Special issue
Including a summary of the 2007–2008 Annual Report

Challenges ahead

Living with uncertainty – lessons from burns care

CUSUM scoring – theory and practice

A view from the other end of the laryngoscope

Making hospitals safer for patients – The Safer Patients Initiative
This issue of the *Bulletin* has one obvious change: the colour of its cover. We hope that this will draw attention to the fact that it contains eight extra pages carrying an abbreviated version of the Royal College Annual Report. Previously, the Annual Report has been sent to over 14,000 Fellows and Members. As part of the RCoA policy of ‘trying to be green’, we have decided that one copy of the full report should go to each anaesthetic department in the UK, and that this reduced eight page version should be included in the *Bulletin* which is sent to all Fellows and Members. The full report is over 50 pages long, and the version included here inevitably does not cover all aspects of the projects undertaken at Churchill House. Even so, it has been quite an exercise to shoehorn the higher profile work into just eight pages. In line with my views on economy of words, we are also hoping that this slimmed down version will encourage more people to read it. It gives a complementary view of the RCoA to accompany the series of articles that we are running on the work of each department. The College is extremely busy at the moment, as the report demonstrates. We will repeat this exercise in each March issue if it is welcomed by readers. The cover of the next issue will return to its corporate magenta colour.

As I write this at the beginning of the first full working week of January, it is dark outside and there is a smattering of snow on the ground – even in the globally warmed south east of England! However, by the time this issue reaches the doormats, there will probably be fields of daffodils in full bloom – such is the way that we have to plan ahead for the editing, final design and layout, proof reading, printing and distribution. This is all quite hard work, and has made me wonder how major publications are produced on a weekly, or even a daily, basis. We are very lucky to have Mandie Kelly and Edwina Jones to ‘make it all happen’; their skills are invaluable. The deadline for receiving copy for the March issue is always before Christmas, earlier than would otherwise be the case due to the holiday, so I thank all who managed to meet the deadline.

In this issue of the *Bulletin*, I have asked my colleague Ken Sim to tell us about the current status of burns anaesthesia in the UK. Our hospital in East Grinstead was founded to offer reconstructive surgery to members of the RAF who suffered burns defending our shores during World War II, and burns anaesthesia is still very much at the heart of the work of our department. Although one of the less high profile subspecialties in anaesthesia, to be burnt is, nevertheless, one of the most distressing injuries that can occur, and one where the anaesthetist can make a real difference.

Please remember to think of submitting an article to the *Bulletin* if you want to share topics of interest with over 14,000 other Fellows, Members and Trainees.

Peter Venn, Editor
Challenges ahead

College activity and consultations
After the lull of Christmas the College has, once again, burst into activity in January. So have those who send out consultations on the e-waves; the GMC with its on-line consultations on the Medical Register and on ‘Tomorrow’s Doctors’, new organisations such as the Care Quality Commission (CQC) and many others that you will be pleased to know will not fall on the desks (or screens) of most of you.

When I wrote in January’s Bulletin about the work of the College I did not specifically address the issue of consultations. All of these are logged and distributed to Council Members, Specialist Societies and others with the necessary expertise as well as the ability to deliver work to a deadline. Some of these consultations are public but others are not and we make efforts to keep all of you abreast of your College’s responses on the website. If you want to take part in this consultation process then please contact the Professional Standards Department through cogunmilade@rcoa.ac.uk.

The National Institute for Academic Anaesthesia (NIAA)
As regular readers will be aware it is now almost a year since we established the National Institute for Academic Anaesthesia (NIAA) in conjunction with the Association of Anaesthetists (AAGBI). During the year, round one of the grants allocation process has taken place under the auspices of the Research Council of the NIAA. It was completed at the beginning of December when £400,000 of grant monies was allocated to a broad range of project applications. The British Journal of Anaesthesia (BJA) and Anaesthesia, the RCoA and the AAGBI currently support the Research Council. This is a landmark for anaesthesia in the UK; it is a clear demonstration that our profession, via the collaboration of its professional bodies, actively supports research and academic anaesthesia for the future of our specialty and the public benefit.

Although the contributing organisations have individually and substantially supported research over many years this new collaboration enables the founding bodies to maximise the number of successful applications where there might otherwise have been a shortfall. I congratulate all involved in this first Grants Allocation Process, particularly Professor David Lambert whose tireless...
work in managing the extensive review process for grant applications was germane to the successful outcome. The Obstetric Anaesthetists Association, the Society for Education in Anaesthesia, the Association of Cardiothoracic Anaesthetists and the Vascular Anaesthesia Society of Great Britain and Ireland have now joined the NIAA Council. We hope that more stakeholders will become members of the collaboration this year.

Anaesthesia safety conference
In early January the College held an Anaesthesia Safety conference in Churchill House. The focus of the day was the launch of the report of the Royal College of Anaesthetists’ Third National Audit Project (NAP3) on the Major Complications of Central Neuraxial Block in the United Kingdom. Many of you will have been involved in this audit, providing information or collating information as the link person in your organisation. The details of the report are on the College website but in essence this prospective study, the largest ever completed on the topic, shows epidurals and spinal anaesthetics are safer than previously reported. The report is published in the BJA and the full hard copy version also contains sections on clinical reviews and learning points. Copies can be obtained from: standards@rcoa.ac.uk.

Many acknowledgments of thanks are due on the completion of this report but I would like to mention Dr Tim Cook, Project Lead for the RCoA, Shirani Nadarajah the chief administrator for the project at the RCoA and Edwina Jones the RCoA projects officer. The 100% response rate of this audit demonstrates that anaesthetists have the confidence to share their clinical data with others in a professionally led project, providing accurate information for patients and improving care. NAP4 on Airway Management is well underway, and we are already in discussion both about the topic and funding of a fifth National Audit Project. It is a mark of the success of the recent National Audit Projects in producing ‘hard’ clinical data that the College is now exploring a fifth project where only three were intended originally. It requires the collaboration of anaesthetists everywhere and I ask for your continued support.

Headley Court
A few weeks before Christmas Douglas Justins, Dean of the Faculty of Pain Medicine, and I had the opportunity to visit Headley Court, the Defence Services Rehabilitation Unit. I would like to take this opportunity to say how impressed I was with the work at Headley Court and to thank Colonel John Etherington and his staff for allowing us to see at first hand the amazing results of their advanced rehabilitation techniques and pain management. It was an incredible example of what can be achieved after trauma and I hope it will translate into civilian practice.

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...THIS AUDIT DEMONSTRATES THAT ANAESTHETISTS HAVE THE CONFIDENCE TO SHARE THEIR CLINICAL DATA WITH OTHERS IN A PROFESSIONALLY LED PROJECT

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European Working Time Directive (EWTD)
Over the last few weeks EWTD has occupied more of my time than I would have wished, and I’m quite certain that it has also occupied the time and effort of many of you for some years. The move towards a 48-hour working week for doctors in training, added to the constraints on their pattern of work, has caused overwhelming problems for some services, including ours, that provide 24-hour emergency cover. There are a few examples of reconfiguring services, some in newly built institutions, which have resulted in improvements for patients and staff. Perhaps the EWTD has been one of the triggers for these, but they are in the minority.

The impact of the EWTD on the quality of training has yet to be calculated but it would be naïve to suppose that there will be no effect. Furthermore, the impact on senior staff, the consultants, is unknown but certainly considerable and must be recognised. I do not make these remarks lightly neither do I confine them to our own disciplines of anaesthesia, intensive care and pain medicine. There are now many examples of consultant staff providing middle grade, 24-hour cover as well as consultant cover. This is not because it is in their job plans, but because they are so concerned about maintaining a safe service for their patients. This is not a sustainable situation.

So, what is the College able to do about this? Realistically I do not believe that the Government can change the law by 1 August 2009. What we can do is provide accurate information from you to the four Departments of Health and the Secretary of State and we have done that both independently as well as through the Academy of Medical Royal Colleges. We will continue to communicate with the Departments of Health, urging them to allow the senior medical staff, working with hospital managers, to find local solutions that they are able to sustain. Surely that is the privilege of being a consultant, to work with others to find a solution if possible, not have solutions imposed. Over the last two years the College has made available on the website,
and in publications, various ways of creating rotas for trainees that will meet EWTD requirements and enable sustainable training. However, if there are not enough people available to fill sustainable rotas no solution is going to work. The College will continue to collect and provide evidence on the outcome of training to the regulator and the Departments of Health.

So what may be the solutions? Whatever they are, they must be planned to deliver for the total medical workforce over the long-term, rather than being a superficial ‘patch’ for the purpose of meeting short-term political ends. Changes in the methods of provision and length of training, more flexible consultant working practices, an increase in consultant numbers: all must be considered and I know that many of you have already implemented change. I am not qualified to say whether there is any possibility of changing European Law. Is Medicine receiving an unfair ‘hit’? Yes it is, because at its roots, the EWTD is Health and Safety Legislation, and the issue of patient safety is always at the forefront in medicine. The UK is most unusual in Europe, because doctors in training contribute to the service in almost every NHS hospital. I can assure you that, as the representative of your College, I will make every effort to impress those at the highest level of the needs of permanent staff and doctors in training, as they aim to deliver safe, high standard care for their patients, both now and in the future.

Elections to Council

Congratulations to all those elected and re-elected to Council in December. We look forward to working with them as they return to Council or join us in March. The election results are shown opposite.

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### ELECTION TO COUNCIL 2009

An election to vacancies on Council of The Royal College of Anaesthetists took place on Friday, 12 December 2008. The votes were counted by the Electoral Reform Society (ERS).

#### Consultant vacancies

There were four consultant vacancies due to the demitting of office by Dr D P Cartwright, Dr K R Myerson and Dr J D Greaves, and the resignation of Dr A-M Rollin. Dr Myerson and Dr Greaves are eligible to stand for a second term. The results were as follows:

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<tr>
<td>MYERSON, Keith Roger</td>
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<tr>
<td>GREAVES, John David</td>
<td>644</td>
</tr>
<tr>
<td>WHITAKER, David Kenneth</td>
<td>1,044</td>
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<td>NOLAN, Deborah Mary</td>
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<tr>
<td>WALDMANN, Carl Samuel</td>
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<tr>
<td>VERMA, Ranjit</td>
<td>618</td>
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<tr>
<td>COLVIN, John Russell</td>
<td>564</td>
</tr>
<tr>
<td>MAGEE, Patrick</td>
<td>527</td>
</tr>
<tr>
<td>PATEMAN, Jane Ann</td>
<td>524</td>
</tr>
<tr>
<td>MAZE, Mervyn</td>
<td>492</td>
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</tbody>
</table>

The total number eligible to vote were 10,159.  
The total number to actually vote were 2,373.  
There were 19 invalid ballot papers received.

#### Trainee vacancy

There was one Trainee vacancy due to Dr A P McGlennan demitting office. The results were as follows:

<table>
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<td>NATARAJAN, Nagendra Krishnan</td>
<td>79</td>
</tr>
<tr>
<td>VAMADEVAN, Shelley</td>
<td>22</td>
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The total number eligible to vote were 1,601.  
The total number actually to vote were 255.  
There were 36 invalid ballot papers received.

#### Staff and Associate Specialist (SAS) vacancy

There was one SAS vacancy due to Dr R Laishley completing his first term of office. Dr Laishley is eligible to stand for a second term. The results were as follows:

<table>
<thead>
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<td>LAISHLEY, Roger</td>
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<table>
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<tr>
<td>NADGIR, Anand Dattatraya</td>
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<td>KUMAR, Rajesh</td>
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</tr>
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</table>

The total number eligible to vote were 10,860.  
The total number actually to vote were 2,526.  
There were 823 invalid ballot papers received.
Living with uncertainty
Lessons from burns care

These days, no-one disputes the need for accountability in healthcare, or that performance should be assessed through a new regulatory framework. However, agreeing the destination does not automatically determine the route. In burns care, assessing services and clinicians requires knowledge and wisdom, and not just data and information.

‘Doctors alone amongst health professionals must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well developed clinical judgement. The doctor’s role must be defined by what is in the best interests of patients and the population served.’ Thus begins a new consensus statement of the Medical Schools Council.¹

Imagine that you read the above, nod appreciatively, and then are summoned to treat a patient with 50% body surface area burns who has been rescued from a smoke filled room. Indeed, this is a situation of clinical complexity and uncertainty, and you are pleased to direct initial management, and onward refer the patient to the regional burn centre. But what happens next?

Progress in burn management
Burn injury management has moved a long way from the chopped animal hair, dried dung and magical invocations favoured by the Ancient Egyptians. More recent advances were accelerated by fledgling regional plastic surgery units in the UK, treating service personnel during World War II. As care options diversified, custom-built burns units were required and the first of these, the purpose built McIndoe Unit, opened in 1965 in East Grinstead at the Queen Victoria Hospital.

However, the pre-eminence of UK burn care has diminished in recent years. Major burn injuries are not only complex but also rare, so the numbers in individual units are inevitably small. The British Isles Burn Injury Database records about 5,000 cases per year from the 18 burns services in England and Wales, with nearly 40% aged less than five years. Only 500 patients per annum suffer major burns of greater than 15% body surface area. The registry records around 100 burn deaths per year, with one third in patients of over 75 years of age. The United States now dominates the international literature, supported by investment in military surgical research, and the Shriners’ charity funding of paediatric burn care.

Dr K M Sim,
Consultant Anaesthetist, McIndoe Burns Unit,
Queen Victoria Hospital, East Grinstead

¹ Dr K M Sim, Consultant Anaesthetist, McIndoe Burns Unit, Queen Victoria Hospital, East Grinstead
'Evidence based medicine is the conscientious explicit and judicious use of current best evidence in making decisions about the care of individual patients.'

In Evelyn Waugh’s novel ‘Scoop’, the newspaper magnate Lord Copper cannot be told ‘no’ directly. Instead, the phrase ‘up to a point’ must be used. So, is the fate of the burned patient governed by evidence-based interventions? Well, up to a point. Commonly, burns management is pragmatic and based on local resources, experience and opinion. There are few randomised controlled trials in trauma care. A screening exercise reviewing 4,000 titles in the Cochrane Database of Systematic Reviews in 2005, found less than 40 that were directly or indirectly relevant to the care of burns.

Despite this, burns treatment has progressed. The enthusiasm and dedication of clinical teams under committed leadership have delivered results. Surgical and anaesthetic techniques, fluid replacement, infection control and nutritional support have all contributed to major reductions in mortality, and an improved quality of survival.

