Members**

**October 2007**
- Dr Catherine Isabella Denise Ludwig
- Dr Satyanarayana Oruganti
- Dr Sameh Botros
- Dr Nagaraj Javaraiah
- Dr Brigitha Anicetus Benedicta Pigera
- Dr Sandeep Kumar Lakhotia

**November 2007**
- Dr Saritha Thirunagari
- Dr Mazurana Maria Flegar

**Associate Member**

**October 2007**
- Dr Gayatri Daniel

**Affiliate**

- Mr David Wilkinson
- Mr Howard Bruce Cox

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Ms Louise Johnson, Course Administrator,
Trent Simulation and Clinical Skills Centre, Queen’s Medical Centre, Nottingham NG7 2UH

**email** Louise.Johnson@nuh.nhs.uk
**tel** 0115 9249924 ext 62113

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For further information, please contact:

Ms Hazel Cherrie
Department of Anaesthesia, Critical Care and Pain Medicine
Royal Infirmary
Little France Crescent
EDINBURGH EH16 4SA

**tel** 0131 242 3151
**fax** 0131 242 3174
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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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MESSAGES FROM MERSEY

We are pleased to take this opportunity to wish all candidates of the Mersey Courses Past – Present – Future Very best wishes for the New Year

These are hard times for anaesthetic trainees, most of it precipitated by the imbroglio of MTAS and the advent of MMC. We sincerely hope that things improve on all fronts this coming year and that, as the dust settles, the future becomes that much clearer.

In the meantime, we thank everyone for their tolerance, encouragement and support over the years and trust that we will continue to merit them.

To all our Alumni and Friends
A Happy and Fulfilling New Year
David Gray, Director

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Accommodation
Previous candidates’ information on the accommodation.
‘Thanks to you I have cleared my Part 1 exam in my first attempt. I had attended both your MCQ and Viva OSCE courses. Of the two courses, I can’t decide which one is better. The MCQ course was excellent. Before I came to the course, I had read a bit but had not done any MCQs and [did] miserably in my [Opening Paper] in the course but then the course put me back on track and helped me see things in the right perspective and helped focus my knowledge onto [sic] the art of answering MCQs. The importance given to Physics and Measurement was the best part of the course. It had a lot of hidden benefits. [Among the hidden benefits] I did not have to read my Physics and Measurement again for my viva and OSCE’.

‘About the Viva/OSCE course, I did wonder why you were concentrating so much on [the] OSCE which is only one part of the exam rather than the Viva which has two parts. But I found to my surprise my fears were totally unjustified as most topics covered in the OSCE part of the course were asked in the Viva exam also. Some of the add-ons to the course like the Base of Skull and X-Ray sessions and Skills Training [were] fantastic as I was able to anticipate and answer before the examiner could finish the question’.

‘Finally, even a person like me who is a hesitant and bad communicator got a compliment from the examiner and [the] actor who played the role after the exams regarding my performance in the Communication session (OSCE). I think it was solely due to the Communication Session and the repeated OSCE practice that when I went into the station I found I could ask questions and provide answers without fear or inhibition as to what may happen or whether what I am doing is right or wrong. That I think is the ultimate achievement of this course.’

‘I’m not sure you if you know but, at the risk of blowing my own trumpet, I was fortunate to be invited to the College Diplomates [sic] Day earlier in the year to collect my Nuffield Prize for the Primary exam. Three candidates from my sitting achieved the scores for the medal and, after a moment’s brainstorming, we established how we all knew each other – you can see the end coming, no doubt – we had met on the Mersey MCQ and OSCE/Oral courses. We thought we should let you know – your efforts must be working.’

‘I am delighted to say I passed both the MCQs and the Clinical on my first attempt having been on the Mersey course. The OSCE/Viva week in particular was a really excellent (and unexpectedly enjoyable!) preparation for the exam. Thank you very much and please pass on my thanks to the Faculty who were fantastic.’

‘Well, I passed the Final FRCA on Monday at the first attempt after being on the SAQ, MCQ and Viva weekend, so thanks very much. Having attended your Primary MCQ and OSCE weeks a couple of years ago, I am sure you’ll understand that returning to Aintree is something I am not planning on doing any time this decade. Plus I am broke! I have attached [photo of two young children] of a couple of people I am (now) going to spend some time with. Once again, thanks very much.’

‘But I remembered your story regarding stress [which] helped me a lot to overcome the stress during my exams in Dublin and I did very well.’

‘You have done it again! You have helped another wandering soul to find his way back! I passed my Final!’

‘I must say that, after having been grilled at your course (which incidentally I thoroughly enjoyed) my manner became much more calm and confident and ready to face the challenge of the exam. So much so that even my wife commented on this marked change in my confidence level and marvelled at how cool and collected I had become. You might consider me cheeky and presumptuous but I will say that I am not going to sit the Part 2 unless I do your courses for the same prior to it.’
Deaths

It is with regret that the College records the deaths of the Fellows listed below.

Dr William E Arnold, Devon
Dr Louis A Hamilton, Derby
Dr R Ray Hill, Daventry
Dr Micale Johnstone, Manchester
Dr Dev Rittoo, Lancashire
Dr David A Sherman, Florida, USA
Dr Dorothy Spence-Sales, London
Dr Sylvia Stewart, Leatherhead
Dr Alexander B M Telfer, Glasgow
Professor Michael D Vickers, Cardiff

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 one year, after which they will be moved to a permanent archive. Please email your text and any photo to website@rcoa.ac.uk.

There are currently obituaries for Dr L Hamilton and Dr D Spence-Sales available on the website via the following address: www.rcoa.ac.uk/obituaries.

Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

Dr Gavin D L Allan, Worthing Hospital, West Sussex
Dr Richard Chapman, Southampton General Hospital
Dr Jonathan Davies, City Hospital, Nottingham
Dr Arshad Ghor, Essex Cardiothoracic Centre, Basildon, Essex
Dr Sudarshana H Gururajaraao, Queen Elizabeth Hospital, King’s Lynn
Dr Emma Helm, Leicester Royal Infirmary
Dr Aidan Marsh, Frenchay Hospital, Bristol
Dr James H C Willmott, Macclesfield District General Hospital, Cheshire
Dr Harriet J Wood, Freeman Hospital, Newcastle

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Mr David Bowman

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Miss Sarah Bishop: 020 7092 1584

Hospital Visits
Miss Afsana Choudhury: 020 7092 1652

Individual Trainees A–Le
Miss Claudia Moran: 020 7092 1554

Individual Trainees Li–Z
Miss Claire Higgins: 020 7092 1553

IT Manager
Mr Richard Cooke: 020 7092 1711

Membership
Miss Karen Slater: 020 7092 1701

Professional Standards Manager
Mr Bob Williams: 020 7092 1698

RA/DRA/CT Appointments
Mrs Karen Morris: 020 7092 1573

Venue Hire
Miss Manja Krech: 020 7092 1510
email: roombookings@rcoa.ac.uk

Website/Bulletin
Mrs Edwina Jones: 020 7092 1692
Mrs Mandie Kelly: 020 7092 1693

Association of Anaesthetists of Great Britain and Ireland

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More detailed information can be obtained from Emma Hollington/Nicola Heard, Educational Events Co-ordinators, 21 Portland Place, London W1B 1PY tel 020 7631 8808/8805 email meetings@aagbi.org website www.aagbi.org.