**Clinical dilemmas**

However, there is plenty of work still to be done. Developments in the immediate resuscitation of major burns have stalled through lack of agreement, either on monitoring standards or resuscitation endpoints. The Parkland formula, the predominant means of calculating fluid resuscitation volumes, evolved from animal work and subsequent field studies in just 11 patients. Its limitations are well recognised. Actual volumes given commonly exceed the calculated Parkland value, resulting in ‘fluid creep’ with recognised morbidity. Simple or unrealistic resuscitation endpoints, coupled with regimens exclusively of crystalloid, contribute to impaired tissue perfusion, compartment syndromes and extended burn depth. Early use of colloids is debated still and, as the colloid versus crystalloid debate rumbles on, transatlantic differences in the cost and availability of new colloid solutions restrict comparisons between regimens.

The management of smoke inhalational injury is clouded similarly by a lack of consensus in diagnosis and definition. Treatment protocols vary considerably. Lung protective strategies during ventilation are broadly accepted, but numerous adjunctive therapies are also used locally. Their efficacy is unknown because no agreed outcome measures are recorded.

**How are early signs of sepsis in major burns to be distinguished from the pro-inflammatory state?**

Whilst the importance of adequate nutritional support to meet the increased metabolic demands of major burns is well recognised, the efficacy and safety of early enteral nutrition remain unproven – with only three randomised controlled trials, totalling 70 patients, deemed eligible for Cochrane review.

The critical care management of major burns is supportive only. Recovery is determined by premorbid health, age and surgical intervention. Surgical techniques, experience and resolve vary. Recovery can be protracted, often posing complex management issues as yet unresolved. How are early signs of sepsis in major burns to be distinguished from the pro-inflammatory state? Should the hormonal and endocrine response to injury be modified and, if so, by what means?

**UK National Burn Care Review**

Diversity of organisation accompanies therapeutic uncertainty. A review of UK national burn care was published in 2001. The report was critical of existing services, citing enormous variation in terms of organisation, staffing, facilities and workload. Intensive care provision for major burn injuries, both in adults and in children, conflicted with NHS standards. The disparity was greatest for the most severely burned children, because co-location of burns expertise and paediatric intensive care was regarded as essential. At the time, only one paediatric burn service in England met with the required staffing standards. There was no national strategy for burns care, and, moreover, a paucity of data on which to base any strategic developments.

The report offered an alternative vision for UK burns services. Patients with significant burns should be managed by burns specialists. A hierarchy of burns services was proposed, directing the most complex injuries to a small number of centres for major burns where expertise, research and future specialist staff training would be concentrated. Services were to be networked by region. Defined burns care standards and enhanced data collection were considered essential steps towards a formal process of service designation and accreditation.

A national burns bed bureau and a nationwide burns major incident plan were proposed.

So where are we now? Is this change delivered? Well, up to a point. There has been investment in individual services, four regional networks are
established covering England and Wales, and operational standards have been defined. The burn injury registry is under development and there is now a bed bureau and a major incident plan.

On the other hand, excessive bureaucracy, local interests, and the failure of central co-ordination of the wider agendas in trauma and paediatric care, have impeded collaboration and progress. The drive towards centralising expertise contrasts with the need to retain flexible capacity and experience in burn injury throughout a network. Some latent capacity is always needed in the event of mass casualties. Opportunities for training are limited – a major concern, given the role of anaesthetists in the triage and transfer from referring hospitals.

There is also a potential problem in the relicensing and recertification of burns specialists. Objective assessment and clinical practice will be measured against standards. Setting those standards will be critical, and must be ‘in the best interests of patients and the population served’. Therefore, a consensus must be reached regarding core standards and outcome measures if assessment is to be workable. One route is through specialist groups and societies. The website of the AAGBI provides links to nearly 40 specialist societies with an anaesthetic focus or involvement.

It has been proposed in the RCoA Academic Strategy Report that such specialist societies should be the platform from which national research networks can evolve. These groups already define relevant knowledge and skills in subspecialty areas, and a supplementary role in assessing organisational change would reduce duplication of effort.

In UK burns care, future progress depends upon co-operation and collaboration and, inevitably, an acceptance of a certain loss of autonomy for individual units. This lesson may apply more widely.

References
3 Stelfox HT, Goverman J. The Number, Content, and Quality of Randomised Controlled Trials in the Prevention and Care of Injuries. J Trauma 2008;65:1488–1493.
6 Wasiak J, Cleland H, Jeffery R. Early versus delayed enteral nutrition support for burn injuries. Cochrane Database of Systematic Reviews 2006 Issue 3.

A reminder that the next meeting of the Senior Fellows Club will be held at the Banqueting Suite of Birmingham City’s Council House on Thursday, 14 May 2009. Professor Peter Hutton, Past President and Professor of Anaesthesia at Queen Elizabeth Hospital, Birmingham, has kindly agreed to provide the Guest Lecture.

By popular request from Senior Fellows, this meeting is being held outside London – the first in some considerable time – and a good attendance is hoped for.

As the programme evolves, details will be posted on the Senior Fellows page of the College website: www.rcoa.ac.uk/seniorfellowsclub
Coming to America
I am both a Diplomate of the American Board of Anesthesiology (ABA) and a Fellow by examination of the Royal College of Anaesthetists (RCoA). With approximately equal time spent training in both countries, you may wonder which training programme I think is the better.

Dr R Homer,
Specialist Registrar, Addenbrooke’s Hospital, Cambridge

I graduated in the UK, where I worked through the senior house officer grade. When my husband’s job moved to Seattle on the west coast of the USA, I continued my training there. After a year out to pass the United States Medical Licensing Examination, I began as an ‘intern’. That year was more intense than my house officer year. However, it was surprisingly enjoyable given that, as a surgical intern, I actually spent most of my time in the operating theatres. My introduction to American anaesthesia subsequently began with a three-year residency training programme.

The University of Washington has a large residency programme administered by a single department. It is spread across four hospitals within Seattle. The University Hospital houses all the major specialties, whilst Harborview acts as a level one trauma centre, Veterans Affairs Puget Sound provides care for former armed services members, and paediatrics is undertaken at the Children’s Hospital and Regional Medical Center. The programme comprises 66 Residents, ten Fellows, 76 permanent Attendings, 31 Certified Registered Nurse Anesthetists (CRNAs), and any number of visiting faculty. US interns equate to old-style pre-registration house officers, whilst Residents are specialty trainees, and Fellows are undertaking extra subspecialty training for a year or two. Attendings are fully trained in their specialty, but I hesitate to say they are equivalent to UK consultants. Although CRNAs are licensed for independent practice in many states, the University of Washington requires them to work under the supervision of an anaesthesiologist. In that sense we, as Residents, worked side by side with nurse anesthetists, whose presence facilitated our protected teaching sessions. Although there was some friction, assignments to peripheral nerve block lists of course, the programme could not run without them. CRNAs are drawn from experienced intensive care, emergency department and
recovery nurses which, in my view, is an important difference from Physicians’ Assistants (Anaesthesia) in the UK.

**Someone to watch over me**

Many will be aware that UK operating department assistants do not have a direct equivalent in the USA. However, there are anaesthetic technicians, usually one per four theatres, who are available to help with the setting up of equipment and hasten room turnover. Another major cultural difference is the absence of anaesthetic rooms in the USA. Thus, all patients undergo induction of anaesthesia on the operating table. Turnover could be rather slow because, with no lay-up rooms, we had to wait until the scrub staff had opened all the instruments before administering anaesthesia. The average list ran from 07.20 to 17.30 hours. Often, there were booked overruns past 19.30 hours. Patients could be sent for much earlier and were kept in the pre-operative holding area, so that delays caused by portering were virtually never an issue. Intravenous access and peripheral nerve blocks could be undertaken in the pre-operative area, whilst the operating room was made ready.

In teaching hospitals and many private practice groups, each anesthesiologist will supervise up to four Residents or CRNAs, each in a different theatre. For billing purposes the Attending anesthesiologist must be present at induction and emergence from anaesthesia, and throughout any critical event. They must remain within the hospital building throughout each case. This inevitably leads to the being Resident on-call – even as head of department! Attending anesthesiologists tend not to have regular lists with specific surgeons, in contrast to the practice of most UK consultants.

One obvious consequence of the billing ‘rules’ is that Residents never work under distant supervision. Every case undertaken, including labour epidurals, would be assessed by the Resident and then discussed with an Attending beforehand. The University of Washington hospitals have electronic patient records in addition to an efficient pre-operative assessment clinic, which provides for much more efficient transfer of information than by leafing through three volumes of UK paper notes. Even admissions for day case surgery (comprising the vast majority) would have a personal anaesthetic plan prepared the night before. The master list for the following day, with Attending and Resident assignments, was generally prepared by lunchtime.

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**One obvious consequence of the billing ‘rules’ is that Residents never work under distant supervision**

On the evening before surgery, Residents were expected to describe each patient on the list to the Attending. This was the case even at the trauma hospital, where half of the cases were urgent. I found that this allowed much more opportunity to think through potential problems.

**Education, education, education!**

My programme was organised in modules prescribed by the Accreditation Council for Graduate Medical Education (ACGME).¹ Modules have to meet specific ACGME-required case numbers and follow a strict curriculum. As new starters in the residency programme, we attended a weekly teaching morning for the first two months. Thereafter, Residents from all three years of the programme would attend one morning of protected teaching every third week. Working the previous night was not considered a valid reason for absence. There was also a departmental Grand Round for an hour each week, and each hospital had at least one further session for Residents rotating through that hospital. These meetings were generally scheduled for 6.00 am! There was a weekly morbidity and mortality meeting at the University Hospital, held during the working day. In addition, we were expected to attend a whole-evening seminar/workshop about once every two months.

Having moved through regions within the UK since my return, I have experienced varying intensities of formal teaching. This has ranged from thrice weekly evening sessions for examination candidates, to a whole day, but slightly less than once every other month. As the pass rate of Residents in the ABA examinations is an important statistic of any programme wishing to attract applicants,² teaching sessions and attendance are taken very seriously. However, I did sometimes feel like a schoolchild. Perhaps on balance the more hands-off UK approach is preferable. Each year, the residency programme directors are required to submit a logbook summary for each Resident in training to the ACGME. This requires a minimum number of cases in all subspecialty areas to be undertaken over the three year programme. Specified numbers of supervised experiences do not, of course, guarantee the ability to perform well independently. However, I am not sure whether our current UK system of demonstrating a procedure successfully just once necessarily carries any greater a guarantee of quality.

To me, the training appeared to be quite inflexible. For instance, less than
full-time training is not an option. Any Resident taking more than 60 days in three years away from clinical work (for annual leave, courses, sick or maternity leave) is required to make up that time at the end of the period of residency training.

We were required to sit a national standardised multiple-choice question examination, the Anesthesia Knowledge Test (AKT), after one, six and 18 months of training. There is no negative marking, and most questions are in the format of single best answer from a choice of five. Scores broken down by subject matter are fed back to both the candidates and the residency programme administrators to assist directed study and teaching. This seems to me more helpful (although also more labour-intensive) than simply being told an overall examination score as happens in the FRCA. Many programmes now require a minimum score in these examinations in order to continue with residency training.

Most residents sit the American Board of Anesthesiology written examination at the end of the third year. After passing the written, the oral examination can be taken during the following calendar year. In contrast to the FRCA structured oral examinations (SOEs), basic science knowledge is assumed, having been tested during the written component. The aim of the oral examination is similar to that of the FRCA, in that it is designed to test a candidate’s clinical judgement, and their ability to prioritise conflicting patient’s needs, justifying a particular technique that they have chosen. According to the ABA newsletter, first time pass rates for the 2006 examination were 88% in the written examination, and 76% in the oral examination,3 contrasting with rather lower figures in the FRCA examinations. I am grateful to the RCoA for counting my ABA certification in lieu of Primary FRCA.

Independence day
In the US system, one’s first solo list does not occur until after completion of the residency training programme. Once I returned to the UK, it took me several months as an SHO to acclimatise to starting a case with only an ODP present, because the pre-induction telephone call to notify my Attending had become such an ingrained ritual. Perhaps this was a personal or a cultural reaction, because many of my American colleagues were expressing the opposite by the end of our second year of residency – in other words, dismay at the prolonged training required of them before being allowed to work independently. I, too, believed that I possessed the required knowledge, skills and judgement at that time, although not in possession of as much experience as I would have liked. My subjective impression was of a much greater intensity of working in the USA. My logbook shows just over 1,600 cases in three years of training in the USA, as opposed to around 500 in my first Specialist Registrar year in the UK. Although numerically similar, the former included rather more trauma, both blunt and penetrating, than I have seen so far in Cambridge.

Completing an American anaesthesia residency programme was a valuable experience, and continues to shape my daily practice. Training within the two systems has been complementary as far as I am concerned. As the graduates of each system proceed to their different situations, I would hesitate to declare one system ‘better’ than the other. Both, I believe, are fit for purpose within their own contexts.

Acknowledgments
My thanks to Dr Liam Brennan, Regional Advisor, Eastern Deanery, for encouraging me to write this piece, and to Karen J Souter MB BS FRCA, Associate Professor and Residency Program Director, Department of Anesthesiology, University of Washington, for helpful comments on the manuscript.

References
1 http://www.acgme.org/acWebsite/navPages/nav_040.asp
There are many methods of assessing the competency of novice trainees in anaesthetics. Techniques vary from informal ‘on-the-job’ assessments, to formal SimMan scenarios. This wide variety of approaches suggests a lack of consensus about the most effective way of measuring a trainee’s competency.

Cumulative SUM (CUSUM) assessment curves potentially provide an effective process by which to assess new starters. They allow immediate feedback on an individual’s progression, and indicate whether a trainee has attained a particular skill, or has caused concern requiring intervention and further training.

CUSUM charts were first described by Page in the 1950s, and were initially used as a quality control tool in industry. They have been used in medicine for several decades, most often in the surgical specialties, and especially in cardiac surgery. Indeed, CUSUM data were used in the Royal College of Surgeons’ analysis of performance during the Bristol Royal Infirmary Inquiry.

A consultant-led trial of CUSUM assessments for novice trainees was carried out at Salford Royal Hospital, starting in August 2007. Two novice trainees were assessed using CUSUM during their initial three months of training. The aim was to identify whether CUSUM would provide useful information for the initial assessment of competencies.

Charting the way to successful curves
The CUSUM score represents the running total of successful and unsuccessful attempts to perform a particular technique. The value attributed to these attempts depends upon the acceptable failure rate for the technique in question. For instance, if the acceptable failure rate is 10%, then for each failed attempt there will be an increment value of 0.9 and for each success there will be a decrement value of 0.1. Figure 1 shows an example of a CUSUM curve.

This demonstrates that an acceptable performance would be depicted by a graph with a horizontal or gently downward sloping line. Plotting the graph also allows the application of horizontal lines at set CUSUM scores that, if crossed, indicate either acceptable progress or the necessity for intervention.

Three procedures with easily identifiable endpoints were selected: oral endotracheal intubations during routine and during rapid sequence induction of anaesthesia, and insertion of a laryngeal mask airway (LMA). The supervising consultant set parameters to identify a successful performance, based loosely upon agreed standards. For instance, endotracheal intubation at the first attempt on direct laryngoscopy was scored as a success. Whilst cricoid pressure or the use of a gum
elastic bougie was permitted, removal of the laryngoscope blade from the airway for any reason, for example, to reposition the head or change the blade, classified the attempt as unsuccessful. Use of an LMA was classified as successful if a good seal was achieved on the first attempt at insertion. Repositioning the LMA, or changing for another type or size, constituted a failed attempt. The period of assessment commenced nine days after the beginning of new starter training, and ended at three months. Both of the new starter trainees collected their respective CUSUM scores.

It was difficult to establish acceptable failure rates from the literature. This was partly due to the differing parameters used to classify an attempt as successful, as well as the different cohorts of individuals being examined. Two studies reported success rates from 87% to 94% for LMA insertion, and from 54% to 93% for endotracheal intubation.7,8 For this study, the acceptable failure rate for all three techniques was set at 10% by the supervising consultant.

The perfect curve?
Over the period of assessment, 108 intubations, 87 LMA insertions, and nine rapid sequence inductions (RSI) were performed. In total, there were 12 failed endotracheal intubations and eight failed LMA insertions. Figures 2, 3 and 4 show the CUSUM curves for each technique for both of the trainees. Following each ‘failed’ attempt, the patient’s airway was subsequently successfully maintained with one further attempt using the same technique, with the exception of one failed LMA insertion where the patient was subsequently intubated.

An imperfect plan?
There are two notable limitations of the study. As mentioned previously, because there were limited data from which to derive the acceptable failure rates, these were decided upon by the supervising consultant. It could be argued that the failure rates are too lenient, however, with novices it seems reasonable to be lenient at first. This can then be revised after
a period of time, for example, following the initial test of competency, and thereafter modified to an acceptable figure corresponding with published data. By this ‘raising of the bar’, the trainee’s performance is measured against known rates of failure, and further progress in skill acquisition is demonstrated.

The second limitation is that the definition of a ‘successful attempt’ could be considered as quite restrictive. It is not uncommon even for an experienced anaesthetist to reposition the head or change the laryngoscope blade, and still to count the intubation as successful. This is evident in the results, because every ‘failed’ attempt was followed in the same patient by successful management of the airway. Therefore, a more appropriate criterion might be defined: ‘Successful management of the airway leading to intubation or LMA insertion within a set period of time, allowing a maximum of three attempts, and without arterial oxygen desaturation or any other evidence of patient harm.’ An alternative example is a definition used in a paper on the assessment of LMA insertion: ‘Detection of expired carbon dioxide within 40 seconds of Guedel airway removal, which subsequently rose to an end-tidal value of at least 4 kPa, together with satisfactory lung expansion and ventilation, without other airway intervention by the anaesthetist.’ These types of definition permit a more realistic application, allowing for more than one attempt to be made, providing that the patient remains stable and well oxygenated. Within these definitions, the success rates, and therefore the CUSUM curves, for both of the trainees would be significantly improved. This might better represent everyday practice, as well as demonstrating an additional skill: that of recognising the safe duration of stable and normoxic apnoea.

Future collaboration with CUSUM curves?
Our data received positive feedback on presentation to a meeting of the Salford Royal Anaesthetic Department, where they were considered unanimously to be a beneficial adjunct to the initial assessment of competencies. As trainees, we believe that the CUSUM charts require little additional information and, other than the limitations discussed, that they provide a simple and useful pictorial representation of our progress.

Another advantage of CUSUM is the speed and autonomy with which the trainee can assemble the curves, in contrast with other forms of assessment that require time and collaboration with a consultant, and are therefore often difficult to organise. The Royal College of Anaesthetists now requires trainees to complete 24 written assessments every six months, including 12 Direct Observations of Procedural Skills (DOPS). A nationally agreed set of CUSUM curves could replace the current DOPS assessments, halving the required paperwork each year.

A nationally agreed set of CUSUM curves could replace the current DOPS assessments, halving the required paperwork each year.

References
CUSUM scoring
Theory and practice

The changes wrought by MTAS and the European Working Time Directive have had a major impact on the duration and methods of assessment of training. In the future, many trainees in the UK will receive an average of only three supervised half-day training lists per week. Therefore, it will be essential for every procedure and every patient to count towards training.

Progress previously evaluated by supervision as an apprentice, with a sizeable case load, has been replaced by a substantially reduced total number of cases and a limited number of work based assessments (WBAs). Such assessments can be formative – allowing a trainee to judge progress against an agreed standard, with feedback being given on areas that need further improvement, or summative – a ‘true or false’ statement as to whether the trainee has reached a desired standard of competence (but not necessarily expertise). Unfortunately, many trainees consider the WBAs to be summative, rather than formative. They may then defer assessment until they feel they can achieve a high score, leaving most of the assessments to be completed just before their Annual Review of Competency Progression (ARCP). This leads to a deluge of requests to trainers for WBAs at the end of each year, with little chance of correcting any competency deficit that may be present. There is a large variation in both the WBAs and clinical experience logged by trainees (Figure 1). So, is there a better system to monitor competency progression? The accompanying article by Fradkin et al in this issue focuses on CUSUM scoring, and the acquisition of airway skills by novice anaesthetists. Here, we consider whether this model might work on a broader scale.

What is CUSUM?
The CUSUM chart, or ‘CUmulative SUMmation chart’, is a learning tool that can be used to track a trainee’s success or failure in a particular technical skill, allowing any trend in performance to be analysed. Examples include industrial and managerial processes, as well as investigative procedures in medicine (colonoscopy, ERCP, renal and breast biopsies). Within anaesthesia, it has been used to evaluate the optimal timing for effective topical local anaesthesia, the application of new clinical knowledge, and the acquisition of practical skills such as intubation, regional anaesthesia and the use of ultrasound.
A CUSUM chart is a graph of outcomes of a series of consecutive procedures. Several forms of CUSUM plots exist.6,8,9 The format most commonly chosen displays performance on the Y axis and the number of procedures on the X axis (Figure 2). Success and failure are defined in advance for a particular procedure, and data are collected. For instance, when using the CUSUM system for every femoral block performed, each success will lead to the graph sloping downwards (negative direction), but if the procedure ‘fails’, the graph slopes upwards (positive direction). The chart will continue to build over time, depending on the number of procedures performed. Once the graph starts moving downwards constantly, proficiency has been achieved.

For any series of procedures (for example, epidural blocks or endotracheal intubations), numbered X1, X2, ..., Xn, the CUSUM score (Sn) can be defined as:

$$S_n = \sum(X_0 - X_i)$$

where $X_i = 1$ for a success and $X_i = 0$ for a failure. $X_0$ is a reference or target value set for the level of performance. A 90% success target is set initially. A success in nine out of ten procedures would then have a target value of 0.9. Thus, for every failed attempt the CUSUM increases by an increment of 0.9, whilst each success reduces the CUSUM by 0.1.

Upper and lower limits can be set to define failure to acquire competency or proficiency. These limits should be specified for each procedure in advance. The position of these lines should be based on the need to avoid type 1 and 2 errors – a premature award of competence, or a premature conclusion of incompetence within a stated number of attempts.
The demand for public accountability places increased emphasis on more objective performance-orientated tests of clinical competence, whilst 10% of trainees reported less than ten intubations per month, the top 10% averaged more than twice that number. As the average number of cases needed to achieve proficiency at intubation may range from 43 (Table 1) to 57, early recognition of a problem is critical. Often no corrective feedback is given after initial training, and a sizeable number of trainees do not achieve proficiency within the training period. We can no longer allow the ‘see one, do one, teach one’ approach to training.

CUSUM data could be used to help assess a department’s performance (Figure 3). The demand for public accountability places increased emphasis on more objective performance-orientated tests of clinical competence, especially where there is a well recognised relationship between numbers treated and clinical outcome in many fields of medicine. The CUSUM score enables a continuous audit of the quality of clinical practice, although a higher failure rate for high volume practitioners might reflect their willingness to tackle more difficult cases, and some form of stratification may be necessary in the analysis.

Disadvantages
Training has undergone a huge overhaul in the last three years, and one might argue that ‘enough is enough’. One of the authors (CL) attempted to evaluate a paper-based CUSUM scoring system for novice anaesthetists learning intubation, although 10% is more widely accepted. Potentially, the system can also identify strengths and weaknesses in trainers. A good trainer may be associated with the more rapid acquisition of a skill in a greater number of trainees.

Benefits
CUSUM provides an objective graph of performance in a newly learned technique in terms of both quantity and quality – something that is missing from current logbooks. This allows the trainee to self-direct learning, and gives the trainer greater confidence in reviewing the trainee’s current skills on first contact. Poor performance may be readily identified before both trainee and trainer become demoralised by repeated failures. As trainees become more experienced, the ‘acceptable failure rate’ can be adjusted downwards. Thus, a trainer can set a standard for an ST1 trainee that is different from that for an ST3. ‘Failure rates’ of 20% have been used for novice anaesthetists learning intubation, although 10% is more widely accepted. Potentially, the system can also identify strengths and weaknesses in trainers. A good trainer may be associated with the more rapid acquisition of a skill in a greater number of trainees.

CUSUM also enables the calculation of the number of training opportunities required for the majority of trainees to complete a training objective. Trainees learn at different rates, and the number of suitable cases varies. At their annual assessment, one of the authors (CL) reviewed the number of cases per month undertaken by 89 trainees at eight different hospitals within the South Thames region. The 10th, 50th and 90th centiles for endotracheal intubation were 9, 14 and 21. Thus, as numbers treated and clinical outcome in many fields of medicine.

The demand for public accountability places increased emphasis on more objective performance-orientated tests of clinical competence

Table 1 Numbers required to achieve proficiency
Data in brackets refer to the number of trainees who reached an ‘acceptable’ failure rate of 20%. Adapted from De Oliveira RG.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral intravenous cannulation</td>
<td>57</td>
<td>44</td>
<td>19–146</td>
</tr>
<tr>
<td>Intubations (4 of 7)</td>
<td>43</td>
<td>34</td>
<td>9–88</td>
</tr>
<tr>
<td>Spinals (7 of 11)</td>
<td>36</td>
<td>20</td>
<td>13–68</td>
</tr>
<tr>
<td>Epidurals (5 of 11)</td>
<td>21</td>
<td>11</td>
<td>9–36</td>
</tr>
</tbody>
</table>

Table 1 Numbers required to achieve proficiency

Data in brackets refer to the number of trainees who reached an ‘acceptable’ failure rate of 20%. Adapted from De Oliveira RG.

Figure 3 Epidural numbers versus outcome
1,850 epidurals performed by 23 consultants over a period of four years were examined to see what proportion ‘failed’, i.e. required a different pain management technique post-operatively.
at www.anesthesialogbook.com. The CUSUM score is recorded in the last tab of the application and reports can be created instantly from any location. This application allows RCoA logbook data to be imported and exported for further analysis. Examples of CUSUM graphs in action can be accessed via the London School of Regional Anaesthesia website www.lsora.co.uk.

For comparison between trainees and trainers to work, it is essential to standardise the definition of ‘success’ or ‘failure’ in advance. Fradkin et al state that the parameters they used were ‘based loosely upon agreed standards’, but the devil is in the detail! Must the trainee have positioned the patient appropriately before attempting intubation without guidance? Is one or two handed cricoid required? Is pre-oxygenation essential before all intubations and, if so, what endpoint should be used? Should these standards be agreed locally, or on an individual trainer basis? Do consultants grade performance in the same way as do senior trainees?

Conclusions
The advent of online completion of CUSUM charts and the common start time of novice anaesthetists now allow helpful graphical feedback of the acquisition of skills among trainee anaesthetists. CUSUM scoring could also usefully provide evidence of continued high standards within a department. The need to standardise assessment in advance is essential. CUSUM scoring should be more widely used, and should be included as part of the RCoA logbook online.

Postscript
The authors would be very interested to hear from trainees and trainers who would be willing to participate in a prospective online audit of competency skills acquisition using CUSUM.

Declaration of interests
CL is a Training Programme Director in the South Eastern School of Anaesthesia, and has recently been appointed Deputy Regional Advisor, South Thames East, but these views are his own rather than those of the School or College.

RB is a founder member of the London School of Regional Anaesthesia, which operates a free web-based logbook system that incorporates CUSUM scoring.

References
11 Gelb DJ. Graders have no learning curve. Neurology 2004; 62(7): A76–A78.
In the May issue of the *Bulletin* (Number 49), I reported that the Patient Liaison Group (PLG) had set up a short life working group to elicit the concerns of patients through the questions that they ask about their forthcoming anaesthetics. It also gave an opportunity to find out more about the sources and quality of the answers provided.

**The general practitioner’s tale**

A mini-questionnaire entitled ‘Answering Patients’ Questions About Their Anaesthetic’ was sent electronically to the 70 members of Council of the Royal College of General Practitioners (RCGP). The responses showed that GPs across the UK receive requests regularly from patients for advice and reassurance about anaesthesia and analgesia. Questions about general anaesthesia occur more often than those concerning local, spinal or epidural techniques, whilst side effects, followed by any risk of death, crop up the most often. Pain or awareness during surgery, together with the recovery experience are also frequently asked questions (FAQs). So, nothing unexpected, but what about the quality of the answers given, considering that only 10% of GP responders had ever looked for relevant information on the RCoA website? Although 90% said that they would welcome more information, a review of the free text list of topics in the survey reveals that most are already covered in existing leaflets published by the RCoA. A typical example was the request for information about ‘what patients can expect when being anaesthetised.’ This is already described in ‘You and Your Anaesthetic,’ and more fully in ‘Anaesthesia Explained’.

Although this exercise was a ‘straw poll’ rather than a validated and rigorously analysed research model, it seems clear that patients do ask their GPs about anaesthesia. Most GPs provide at least some of the answers themselves, or ask their GP colleagues for advice, and only 30% ticked ‘local hospital’ as an information source. Therefore, there is a need to try to raise GP awareness of, and promote patient access to, existing RCoA information.

The PLG recommended to RCoA Council that the RCGP be invited to provide a website link to the patient information page on the RCoA website, and that this resource is drawn to the attention of their membership. In addition, the PLG suggested that the RCoA consider offering additional guidelines to GPs, perhaps in the form of FAQs, and that Egton Medical Information Systems (EMIS), the software system used by most GPs, be contacted to promote joined up and reliable patient information.

**The pre-assessment clinic’s tale**

The GP questionnaire was adapted for use by a group of anaesthetic pre-assessment nurses. Although confined to one region and to an even smaller sample than that of the GPs, making direct comparisons difficult, it is clear that similar concerns were raised. Like the GPs, few nurses were aware of the RCoA website, and the majority said that they would welcome information that is, in fact, already available.

The PLG recommends that departments of anaesthesia are asked to publicise the RCoA patient information to pre-assessment nurses, and to consider providing a sample of leaflets on topics and risks not already covered by local information sheets. We hope that pre-assessment clinics (PACs) will consider accessing the patient information web link, and that this link will be available in local information given to patients.

In the same region, a separate questionnaire was given to patients for completion after their PAC consultation, and the 88 responses revealed that about 25% had attended with specific queries about their forthcoming anaesthetic. The most common questions included choosing between local and general anaesthesia, waking during surgery, being sick afterwards, and the relevance of a previous adverse reaction. Particularly interesting was the fact that a total of 34 concerns relating
to the anaesthetic were raised before seeing a nurse in a PAC, some causing extreme worry, whereas after the consultation this number had reduced to 11. Out of the six concerns that patients were specifically asked about, feeling or being sick scored the highest in terms of causing anxiety, closely followed by not waking up after, or waking up during, the operation.

The PLG recommends that primary care trusts are provided with this information, and consider commissioning more PACs. Apart from improving the patient experience both psychologically and physiologically, the cost may be offset by the beneficial effect of reducing fear and anxiety. It is known that patients suffering from these unpleasant emotions may be more vulnerable to post-operative nausea and vomiting (PONV), and may have an increased perception of pain, both of which can have an effect on resources by delaying discharge and causing an increase in overnight stays after day surgery. At the Current Concepts Symposium at the RCoA in November, it was suggested that about 30% of patients are affected by post-operative nausea and vomiting and that, in the USA, patients are prepared to pay an extra $100 to try and avoid it!

The Patient Advice and Liaison Service’s tale

Although Council members sponsored questionnaires sent to their local Patient Advice and Liaison Service (PALS), disappointingly, only four responded. No responder received more than one query per month on average, and they tended to refer on to the anaesthetic department. Therefore, the PLG does not recommend using PALS as a potential source of information to patients about anaesthesia.

The RCoA patient information unit Q&A database

A survey was undertaken of enquiries received by the RCoA from patients over the past five years to identify trends. The conclusion was that many concerns are already covered within existing information leaflets, and that others could be addressed through regular leaflet reviews. This further highlights the fact that existing material produced by the RCoA is not currently utilised fully.

The PLG recommends that efforts are made to raise awareness in both the primary and secondary care sectors about the rich source of patient information available on the RCoA website and that departments of anaesthesia are asked to actively promote the use of existing leaflets and links.

It won’t happen without your help

Since our recommendations were accepted by Council, an implementation group has been convened, which includes the respective Chairmen of the Communications and Professional Standards Committees. However, we need anaesthetists across the UK to make things happen at local level.

Whilst College crested letters sent to medical directors or chief executives will be a start, we need local persuasion and enthusiasm as well from the doctors who will benefit from patients who are better informed about anaesthesia prior to meeting them. Last year, I received a letter from some consultant anaesthetists who had set up a focus group to look at the process of consent within their trust. They were concerned about the validity of consent obtained from patients who had not received timely general information. Perhaps more publicity will help them in working with their management to get this sorted – it’s not rocket science.

One of the anaesthetist members of the PLG recently described how she combines informing her local GPs with raising the profile of anaesthesia: ‘Surgeons quite often refer patients who are old or ill or complicated (usually all three) directly to me for an anaesthetic opinion. I write back with my assessment, which always includes a detailed management plan for optimising the patient pre-operatively, and for dealing with any potential complications which may arise. I have copied this letter to the patient’s GP for many years now, with a number of benefits. It means that I have contact with local GPs and can telephone to ask about patients’ histories when necessary, because they know who I am. It helps them understand that anaesthetists are real doctors who do more than inject propofol and do the crossword, so it’s good PR for the specialty. Most importantly, it helps them to understand what is planned for their patients so that they can answer questions with real knowledge. It seems like quite a good return for something which is effectively free in terms of time, effort and resource (just a copied in letter).’

Other suggestions will be welcomed by the PLG at the RCoA.

Information sources and leaflets

Raising the Standard: Information for Patients (February 2003).
www.rcoa.ac.uk/index.asp?PageID=126
www.rcoa.ac.uk/index.asp?PageID=69

Acknowledgements

Professor Steve Field, President of the RCGP, for his sponsorship of the GP Questionnaire.

Dr Mike Wee, Vice-President of the AAGBI (and AAGBI representative on the PLG) for facilitating the PACs strand of the project.

Dr Anna-Maria Rollin, Council Member of the PLG, for her objective advice and unfailing support.
The Faculty Board is establishing two Committees to assist with the work of the Faculty. The Training and Assessment Committee will be chaired by Dr Kate Grady and the Professional Standards Committee will be chaired by Dr Karen Simpson. These committees will broaden participation in the running of the Faculty whilst preventing the Board from being overwhelmed by relatively minor administrative matters.

**Routes of entry to Fellowship**

Attempts by the Faculty Board and College Council to clarify the regulations for entry to Fellowship have been complicated by two recent developments. The categories of Fellowship under consideration are 'Special Application' and 'ad eundem'.

The first development is that College Council is undertaking a review of the College's Fellowship *ad eundem* for which applicants must demonstrate that they have made a significant contribution to the work of the College. The review has only just begun but to avoid future confusion, Council may decide that the Faculty's route to Fellowship *ad eundem* should mirror the College's route to FRCA *ad eundem*. This route to the Faculty has been closed to applications whilst the review is in progress. A likely outcome of the review is that the Special Application route will be for non-anaesthetists only.

The second important development is that the College of Anaesthetists of the Royal College of Surgeons in Ireland has recently introduced a Fellowship in Pain Medicine so that consultants who hold the FCARCSI qualification can now apply for the Fellowship in Pain Medicine of the College of Anaesthetists of the Royal College of Surgeons in Ireland. Understandably, the Irish College is keen for its Fellows to join the Irish Pain Faculty. There are a number of consultants who do not have FRCA who specialise in pain medicine in the NHS and it is believed that the vast majority of these consultants are Fellows of the Irish College so that they now have their own Faculty.

Notwithstanding these developments it is important to note that any person holding a substantive or honorary NHS consultant post with sessional or other contracted clinical commitment in pain medicine may apply for Associate Fellowship of the RCoA's Faculty. Pain medicine describes the work of specialist medical practitioners who undertake the comprehensive management of patients with acute, chronic and cancer pain using physical, pharmacological, interventional and psychological techniques in a multidisciplinary setting. Details of Associate Fellowship will be posted on the website.

**Revalidation**

The Faculty continues to develop a range of items to assist pain specialists in the revalidation process. It is planned to pilot various parts of the scheme during 2009. The aim is to develop procedures that are meaningful and manageable for busy doctors looking at both the individuals and the departments in which they practise. The question of dual revalidation keeps appearing; do anaesthetists who practise both anaesthesia and pain require a double helping of CPD, or just half of each?

**Training**

One of the first tasks for the new Training and Assessment Committee will be to design some form of final assessment for advanced pain trainees. Such a scheme will not be launched without adequate notice.

The RCoA Training Committee has reconsidered questions about the duration of advanced training in pain medicine. There was little support for allowing more than 12 months for advanced training but in special cases the time for pain medicine training can be extended so that the trainee can obtain all the required competencies and gain the necessary experience. It was noted that the Regional Advisors in Pain Medicine should negotiate with Regional Advisors in anaesthesia, Programme Directors and Trusts so that the trainees concerned are not disadvantaged.

A Study Day for advanced trainees will be held at the College in Spring 2009. An FPM Fellows Meeting will be held at the College on 17 November 2009. Information about both meetings will be published soon.
Would you like to organise an event with the RCoA? If so, please visit our website and click on the new event ideas link on the Meetings and Events page to complete a proposal form.
Events Programme 2009

17 June 2009 (code: C18)
INTRODUCTION TO TEACHING
Royal College of Anaesthetists, London
Registration fee: £190
(£125 for registered Trainees)

17–19 June 2009 (code: A32)
CURRENT TOPICS – LIVERPOOL
Radisson Hotel, Liverpool
Registration fee: £430
See page 36 for details

SEPTEMBER
21 September 2009 (code: B63)
NIAA MILITARY SHOWCASE EVENT
Royal College of Anaesthetists, London
Registration fee: £150

22 September 2009 (code: C63)
CORE TOPIC MEETING – FLUID MANAGEMENT
Royal College of Anaesthetists, London
Registration fee: £240
(£180 for registered Trainees)

23 September 2009 2009 (code: D43)
ADVANCED AIRWAY WORKSHOP
Royal College of Anaesthetists, London
Registration fee: £230

24–25 September 2009 (code: D29)
TRAINING IN EMERGENCY MEDICINE (TEAM) WORKSHOP
Royal College of Anaesthetists, London
Registration fee: £380

28–29 September 2009 (code: A37)
TEACHING METHODS WORKSHOPS
Royal College of Anaesthetists, London
Registration fee: £385
(£290 for registered Trainees)

OCTOBER
5 October 2009
AIRWAY WORKSHOP – GLASGOW
University of Glasgow
Registration fee: £240
(£180 for registered Trainees)

7 October 2009 (code: C97)
CORE TOPIC DAY – BELFAST
Waterfront Hall, Belfast
Registration fee: £240
(£180 for registered Trainees)

14 October 2009 (code: D04)
ULTRASOUND WORKSHOP
Royal College of Anaesthetists, London
Registration fee: £220
(£165 for registered Trainees)

27 October 2009 (code: C79)
CORE TOPIC DAY
Royal College of Anaesthetists, London
Registration fee: £240
(£180 for registered Trainees)

NOVEMBER
3 November 2009 (code: C49)
FY2 TRAINEE EVENT
Royal College of Anaesthetists, London
Registration fee: £25

5–6 November 2009 (code: B05)
CURRENT CONCEPTS SYMPOSIUM
Royal College of Anaesthetists, London
Registration fee: £410
(£310 for registered Trainees)

7 November 2009 (code: A76)
CME DAY
Royal College of Anaesthetists, London
Registration fee to be advised

10 November 2009 (code: C43)
RESEARCH METHODOLOGY WORKSHOP
Royal College of Anaesthetists, London
Registration fee: £130

16 November 2009 (code: A78)
FACULTY OF PAIN MEDICINE MEETING
For Fellows and Members of the FPM
Royal College of Anaesthetists, London
Registration fee: £150

19 November 2009 (code: C65)
AIRWAY WORKSHOP
Royal College of Anaesthetists, London
Registration fee: £240
(£180 for registered Trainees)

November 2009 (code: C29)
APA LINKMAN MEETING
Royal College of Anaesthetists, London
Registration fee: £90

30 Nov – 1 Dec 2009 (code: C80)
TEACHING METHODS WORKSHOP
Royal College of Anaesthetists, London
Registration fee: £385
(£290 for registered Trainees)

2010: FEBRUARY
1–3 February
CURRENT TOPICS MEETING
Royal College of Anaesthetists, London
Registration fee: £450

15–26 February (code: A82)
FINAL FRCA COURSE
Royal College of Anaesthetists
Registration fee: £590

2010: MARCH
17–18 March (code: A03)
ANNIVERSARY MEETING
Venue to be confirmed
Registration fee: £410
(£310 for registered Trainees)
With a focus on clinical scenario, group discussion and hands-on skill practice, the ultrasound workshop will cover a number of topics using experienced small group teachers to improve knowledge and competencies in ultrasound guided regional anaesthesia.

**ULTRASOUND WORKSHOP**

12 March 2009 (code: D23)
14 October 2009 (code: D04)
The Royal College of Anaesthetists, London

**APPROVED FOR 5 CPD POINTS**

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

**Experienced Faculty will cover the following sessions**

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

**Course Organisers**

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

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**AIRWAY MANAGEMENT – TRAINING THE TRAINER**

24 March 2009 (code: A79)
The Royal College of Anaesthetists, London

Registration fee: £180

**APPROVED FOR 5 CPD POINTS**

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

**Experienced Faculty will cover the following sessions**

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

**Course Organisers**

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

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**AIRWAY WORKSHOPS**

22 April 2009 (code: C12);
3 June 2009 (code: C81);
19 November 2009 (code: C65)
The Royal College of Anaesthetists, London

**APPROVED FOR 5 CPD POINTS**

The RCoA Airway Workshops are an opportunity to gain hands-on practice with airway equipment and teaching in core airway skills from experienced consultants. Appropriate for all grades of anaesthetists from CT1 to Consultants.

Topics covered include:

- Fibreoptic handling skills and techniques for awake FOI
- Uses of a new/established supraglottic airways
- Rescue techniques including cricothyrotomy
- Extubation, follow-up and case scenarios
- Video laryngoscopy
- Teaching and practice is conducted in small groups with six to eight workshops.

Workshops are based at the Royal College in London, Cardiff, Edinburgh and Glasgow.

**Workshop Organisers:** Dr Ravi Bhagrath, Dr Tony Turley, Dr Tom Ireland and Dr Alistair McNarry.

**THESE WORKSHOPS HAVE PROVED TO BE VERY POPULAR WORKSHOPS REQUIRING EARLY BOOKING.**
**Introduction and welcome**  
Dr Sue Mallett, Royal Free Hospital, London

**Session 1: Perioperative haemostasis and thrombosis**  
**Chairman: Dr Sue Mallett**
- Transfusion Triggers: what’s the evidence?  
  Dr Neil Soni, Chelsea & Westminster Hospital, London
- Acquired coagulopathy: When and how should we treat?  
  Dr Clare Melikian, Royal Free Hospital, London
- Thromboprophylaxis: What the anaesthetist needs to know.  
  Professor Beverley Hunt, Guys & St Thomas’s Hospital, London

**Session 2: Ethics and medicolegal aspects of current practice**  
**Chairman: Dr George Collee**
- Ethicolegal issues in non heart beating organ donation: The challenges for the anaesthetist  
  Dr Martin Smith, National Hospital for Neurology & Neurosurgery, London
- Lessons learnt from medical litigation cases  
  Dr Mike Pegg, Royal Free Hospital, London

**Session 3: The Difficult Airway**  
**Chairman: Dr Sue Mallett**
- Airway management: Have we taken the wrong turning?  
  Dr Ian Calder, National Hospital for Neurology & Neurosurgery, London
- Alternatives to intubation  
  Dr Anil Patel, Royal National Throat Nose and Ear Hospital

**Close of meeting**

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**CORE TOPICS DAY**  
15 April 2009 (code: A93)  
The Royal College of Anaesthetists, London
Registration fee: £230 (£175 for registered trainees)  
APPROVED FOR 5 CPD POINTS

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**AIRWAY DAY**  
22 May 2009 (code: C19)  
The Royal College of Anaesthetists, London
Registration fee: £230 (£175 for registered trainees)  
APPROVED FOR 5 CPD POINTS

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**Session 1**  
**Chair: Dr Chris Frerk**
- Mask ventilation before relaxants  
  Dr Ian Calder National Hospital for Neurology & Neurosurgery Queens Square
- Training in basic airway skills  
  Dr Mark Stacey, University Hospital of Wales, Cardiff
- Lessons from failed pre hospital airway management  
  Dave Lockey

**Lunch**

**Session 2**  
**Chair: Dr Tim Cook**
- Human factors and airway management  
  Chris Frerk Northampton General Hospital
- Rapid Sequence Induction – what’s new?  
  Richard Vanner Cheltenham
- Suggamadex and airway management  
  Iain Moppett Nottingham
- National Audit 4: update on progress  
  Nick Woodall Norfolk & Norwich
- Open discussion: ask the panel anything  
  Led by Dr Chris Frerk

**Close of meeting**

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Dr Chris Frerk, Northampton General Hospital

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**Close of meeting**
President’s Report

Mr K Storey

In 2008, an inspection by Her Majesty’s Revenue and Customs (HMRC) gave us a clean bill of health with regard to our expense payments. We make over 4,000 payments a year, and it is important that receipts are sent when reclaiming expenses for activities carried out on behalf of the College.

Membership

The number of Fellows, Members and Trainees of the College continues to grow, and the current total is 14,232. As 90% of these are within the UK this makes us one of the largest of all the Medical Royal Colleges. We conduct a census every three years and I cross refer the total number from this to those practising anaesthetists registered with the College – not an exact science, but useful to estimate the percentage that are linked to the College. Although our numbers have increased, I believe that a fair number of anaesthetists are still practising in the UK who do not have a current link to the College. There is a membership category for all practising anaesthetists, so if you know someone who has either lapsed, or has trained overseas, please encourage them to contact the membership department so that we can welcome them into the fold.

Examinations

June saw the largest sitting ever of the Final FRCA with 574 candidates. All the examiners responded magnificently, drew deep into their reserves and completed all examinations without the need to extend for longer than a week. As a very small token of appreciation they had their formal dinner in the Council Chamber, rather than at an outside venue, probably because they would not have had time to travel anywhere else! Thank you all: it is greatly appreciated.

Finances

Last year the College paid back all its loans following the relocation to Churchill House, and this year I am very pleased to report that the surplus we have generated has allowed us to start to build up some contingency reserves. We are now in a healthy position again, assisted by some donations and legacies that we were fortunate to receive.

Revalidation

The challenge of revalidation will take centre stage in 2009 and I am sure that the College will rise to this as it has with previous changes. Thank you to all Fellows, Members, Trainees and staff who support the College.

President’s Report

Dr J Hulf

I would like, at the start of this report to thank all those who have worked tirelessly for the College and our specialty over the last year.

In February 2008 Council bade farewell to Griselda Cooper, John Curran, Chris Heneghan and Rajinder Mirakhur. All were ‘elder statesmen’ and we miss them but wish them well, as we do Stuart Gold, an elected trainee member, who also left Council.

In March we welcomed Anna Batchelor, Chandra Kumar, Robert Sneyd, Jean-Pierre Van Besouw and Peter Venn as consultant members, and Ramani Moonesinghe as a trainee member. Andy Lim was re-elected as a specialty doctor representative. I was elected President for my final year, with Chris Dodds and Peter Nightingale as Senior and Junior Vice-Presidents. I am indebted to both for their hard work.

The first ‘President’s Prize’ was introduced at the Anaesthetic Research Society in January 2008. Interest has been substantial and the quality very encouraging. We hope that this will raise awareness of our specialty among undergraduates. Two foundation doctor ‘days’ have been held and I’m very grateful to Dr Hazel Adams for her initiative.

The Safe Anaesthesia Liaison Group set up the first specialty specific portal into the National Reporting and Learning System (NRLS) for critical incidents. Sir Liam Donaldson attended the launch in September.

In January 2008, Lt Colonel Peter Mahoney was appointed the first Professor of Defence Anaesthesia and Critical Care at the Royal Centre for Defence Medicine. This is a joint appointment between the RCoA and the Ministry of Defence.

Not only was 2008 the 60th birthday of the NHS, but also the 60th anniversary of the founding of the Faculty of Anaesthetists at the Royal College of Surgeons in England. The latter was celebrated at a glittering occasion in St James’s Palace in the presence of our Patron, Her Royal Highness, The Princess Royal.

We are working through the Academy of Medical Royal Colleges to ensure a consistent approach to revalidation, and particularly re-certification. Departmental Accreditation is also on the agenda.

As President I express my sincere thanks to all who have contributed to the College and our profession.
Vice-Presidents’ Report

Professor C Dodds, Dr P Nightingale

Two Vice-Presidents are elected by Council annually for a maximum of two years. Chris Dodds is in his second, whilst Pete Nightingale is in his first, year.

The Vice-Presidents support the President in ceremonial duties, and actively participate in College administration. A weekly meeting of the President, Vice-Presidents, Chief Executive and Directors ensures co-ordinated decisions on a wide range of enquiries from the media, politicians and public.

A Vice-President chairs or attends meetings of all the major College Committees. Chris Dodds chairs the Nominations Committee and the Revalidation Working Group, sits on the Board of the Faculty of Pain Medicine, the Intercollegiate Board for Training in Intensive Care Medicine and the National Institute for Academic Anaesthesia as well as the Finance, Joint Committee of Good Practice, Quality Assurance and Training Committees. Pete Nightingale chairs the Intercollegiate Board for Training in Intensive Care Medicine, and sits on the Training, Nominations, Finance, Examinations, and Academy Specialty Training Committees and the Patient Liaison Group.

Chris Dodds leads on revalidation for anaesthesia. Developing multisource feedback (MSF) and e-portfolio are part of this work. Pilots will take place from early spring 2009.

Pete Nightingale represents the College in Intensive Care and Inter-Collegiate matters at the Academy and the Department of Health. The sea change that followed MTAS has increased activity within the MMC arena, and Pete Nightingale and the President are frequent visitors to the Department of Health, ensuring that anaesthesia is represented fully.

Pete Nightingale is leading a multi-professional forum on sedation, for areas including dentistry and gastrointestinal endoscopy. The development of joint standards will increase patient safety and inform the new Care Quality Commission (CQC). Led by Maria Rollin, piloting of departmental accreditation will also inform the CQC and commissioners.

Chris Dodds is Co-Chair of the RCS (Eng)/RCoA Efficient Utilization of Theatres Working Party, and a member of the intercollegiate Trauma Standards Working Party.

With the President, the Vice-Presidents are committed to close links with Fellows and Members.

Communications Committee

Dr K Myerson

Despite a revolution in communications with the ability to speak instantly to anyone anywhere at any time, when it comes to exchanging ideas, we can still be hampered by poor communication. For a professional body like the Royal College, a free exchange of ideas is crucial. The Communications Committee ensures that the College keeps in touch with Members and Fellows, but also with the public – a requirement of our Royal Charter.

The Bulletin

Substantially revamped in January 2007, the Bulletin has continued to provide a measured and thoughtful analysis of current affairs with a balance of views, thanks to our capable Editorial Officer, Mandie Kelly, and our Projects Officer, Edwina Jones. New ‘themed’ issues have allowed us to explore certain topics in more depth towards developing safer practice, including management for anaesthetists and the use of ‘human factors’ knowledge.

After three years as Editor, Keith Myerson handed on the editorship to Peter Venn in November 2008, leaving the Bulletin in good hands. Keith remains as Chairman of the Communications Committee. Thanks are due to Anne Murray and Richard Young of the Patient Liaison Group (PLG) for their contributions, and to Elspeth Lee’s excellent proof reading services towards the dignity and prestige of a College publication.

The website

Under the guidance of Andy Lim and following a recent face-lift, the website provides up-to-the minute news and analysis, making it a popular resource for both the media and the public. We are most grateful to Grünenthal for sponsoring the Bulletin.

Members of RCoA Council, November 2008
Examinations Report

Dr A Tomlinson

The FRCA Examination: Academic Year 2007/8

The Examinations Committee, chaired by Dr Andy Tomlinson, met four times.

Primary FRCA Examinations

Dr J-P van Besouw chairs the Primary Board of Examiners. Dr Sue Hill chairs the Primary MCQ examination.

All four Primary FRCA MCQ examinations were stand-alone: 492 (49.5%) of 995 candidates passed. An additional MCQ examination was held in November for candidates disadvantaged by the MTAS/MMC chaos in the summer of 2007.

392 of 623 (63%) passed the three Primary OSCE/SOE examinations. The reduced number of candidates and the lower pass rates this academic year are thought to be partly due to the MTAS/MMC process.

Final FRCA Examinations

The two Final FRCA examinations were chaired by Dr Peter Nightingale. 542 (52%) of 1,041 candidates passed these examinations – similar to previous years. 324 candidates (31%) failed the MCQ and SAQ papers, a slight increase.

The paper setting day was performed electronically in October, an attempt to reduce the time and cost of bringing examiners to London. Although the examination paper was produced to its usual high standard, it was agreed that the meeting of examiners at the College is invaluable and will continue.

Prizes

Prizes are awarded to outstanding candidates who achieve a score of 2+ in each section of the examination at their first attempt. The Nuffield prize was awarded to Dr Abigail Whiteman at the October 2007 Primary. There was no award at the January or May 2008 Primary exams.

The Magill prize in the autumn 2007 Final examination was awarded to Dr Catherine Teresa Sheehan, and the Macintosh prize was awarded to Dr Rashmi Durairaj Menon at the summer 2008 Final examination.

Guidance to Unsuccessful Candidates

Guidance is mandatory for candidates who have failed either the Primary FRCA on two occasions or the Final FRCA on three occasions before a further attempt is permitted. Guidance interviews, conducted by two experienced examiners, have been held at several locations around the country and at the College in London. These interviews improve the performance of many candidates at subsequent attempts, particularly if attended by the candidate’s College Tutor.

Examinerships

The College is indebted to all its examiners. New examiners are recruited to the Board of Primary Examiners, with experienced Primary examiners moving to the Board of Final Examiners. The number of applicants remains high and 16 new examiners were selected this year. Further details on eligibility are available from the Examinations Department.

Publications


Overseas Examinations

The College sends examiners to its sister Colleges in Bangladesh, Ireland, Hong Kong, Pakistan, Singapore, Sri Lanka and the West Indies. Reports are submitted to the Examinations Committee and detailed feedback is offered. Satisfactory reports form the basis for continuing exemption from the RCoA Primary examination.

And finally...

The College is indebted, as always, to its PLG members and to the Examinations Department led by Graham Clissett, the Examinations Manager.
The Professional Standards Directorate (PSD) is responsible for guidelines, standards, best practice, audit, informatics, patient safety and liaison, advisory appointment committees and physicians’ assistants – among many other tasks. The Director is Mr Charlie McLaughlan, and the Professional Standards Committee (PSC) is chaired by Professor Julian Bion. Mr Bob Williams manages the Directorate which also provides secretarial support to the offices of the President and Vice-Presidents.

Activities during the past year have included the following:

**Patient Information Leaflets**

Dr Lucy White has led the development of patient leaflets, with Dr Josie Brown as the specific lead for children’s information. The College and the Association of Paediatric Anaesthetists jointly have funded the production of three attractive leaflets with coloured illustrations for children of different ages. We anticipate completion during the spring of 2009.

Additional information for patients and healthcare staff is provided through the medium of frequently asked questions presented on the College’s website, moderated by Professor David Hatch.

**Audit of Current Practice**

The College’s fourth National Audit Project (NAP4), studying complications of airway management, is led by Dr Tim Cook, partnered by Dr Nicholas Woodall representing the Difficult Airway Society (DAS). The project has been endorsed by the four Chief Medical Officers, the Patient Information Advisory Group (PIAG) of the DoH, and the National Research Ethics Service (NRES).

**Patient Safety**

During 2008 the College strengthened its links with the National Patient Safety Agency (NPSA) involving three joint projects:

- Anaesthesia Critical Incident Reporting (lead: Professor Ravi Mahajan) – piloted in 12 hospitals, identified 149 critical incidents, of which three were fatal but not related to anaesthesia. A rapid response warning system from the NPSA has been developed with feedback to a new Safe Anaesthesia Liaison Group (SALG) – principal representatives being the RCoA and AAGBI.

- Double-checking of anaesthetic drug administration in theatres (lead: Professor Ravi Mahajan) – using simple person-to-person checking at several UK hospitals, and pre-filled syringe bar-coding at Papworth and Wrexham hospitals.

- Throat pack safety (lead: Dr John Curran) – considering their use and complications.

The critical incident reporting project uses an electronic anaesthesia ‘e-form’, provided by the NPSA and many of the trial sites will continue to use it to record and report future incidents. The NPSA anonymises the reports for consideration by the SALG, who consider next steps.

**Professional Excellence**

The Tooke report challenged doctors to clarify roles, and focus on excellence and the development of Physicians’ Assistant (Anaesthesia) (PA[A]) further emphasised the need to define the role of the doctor. Two working groups focus on the Role of the Doctor (co-leads: Drs John Colvin and Hywel Jones), and defining excellence (lead: Dr David Greaves). Their conclusions will be integrated into the revalidation work of Professor Chris Dodds.

**Guidelines for the Provision of Anaesthetic Services (GPAS)**

Developed in 1994 for purchasers and managers, and revised in 1999, this document is undergoing a further revision by Dr Helen Wise. It is likely to be a standard for departmental accreditation and a loose-leaf binder version will be produced, as well as availability through the website. This document and the Departmental Accreditation Document will form the core documents that advise the Care Quality Commission in 2009.
The Training Committee identifies policy requiring input from Council and deals with questions from trainees.

The Medical Secretary chairs the Training Committee, which met six times between September 2007 and August 2008. The Committee comprises nine ex-officio members. There are also five co-opted members representing the Regional Advisors, College Tutors, Patient Liaison Group, the AAGBI, and the Group of Anaesthetists in Training. Unless already represented, there is a member of the College Advisory Boards from Northern Ireland, Scotland and Wales.

Dr Peter Nightingale served as Medical Secretary until June 2008, and was succeeded by Dr Andrew Tomlinson. Dr Anne Thornberry was appointed Deputy Medical Secretary. The Director of Training is Mr David Bowman and he is assisted ably by the College Staff: Miss Claudia Moran; Miss Claire Higgins and Miss Carly Melbourne. Mr James Goodwin served as Secretary to the Training Committee until January 2008.

Modernising Medical Careers

The problems associated with MTAS are slowly resolving and MMC has been working to improve the recruitment processes across the four nations. Dr Judith Hulf is a member of the MMC Programme Board for England which is working to improve all aspects of recruitment and the delivery of training. A national person specification for training years 1, 2 and 3 will be used for recruitment in 2009, moving towards a national recruitment system specific to anaesthesia.

From 2008, England, Northern Ireland and Wales uncoupled training between years 2 and 3. Scotland decided initially to continue with run through training, but has subsequently decided to harmonise anaesthesia training with the other nations, and will uncouple in August 2009.

Throughout the UK, College Tutors, Regional Advisors and Deputies, Educational Supervisors and Training Programme Directors have worked hard to deliver training in anaesthesia and ACCS programmes, despite the variety of rules that apply according to the start date of training.

Postgraduate Medical Education and Training Board (PMETB)

Curriculum development has continued as the College works to meet the standards defined by the PMETB. The College is undertaking a review of the curriculum to ensure that it meets the needs of the NHS for the future.

A new syllabus for military anaesthesia has been approved by the PMETB and is now incorporated into the CCT in Anaesthetics for advanced level training. Written by the Defence Medical Services for deployed medical staff, some of the competencies are equally relevant to civilian practice.

Other areas under consideration by the PMETB include anaesthesia for developing countries, conscious sedation in dentistry, emergency surgery and remote and rural anaesthesia. Anaesthesia in developing countries is aimed at those trainees who wish to develop their skills in a resource limited environment, and was developed with input from Médecins Sans Frontières. The College supports international development as identified in the Crisp Report.

The conscious sedation syllabus for dentistry is the first in a series for sedation techniques. Increasing numbers of doctors are referred to the GMC for poor clinical practice in this area. The syllabus sets standards for sedation in dentistry, and is an optional advanced module for trainees.

The emergency surgery syllabus covers the basic, intermediate and higher levels within the training programme, and will be one of the general units of training.

The College’s Advisory Board for Scotland has developed the remote and rural anaesthesia syllabus to meet a specific need for some of the more distant areas of Scotland.

Assessment of training

The College has worked with the Society for Education in Anaesthesia, UK, to deliver training for consultants in using the new assessment tools, thus ensuring trainees are assessed in accordance with the PMETB’s principles. Assessment courses have been run across the UK.

The Training Committee would like to thank those who have worked with commitment and energy to maintain the standards of anaesthetic medical training during this period of immense change.
EQUVALENCE COMMITTEE
Dr H Jones

My first task as Chairman is to thank Dr Heneghan for his hard work in chairing the committee for the past six years. I also thank the Committee members who have undertaken the arduous work of the group, and the College staff, who have delivered the good practice on which the Committee is based.

ROLE OF THE COMMITTEE
The role of the Equivalence Committee is to advise PMETB on the suitability of applicants for entry to the Specialist Register through Article 14, which recognises knowledge, skills and attitudes gained by experience, as well as from those gained from training posts.

The procedure involves reviewing evidence that supports equivalent training and experience to that of a newly qualified consultant in the UK. An important component is information from the six references that attest to the duties of a doctor. This may come from logbooks, continuing professional development, and letters of gratitude from patients and colleagues. These are assessed in addition to the curriculum vitae and postgraduate qualifications. This can amount to several hundreds of pages of documentation that require analysis.

APPLICATION SUB-TYPES
Whilst the majority of cases assessed by the Committee are through sub-article 14(4), which relates to the major CCT specialties of anaesthesia and intensive care medicine, applicants can also be placed on the Register under Article 14(5)(a), which relates to non-CCT specialties such paediatric or cardiac anaesthesia. Applicants must have received at least six months uninterrupted training outside the UK in the relevant non-CCT specialty. Academics can also apply under Article 14(5)(b).

ANNUAL WORKLOAD
From October 2007 to September 2008, the Committee considered 59 applicants, of whom 38 were recommended for inclusion in the UK Specialist Register.

FACULTY OF PAIN MEDICINE OF THE ROYAL COLLEGE OF ANAESTHETISTS
Dr D Justins

Fellowship of the Faculty of Pain Medicine now exceeds 500. The Privy Council approved the alterations to the College’s Ordinances to allow the use of post-nominals, FFPMRCA, by Fellows of the Faculty. An admission ceremony for Fellows was held during the BJA/RCoA Anniversary Meeting on the 13th March 2008.

Dr D Justins and Dr K Simpson were re-elected as Dean and Vice-Dean respectively. A trainee member, Dr R Kennedy, and a lay member, Mrs K Rivett have been co-opted to the Board.

The Faculty has two committees: for professional standards, and training and assessment.

The Faculty Board and College Council discussed the regulations concerning routes of entry to the Special Application and ad eundem categories of fellowship. Non-FRCA NHS consultants in pain medicine who are ineligible to apply for Foundation Fellowship can apply for other categories of membership (Member, Associate Member and Affiliate).

Preparation for revalidation within the Faculty mirrors that of the College. ‘The Good Pain Medicine Specialist’ describes good practice. A departmental portfolio is being written, and sections on pain within ‘Guidelines for the Provision of Anaesthetic Services’ are being revised.

The Board addressed sessions for acute pain consultants, the protection of acute and chronic pain services, the requirements for retraining of consultants in pain medicine, and the duration of advanced training.

The pain medicine section of the curriculum for the CCT in anaesthesia has been revised. New assessment methods were introduced after training for the Regional Advisors. ‘Providing advanced training in pain medicine for anaesthetists: guide for regional advisors, trainers and trainees’ is available on the website.

The Faculty is grateful for the enthusiastic support that it receives from the College.

The National Institute for Academic Anaesthesia (NIAA) was established in March 2008, and represents a milestone for the academic base of our specialty.

The NIAA is a joint venture between the RCoA and Association of Anaesthetists of Great Britain and Ireland (AAGBI). The Board has set up the NIAA Research Council, Academic Training Centre and Health Service Research Centre, with specific terms of reference.

A Research Council has been established with initial funding partners (AAGBI, RCoA, British Journal of Anaesthesia and Anaesthesia). All research grants from these bodies are now advertised, assessed and awarded utilising a rigorous, competitive peer review process. In the first round of applications £480,000 was awarded. Round 2 is underway. The NIAA Research Priority Exercise is an important project. All Fellows have been invited to contribute to this.

Supporting academic training

Professor R Sneyd has been appointed as national academic trainee advisor. The NIAA is engaging with Walport and other academic trainees. In addition, we are supporting the new MOD/RCoA Professor of Anaesthesia (Lt Col P Mahoney) in his task of developing academia within our armed services. The first military academic training seminar was held in November 2008.

The College has been involved in several national audits and we wish to develop this through the Health Service Research Centre within the NIAA next year.

Partnership working

It is essential that we work with other stakeholders within our profession. Already, the Obstetrics Anaesthetists’ Association, Anaesthetic Research Society, Association of Cardiothoracic Anaesthetists and Society for Education in Anaesthesia have become actively involved.

The NIAA has been created to assist the work of any anaesthetist undertaking academic activity in the UK and to represent our profession nationally. The huge agenda is challenging, but we believe that the NIAA will enhance the academic profile of our profession.

The Patient Liaison Group met formally on four occasions during the year, and regularly communicated by email.

Janette Roberts and David Whitfield were welcomed to the lay membership in September and June saw the departure of Peter Gosling, a consistent contributor to the work of the group over six years. His thorough approach, attention to detail and support for colleagues were greatly valued.

Throughout the year the PLG continued to provide a lay perspective to an increasing number of College committees, working parties and related external expert groups. The group was represented at national meetings and contributed to consultations from a patient/public viewpoint. However, it was felt that much of our advice to Council had been reactive and that the group should be more pro-active in communicating with the patients whose interests the PLG represents. A Short Life Working Group was set up in October 2007 to consider ways to improve communication with patients at a local level, and a draft final report was considered in June 2008. The PLG pages within the RCoA website are regularly reviewed and updated.

A standing item on the PLG agenda is to consider questions and concerns (fully anonymised) which have been received from the general public by the Patient Information Unit. One such concern related to information given to post-mastectomy patients who are at risk of developing lymphoedema, and in particular to the response of anaesthetists when patients refer to advice they have received about the need to avoid using the ‘at risk’ arm during further procedures. Professor Dodds, in collaboration with a surgical colleague, was asked by the PLG to produce information for both doctors and patients which reflects current evidence. Drafts were ready for consultation by the end of June.

The PLG also reviewed past contributions to the PLG Debates pages of the Bulletin, and decided that instead of relying upon its Chairman to produce 90% of the articles, there should be a wider mix of authors, with regularly invited guest articles. This policy started well, with a powerful article in the March issue by Martin Bromiley, ‘Have you ever made a mistake?’ stimulating considerable debate amongst anaesthetists.

Jane Griggs has provided invaluable administrative support to the PLG since joining the Professional Standards Directorate in November 2007.
Scottish Advisory Board

The Board has been engaged in the following activities over the past year. Governance and quality management of training has been developed with NHS Education Scotland (NES). The President met with the Scottish CMO to discuss revalidation, workforce, MMC, and remote and rural training. Scotland continues towards a consultant-based service.

The Scottish Board continues to influence training in Scotland through both the NES Anaesthesia and Emergency Medicine Specialty Training Board and the Deaneries. The Board contributes to Scottish Academy and Health Department initiatives on medical workforce planning, revalidation and post-CCT training.

‘Reshaping Scotland’s Medical Workforce 2008–2018’ emphasises the place of the CCT in anaesthesia as a standard for independent consultant practice. Delivery of training will be realigned with other parts of the UK, with uncoupling of three-year ACCS, and two-year core training from 2009.

With NHS Quality Improvement Scotland (NHSQIS), the Board will revise ‘Standards for Anaesthesia’ in 2009. A benchmarking report on chronic pain services in Scotland has been discussed with NHSQIS and the CMO. The Board continues to press NHSQIS on critical care standards.

Farewell and thanks to Dr John McClure, elected member, Honorary Secretary and latterly Chair of the Board. Sylvia Corbett succeeds Janette McBride as secretary.

Dr J R Colvin

Welsh Advisory Board

The Advisory Board for Wales was created in 2008 in response to the devolved responsibility for healthcare of the Welsh Assembly Government.

The College and the Welsh Assembly Government communicate through the Board on education, standard setting and revalidation in anaesthesia, intensive care and pain medicine, representing consultants, specialty doctors and trainees.

The President, Dr Judith Hulf, attended the first meeting of the Board on 11 July 2008. She was assured that the Welsh Board, along with Scotland and Northern Ireland, would ensure the same high standards of care between all four nations.

Dr Hulf also met with the Welsh Health Minister, Mrs Edwina Hart, and the CMO and deputy, Dr Tony Jewel and Professor Mike Harmer. Consultative mechanisms were discussed in light of the reorganisation of the NHS in Wales in 2009. The improved advice and consultation brought by the Board will benefit the healthcare delivered to patients.

Dr H Jones

Northern Ireland Advisory Board

The Board met twice this year. Training has now uncoupled. This year, 16 trainees gained CCT, and 17 trainees were appointed to CT1 and ST3 posts. The NI School will pilot the e-portfolio for junior trainees. It remains unclear how revalidation will work in NI.

There are concerns about the impact of Physicians’ Assistants (Anaesthesia) (PA(A)) on training. It was noted that four PA(A)s had completed training in NI but that further recruitment is currently in abeyance. Dr Clive Stanley will succeed Dr Bob Darling as Regional Advisor in October.

The annual Joint Colleges Core Topics Day was held in September and was attended by around 100 delegates. The topics were wide ranging and well received. A lay representative was appointed to the Board in December.

Mrs Andrea Pollock has retired from the School of Anaesthesia. The Board wishes her well in her future career.

Professor J P H Fee

Members of RCoA staff, November 2008
WEDNESDAY, 27 MAY
Session 1: Preoperative assessment of the cardiac patient
Chairman: Professor P Foëx
- ECG and ambulatory monitoring
  Dr H Higham, Oxford
- Screening for coronary artery disease
  Dr A Kelion, Middlesex
- Cardiopulmonary testing (CPX) for all
  Dr M Swart, Torbay

Session 2: The adult with congenital heart disease
Chairman to be advised
- Overview of grown-up congenital heart disease
  Professor J Deanfield, London
- Anaesthesia for non-cardiac surgery in the grown-up with congenital heart disease
  Dr R Hurley, London

Session 3: The patient with chronic heart failure
Chairman to be advised
- Advances in inotropic support
  Dr R O Feneck, London
- Pathophysiology of heart failure
  Professor A Struthers, Dundee
- Anaesthetic management of patients with heart failure/heart transplant
  Dr D Royston, Middlesex

Session 4: The surgical patient with coronary disease
Chairman: Professor J Sear, Oxford
- Pathophysiology of coronary heart disease
  Dr C Forfar, Oxford
- Do percutaneous interventions protect the surgical patient?
  Professor P Foëx, Oxford
- Antiplatelet drugs: cardiologists friends, surgeons foes
  Dr G Flood, Dublin

Drinks reception for all participants

THURSDAY, 28 MAY
Session 5: Drugs and the cardiac patient
Chairman: to be advised
- Inhibitors of the renin-angiotensin-aldosterone system: implications for anaesthetists
  Professor P Coriat, France
- Do alpha2 agonists protect?
  Dr M Tramer, France
- Anaesthetic myocardial preconditioning
  Dr De Hert, Amsterdam

Session 6: Valvular heart disease/pulmonary hypertension
Chairman: to be advised
- Pathophysiology of valvular heart disease
  Dr L Cotter, Manchester
- Anaesthetic management of the patient with valvular heart disease
  Dr M Patrick, Manchester
- The patient with pulmonary hypertension
  Dr S Finney, London

Session 7: Current controversies
Chairman: to be advised
- High blood pressure at pre-admission – who should be referred?
  Professor J W Sear, Oxford
- Should all patients at risk receive statins?
  Dr B Biccard, South Africa
- Beta-blockers – what perioperative indications in 2009?
  Professor P Foëx, Oxford

Key Note Lecture
- Prevention or active treatment of cardiac complications
  Professor P Coriat, France
TEACHING METHODS WORKSHOP
10–11 June 2009 (code: B36)
30 Nov – 1 Dec 2009 (code: C80)
The Royal College of Anaesthetists, London
Registration fee: £365 (£310 for registered trainees)
APPROVED FOR 10 CPD POINTS

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.

- Basic principles of education
- Workplace based teaching
- Teaching practical skills
- Non-technical skills
- Assessment of professionals
- Giving feedback
- Small group teaching
- Preparing and delivering a lecture
- Making effective use of AV aids
- Discussions/breakout group work sessions

REGIONAL CURRENT TOPICS MEETING – LIVERPOOL
17–19 June 2009 (code: A32)
The Radisson SAS Hotel, Liverpool
Registration fee: £430
APPROVED FOR 15 CPD POINTS

Topics and speakers already confirmed for the meeting:
- Introduction to the 3 day meeting
  Dr Euan Shearer, Aintree NHS Trust
- Revalidation issues
  Dr Thomas Clutton-Brock, Birmingham
- NIV in critical illness: an update
  Dr Andrew Bentley, Manchester
- Muscle relaxation: Where now?
  Prof Jennie Hunter, University of Liverpool
- Decision making and critical thinking: errors and safety
  Dr Arpan Guha, Liverpool & Broadgreen Trust
- Anaesthetic management of the gravitationally Challenged
  Dr Euan Shearer, Aintree NHS Trust
- Cardiology for anaesthetists, what’s new?
  Dr M Burgess, Aintree NHS Trust

Further topics include:

**Wednesday 17th June**
- Therapeutic hypothermia
- Evidence based medicine in Anaesthesia
- Local blocks in children
- Future of day surgery
- Anaesthesia for carotid artery surgery

**Thursday 18th June**
- CPX testing: an update
- The management of chronic neuropathic pain
- Radiology for Anaesthetists
- The mental capacity act and anaesthesia
- OSA and Anaesthesia
- Early warning scores in Obstetrics
- An update on cardiothoracic anaesthesia

**Friday 19th June**
- Surgery for the management of morbid obesity
- USS in the acutely ill & anaesthesia
- Update on Paediatric anaesthesia

Expert speakers have been invited to lecture from the North West region and beyond

FINAL FRCA COURSE
7–18 September 2009 (code: A79)
15–26 February 2010 (code: A82)
The Royal College of Anaesthetists, London
Registration fee: £560
APPROVED FOR 15 CPD POINTS

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 which run from 4.30 pm to 6.00 pm.

The programme covers various subjects but will include topics such as:

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

**Event Programmes 2009**

WWW.RCOA.AC.UK/EVENTS
CURRENT CONCEPTS SYMPOSIUM

5–6 November 2009 (code: B05)
The Royal College of Anaesthetists, London
Registration fee: £410 (£310 for registered trainees)
APPROVED FOR 10 CPD POINTS

THURSDAY, 5 NOVEMBER

Session 1: Preoperative assessment in the 21st century
- Current preoperative assessment – what and when
- Which examinations and tests
- Informing patients; risks and complications of anaesthesia

Session 2: Why, when and how to optimize patients?
- Is preoptimization of patients undergoing major surgery justified?
- Preoptimization of higher risk patients
- Can you optimise the multi-trauma patient with a head injury?

Session 3: Newer concepts and drugs
- Technology in anaesthetic drug manufacturing
- Methods of drug delivery
- Substance abuse, risk and anaesthesia

Session 4: Patient’s safety – moving forwards
- National reporting and learning centre-safer surgery
- Recent innovations in equipment/medical devices/wireless/nanotechnology/bluetooth technology

FRIDAY, 6 NOVEMBER

Session 5: Environment and anaesthesia
- Climate change and health
- Anaesthesia’s part in the problem
- Combatting Climate Change Due to Anaesthesia or Energy Reduction in Anaesthesia

Session 6: Research and innovations
- The role of the NIAA – research is not just for the boffins!
- Evidence and practice
- Systematic review and the role of the Cochrane Anaesthesia review Group

Session 7: Changing goals in critical care
- Surviving sepsis guidelines – time for demolition
- Controversy in Outreach
- Whose body is it?

Session 8: Paediatric anaesthesia
- Airway management in children
- Sedation in children
- Managing acute pain in children

Close of the meeting

COURSE ORGANISER – PROFESSOR CHANDRA KUMAR
This programme is subject to change
Please complete and return this form to:
Finance Department, The Royal College of Anaesthetists, Churchill House,
35 Red Lion Square, London WC1R 4SG  Switchboard 020 7092 1500  Fax 020 7092 1733  email events@rcoa.ac.uk
ADDITIONAL FORMS ARE AVAILABLE TO DOWNLOAD FROM OUR WEBSITE

Your details

Full name: ________________________________

Please use BLOCK CAPITALS.

College Reference Number (CRN): ____________

GMC Number: ________________

Address: _______________________________________

Postcode: ____________________________

Please ensure you complete your full postal address.

Telephone: ____________________________

Email: __________________________

This address is (tick one only): [ ] Temporary [ ] Permanent

Date of Birth: ___ ___ ___ M M Y Y

Present appointment and hospital: __________________________

Event details

Date: ___ ___ ___ M M Y Y  Code: __________

Event Title: ____________________________

Registration fee: £ __________

How did you hear about this event?

- Our events are open to all grades of anaesthetists, unless specifically stated otherwise.
- When an event is full, this will be publicised on the website. To be put on a waiting list, please contact the Events Department on 020 7092 1670. We will then contact you as soon as a place becomes available.
- All of our events have CPD approval of five points for a full day and three points for a half day, with the exception of FRCA revision courses, which carry a maximum of 15 points, for non-trainees only.
- Lunch is included in the registration fee unless otherwise indicated.
- This generic application form is to be used for all events. Further copies of the form are available from the College website.

Booking and payment

- 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):

Cardholder’s name: ____________________________

Please use BLOCK CAPITALS.

Signature: ____________________________

Card number: ____________________________

Valid from: ___ ___ ___  Expiry Date: ___ ___ ___  Issue number (if applicable): ________  Security Code: ________

How did you hear about this event?
A view from the other end of the laryngoscope

Dr S L Armstrong,
Specialist Registrar, South West Thames rotation, London

Following some night shifts, I was woken at 2 am by a strange pain around my umbilicus, unlike any that I had experienced before. To be honest it wasn’t really that bad – a bit like indigestion. Ironically, the very first thought I had was ‘hmmm... periumbilical pain – I wonder if this is appendicitis?’ followed quickly by ‘don’t be ridiculous – it’s more likely to be that curry you ate.’

I reached for the paracetamol and Gaviscon and went back to sleep. I spent the following 16 hours convincing myself that I was being a hypochondriac, as I sequentially lost my appetite and became feverish, with the pain migrating steadily to my right iliac fossa. At 10 pm that evening after much self-examination (mainly prodding of my own stomach to elicit rebound tenderness followed by yelps of pain), I finally accepted that I might be unwell, and that I ought to go to A&E. Herein was the first problem. I was in central London and out for dinner, far from home and surrounded by a myriad of emergency departments, all of which were likely to be heaving with drunken revellers on a Friday night. Where to go? I ruled out any hospital that I hadn’t worked in, and those that were too far away to go to by taxi. In the end I plumped for the hospital where I had been an SHO both in A&E and anaesthetics, with the vain hope that I might know the odd A&E nurse and therefore be spared a few extra hours in triage.

‘I’m an anaesthetist and I’ve got appendicitis’

One very sympathetic receptionist, two surgeons, some intravenous morphine and four hours later, I was sitting on a ward awaiting the imminent removal of my appendix. I might point out that I had to request antiemetics be given with the morphine, and that also I had to tell the A&E consultant the dose of ondansetron to prescribe.

The surgeon came to visit again to take my consent. By this point I was definitely peritonitic, and even I had to concede that I was now officially sick. I was offered the choice of an open or a laparoscopic appendicectomy. I initially protested at the thought of laparoscopic surgery (‘you’re not coming near me with a trocar’), but the very nice consultant surgeon said that he would do it himself, and because I was still a young(ish) female, it would be ‘advisable to give you an MOT whilst we’re there.’ The visit by the anaesthetic
SpR was awkward to say the least – amounting to a single question for pre-operative assessment – ‘Is there anything I need to know?’ followed by: ‘I’ll call the consultant on-call.’

Control freak? Moi?
Prior to the operation I was irrationally scared of the GA – far more so than of the surgery. A straw poll of my colleagues reveals that I am not the only one. Would I be a difficult intubation? Unlikely – you can practically see my epiglottis if I open my mouth very widely. Would I have an anaphylactic reaction to the drugs? Would they give me the suxamethonium before I was properly asleep? Would I be easy to reverse? Would I be aware? On reflection I presume that this was a combination of far too much knowledge and the shock of facing emergency surgery in the middle of the night. I am sure that if I’d had time to consider an elective operation I would have felt more prepared. I wonder if we really think enough about the impact that psychological preparation (or lack of) has on our patients, or how much information they really comprehend in the emergency situation. It is quite difficult to take anything seriously after 10 mgs of morphine.

The anaesthetic itself was great, albeit a truly surreal experience. My memories are of the consultant reminiscing about a viva practice session they had given me when I was an SHO, when I was floored suddenly by a slug of fentanyl, followed by a vague tugging sensation in my throat as I woke up. I had a rapid sequence induction with thiopentone and suxamethonium (if you ignore the fentanyl) and suffered no ill-effects as a result, other than having a mild sore throat.

Calm before the storm
At first, I felt great post-operatively. There was no pain nor sickness, and I was chatting on the phone soon afterwards, saying that I would be out of hospital that day. I note, in retrospect, that this is often the time that we visit our patients post-operatively before disappearing off to do the next case on the emergency list, happy in the knowledge that we have provided a good anaesthetic service. Unfortunately, this was the calm before the storm.

Firstly, I went into urinary retention and required catheterising. Then the pain kicked in towards the end of the day – generalised abdominal and sharp right-sided shoulder tip pain that I can only describe as similar to having a knitting needle driven into your deltoid muscle. This was followed shortly afterwards by intense pain in the laparoscopic wounds as the local infiltration wore off. All of this was despite being on regular paracetamol, diclofenac and codeine. I was unaware that it would be quite so unpleasant. My anaesthetist kindly had offered me a PCA in the anaesthetic room but, in retrospect foolishly, I had said that I would be fine with regular pain relief and rescue morphine on the ward. However, I never anticipated the problems that I subsequently experienced in obtaining the said pain relief.

During the night the nurses were incredibly busy with a sick septic patient, and so I waited for over an hour before I could have any analgesia. Then, I received 5 mg of Oramorph to ‘see how I went’ – which wasn’t very far. Despite the prescription for 0–20 mg two to four hourly, I was told that I was not allowed anymore until four hours later. Rather than engage in a lengthy conversation regarding the pharmacokinetics and pharmacodynamics of oral morphine, I asked them to bleep the surgical SHO who finally came to my rescue with a syringe, a label and 10 mg of morphine. I definitely do not mean to be derogatory about the nursing staff – the standard of their care was fantastic. I knew that they were particularly busy but to the point where I felt guilty asking for analgesia, despite being incredibly uncomfortable. I wonder how often this happens to patients, helpless on the ward, and without the ability to bully a lowly SHO into prescribing for them in a way that hits the spot, and is outside the normal practice of ward nurses.

The next morning I was much improved when the consultant surgeon came to see me, and we talked about my experience overnight. He told me that he had observed that although the recovery from laparoscopic appendicectomy is undoubtedly quicker than from an open procedure, the post-operative pain in the first 24 hours is often much worse. I suspect that this is not appreciated by some junior anaesthetists whose staple on-call diet is ‘the appendix’, an operation that is perceived to be fairly minor. I went home later that morning and made a relatively speedy recovery, unfortunately just in time for my next set of night shifts.

Take home message
In summary my learning points from this experience are:

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Prior to the operation I was irrationally scared of the GA – far more so than of the surgery. A straw poll of my colleagues reveals that I am not the only one.
As We Were ...

My first few afternoons on duty I found terrifying. A chief’s round was a solemn occasion, requiring absolute silence. Sister, supported by her staff nurse carrying everything that might be required, would meet the great man, his entourage in train, at the door... All ward work was suspended during a round. One or two of the older sisters allowed us to serve tea in the wake of the procession, but in most wards even this was postponed.

Theatre days were rather different. The rule was that the ward sister was in the theatre throughout all operations. I once heard an anaesthetist describe it ‘Sisters and ether must be administered together, one never to be taken without the other’. So when sister was most needed in the ward, she was perforce out of it. The least responsible work was taking patients up to the theatre and bringing back those already operated on. What a mercy apprehensive patients had no idea of the feelings of the junior nurses on whom they relied for reassurance. Anaesthetics have changed since then and the use of a recovery room adjoining the theatre lessens the need for immediate postoperative care in the wards. We were instructed in the care of the unconscious patient but I, personally, always felt that the lift boy, who was, after all, doing it all day every day, would help in an emergency.

Preparing patients for the theatre and looking after them on return could not interfere with the normal routine of patients’ teas. Tea for the nursing staff though, also the junior nurses’ responsibility, was apt to be sketchy.


A superb and entertaining account of training, nursing, and ward organisation during the 1920s and ‘30s. Should be required reading for those seeking to raise standards in our hospitals today.

Dr David Zuck
History of Anaesthesia Society
Complications are unintended consequences of care, and it has been estimated that there is a one in 300 chance of being harmed by healthcare. These events increase length of stay and the risk of hospital mortality. A great number of complications might be prevented or reduced by the application of evidence-based practice and by simplifying core processes. It has been suggested that ‘lean thinking’ – a concept pioneered by the Toyota Car industry over the last 50 years – can translate to healthcare.

Lean thinking is a management system that engages every employee in streamlining processes, with the aim of minimising error and inefficiency. The Safer Patients Initiative (SPI) borrows from this industrial management strategy, encouraging hospitals to concentrate on clinical systems as a way of improving safety. It seeks to change the culture of an organisation fundamentally, by focusing on building quality and value into systems and processes, through engaging and empowering staff to find improvements.

The Safer Patients Initiative
Musgrove Park Hospital, Taunton, was selected as one of 20 hospitals in phase 2 of the SPI which was financed by the Healthcare Foundation (a UK charity), and implemented in conjunction with the Institute for Healthcare Improvement (IHI) from Boston, USA.

The SPI was based on the ‘100,000 lives’ campaign in the USA, which aims to save 100,000 lives in 3,100 hospitals over an 18-month period, by the reliable implementation of six interventions, including prevention of surgical site infection and prevention of adverse drug events.

All hospitals in the SPI were paired with a similar sized hospital to facilitate the sharing of ideas, both successes and failures, and to engender healthy competition. Taunton was paired with Torbay Hospital, and the project was funded for a two year period from 2006 to 2008.

The SPI combined five of the interventions from the 100,000 lives campaign with ten other change elements. These ‘change packages’
were aimed at the following five work areas: critical care, general ward, leadership, medicines management and peri-operative care. This article will concentrate on peri-operative and critical care.

The SPI method of change

The change packages for each work area are based on evidence-based interventions that can be measured, for example, the percentage of prophylactic antibiotics given on-time before surgical incision. In order to improve an outcome such as the reduction in surgical site infection, the process of improvement dictates that all of the interventions must occur every time if indicated. The development of reliable processes, based on good systems that are not dependant on individual knowledge, is the Holy Grail.

Reliable processes were developed using rapid cycle change tools that have been used in the manufacturing industry. This involves planning an intervention such as a new method for checking that appropriate antibiotics have been given before entering theatres, trying it for a single patient, and studying the success before making an action plan (the Plan, Do, Study, Act or PDSA cycle). If the intervention works, it is repeated on a list of patients, the method is refined and the ‘reliable process’ is disseminated across other areas. This is a very different process from using audit cycles that are good at identifying problems, but often do not achieve a reliable change in practice.

Data were collected in each work area and fed back to the IHI for analysis. The data were collected monthly and covered all of the process measures and outcome data.

Peri-operative work area

This change package focused on the reduction of surgical site infection, the reduction of adverse cardiac events and the creation of a team culture in theatres. Data were collected on the processes that are outlined below.

Surgical site infection prevention bundle

Surgical site infection is the second most common type of adverse event occurring in hospitalised patients. Surgical site infections have been shown to increase mortality, readmission rate, length of stay and cost for patients who incur them. Sterile instruments and avoidance of unnecessary damage to tissues are a given. However, other highly effective methods of infection avoidance are far less widely followed, despite a solid evidence base. They include:

1. Administration of prophylactic antibiotics, where indicated, within 60 minutes before surgical incision.

2. Hair removal with electric clippers, and not razors, if indicated before surgery.

3. Achieving peri-operative normothermia, measured by a temperature of 36°C on admission to recovery.


It has been estimated that 40–60% of surgical site infections are preventable by implementing these four components of care. At our hospital, there were no systems in place to ensure that these processes were carried out in the correct manner. Prophylactic antibiotics are now administered in the anaesthetic room, the drug and dose having been discussed previously at the safety briefing. In addition, verbal and visual reminders have been introduced as a failsafe. Patients are now advised not to shave areas prior to theatre, and razors have been removed from the wards and the operating theatre. Should shaving be necessary, it is performed in theatre using electric clippers. Temperature and blood glucose (if indicated) are part of a core

Data were collected in each work area and fed back to the IHI for analysis. The data were collected monthly and covered all of the process measures and outcome data.

Figure 1 Outcome

Percentage of on-time antibiotic administration.
The safety briefings have not only improved communication, but have also increased morale and involved non-medical team members more in the care of patients.

Peri-operative briefings

Teamwork is essential in healthcare and good communication within the team is indicative of the organisational culture. Communication failure is at the core of nearly every medical error and adverse event.

We have introduced the safety briefing. The briefing occurs between ten and fifteen minutes before the list starts and with all team members present. The idea is to establish a sense of team, set an open environment for communication, and review the plan for the entire operating list, going through each patient and procedure one by one.

Everyone is considered an equally important member of the team regardless of their role, and all are encouraged to contribute to the discussion. If non-clinical or non-professional staff are not treated as equal, they will be less likely to point out an unsafe condition or potential error when they see it. These team members may not be subject to the same biases as those who know the process well. The safety briefings have not only improved communication, but have also increased morale and involved non-medical team members more in the care of patients.

Critical care

The basis of good critical care is organisation and teamwork. Prior to the SPI, our unit was reasonably well organised, reflected in outcomes consistently amongst the best in the UK with respect to risk adjusted mortality. However, with the help of this project we attempted to introduce evidence-based care for all patients at all times (rather than sometimes). This encompassed a ventilator care bundle, tight glycaemic control, daily goals, rigorous attention to hand washing, a central line care bundle and daily multidisciplinary handover.

Whilst much of this was already in place, the major difference was the introduction of rigorous attention to ensuring that basic care was always adhered to. For example, sitting a ventilated patient 30° head up, whilst generally considered a good idea, was not always achieved because staff either didn’t realise they should do it, or because they simply forgot. Systems were introduced to ensure that this, and other processes, always happened when indicated. In addition, a few innovative ideas were introduced, the most effective being communication white boards adjacent to each patient’s bed, providing a focus for everyone involved in the patient’s care, and encouraging progress whenever possible. Daily goals for the patient
are recorded, either of a clinical or more holistic nature, such as getting the patient out of bed or taking them outside in a wheelchair.

Finally, via the use of PDSA cycles, many of the small changes required to institute this level of care were introduced both rapidly and successfully. Staff drove change without the process becoming bogged down in endless committees and meetings. This was a refreshing difference from normal clinical practice. Throughout this period there was careful attention to data collection, so that we could accurately monitor progress in establishing reliable systems and review predefined patient outcomes.

**Successes and difficulties**

The IHI set out specific aims for participating trusts within the two year time frame. The most important of these was a reduction in hospital mortality, and in this respect our trust has achieved a sustained reduction in the Hospital Standardised Mortality Rate (HMSR) of 15%, which represents approximately 150 fewer deaths per year (Figure 2).

In the peri-operative group there are now robust systems for safety briefings across all theatre complexes, and this has improved patient safety and communication. Reliable processes have also been introduced to reduce the incidence of surgical site infection and reduce the incidence of adverse cardiac events.

In terms of the critical care goals, we have delivered a large reduction in ventilator assisted pneumonia, elimination of MRSA cross infection, elimination of central venous catheter infection and a reduction in ICU length of stay.

Healthcare involves human beings, and mistakes will therefore happen. The Safer Patients Initiative has shown us that through the introduction of standardised processes and robust systems, underpinned by evidence-based medicine, it is possible to reduce errors and thus improve the outcome for patients.5

**References**

A Manager’s view

The Professional Standards Directorate (PSD) sets criteria for the delivery of service, both by anaesthesia departments and by individual anaesthetists. This encompasses most other areas of anaesthesia besides training and examinations. This includes specialty doctor recruitment and Advisory Appointments Committees (AACs), anaesthetic service guidelines, maintenance of good practice, individual and service reviews, patient safety, information for patients, and communicating about all aspects of the work of the Royal College.

A day in the life of the staff

09:00 hours: Shirani Nadarajah, Professional Standards Administrator, arrives and opens her emails to find a variety of enquiries that have arrived overnight. One is from an anaesthetist leading the National Audit Projects (currently NAP 4, entitled Major Complications of Airway Management in the UK, and previously NAP 3, entitled Major Complications of Central Neuraxial Blocks). Shirani has been asked to assist in co-ordinating a meeting of the NAP 4 consultation group at the College. Other emails are received from concerned patients and professionals. Enquiries include ‘whether there is any truth behind the alleged true story of people waking up during an operation, as portrayed in the recent American film AWAKE’ and ‘I am in my final year as a medical student and have written a procedure for safer delivery of anaesthesia – could someone from the College give an opinion or offer guidance?’

Outside work, Shirani’s interests include sport, EastEnders and shopping!

09:30 hours: Professor David Hatch (an ex Vice-President), the Professional Standards Advisor, has received two of Shirani’s emails, forwarded for his expert opinion. After assessing their content, he will suggest recommendations and prepare a sympathetic and measured response. It may be that a holding reply is required before an informed answer can be provided, while specialist advice is sought from specific experts. However, before he has a chance to research further, the Director invites him into his office to discuss a sensitive issue regarding a doctor in difficulty. David is able to bring current GMC expertise to this matter because he maintains a close working relationship with the GMC.

David’s interests include canal boat holidays, and he is an accomplished magician, known as ‘Professor Whizzo’. Could magic be the new anaesthetic?
10:00 hours: Anita Mattis, Senior Advisory Appointments Committee Administrator, has already had a busy morning. She has received a number of short notice requests for College Assessors at forthcoming consultant AACs. There is an urgent requirement to convene a committee at an NHS trust in the West Midlands, whilst another is required at one of the new foundation trusts in the North East. She has spent much of the morning trying to find a specialist in paediatric anaesthesia. This has proved to be very difficult because the trust has left it too late for the normal statutory process (at least eight weeks is usually required) to run its course. However, she is successful in finding an appropriately qualified specialist because of her long-standing relationship with trusts and assessors. The College rarely fails to find an assessor, even for foundation trusts where there is no mandatory requirement to do so.

Anita’s interests include gardening and shopping!

10:30 hours: Jane Griggs, Administrative Officer, is in deep conversation with the Chairman of the Patient Liaison Group (PLG). They are discussing the next agenda for the group meeting, as well as the myriad of papers to be considered. The PLG forms an integral part of much College business, providing lay representation on most internal College committees, and some external consultation groups. In the meantime, Jane has postponed some work she is preparing for the Director on a relatively new topic – the formation of Anaesthesia Review Teams (ARTs). She is currently populating a database of specialists to visit hospitals, and support trusts by reviewing working practices within their anaesthesia departments. Jane also works closely with Anita, preparing AACs, and is currently co-ordinating a draft report on the recent educational day held for College Assessors and Scottish Panellists.

Jane’s interests include Arsenal Football Club, EastEnders, travel and shopping (is there a theme developing here?).

11:00 hours: Amanda Regan, Executive Assistant to the President, is hard at work. Although most staff will arrive at the office by 09:00 hours, Amanda has been busy for much longer. Today is Wednesday, and Council will be in session. During the past week Amanda has been preparing the ground ensuring that the Council Agenda, and many supporting papers associated with this important monthly meeting, are prepared and dispatched in the usual timely and meticulous manner.

Revalidation is a growth industry for Medical Royal Colleges ... In the future, it is likely to dominate the work of the PSD.

It is imperative that everything prior to, and during, the meeting runs to order. Recording the complex minutes of the day means that Amanda has put to one side (for today only) further pressing work on applications to the Advisory Committee on Clinical Excellence Awards. Amanda filters enquiries for the President, ensuring that her diary for both College and clinical work are co-ordinated.

Amanda’s interests include ‘getting away from it all’ in a folding caravan (you will have to ask her) and shopping!

11:30 hours: Whilst Amanda attends Council, Clara Ogunmilade, secretary to the President’s Office, is busy covering the arrival of the routine daily enquiries. Clara has also arrived early today, to assist Amanda in final preparations for today’s Council meeting. At the same time she is preparing for a revalidation meeting, chaired by the Senior Vice-President, which will take place immediately following Council later in the day. Revalidation is a growth industry for Medical Royal Colleges, especially for the larger specialties such as anaesthesia. In the future, it is likely to dominate the work of the PSD. There are also formal invitation cards scattered all over her desk (organised of course – we are professional standards!). Clara is currently administering four official College dinners, one of which is the President’s dinner. Another (which the staff consider the most important), is the staff Christmas lunch.

Clara’s interests include spending time with her children and shopping!

12:00 hours: Mandie Kelly is the PSD Editorial Officer. She is an expert in IT, and ensures that the website is kept up to date and runs properly. You will find both Mandie and her colleague, Edwina Jones, window blinds down behind them, working in front of a white wall of MAC computers, and talking in a technical language that only they understand. Right at this moment she is on the phone, discussing printing charges with one of the College suppliers. Since the economic down turn, one of College printers has gone into administration, and we are tendering for a replacement. Her role is diverse, and she is working also today on a seating plan for one of the College dinners. However, important as the seating plan is, there is a College Bulletin deadline to consider, and the Bulletin Editor is hovering around her desk, waiting to discuss final copy for the next issue. Mandie works closely with Edwina as part of a two person communications team. Suddenly, she is asked to upload on to the website an urgent press
release, written by the President. Which should she do first? Decisions have to be made – but, naturally, the President comes first!

Mandie’s interests include her daughter Anna, EastEnders and, you have guessed it, shopping!

12:30 hours: Edwina Jones, PSD Project Officer and Director’s Assistant, is currently on the phone talking to BBC Television who require a doctor to advise them on an upcoming drama, to be broadcast in the New Year. Edwina is regularly involved in fielding media enquiries, and the media always want a quote on any topic immediately – nothing new there. Edwina is currently assisting Mandie with the Bulletin – they alternate responsibility for each issue. However, she also has another pressing task. She is secretary to the Professional Standards Committee, which is taking place at 14:00 hours. The agenda is always wide-reaching. Today, a major College document, ‘Guidelines for the Provision of Anaesthetic Services’ – eagerly awaited and some two years in development – is likely to be given the go ahead for publication. Edwina possesses extensive knowledge of all of the College publications (for example, the 11 patient information leaflets which are especially sought after by the public). She is involved from the inception of all College documents. She follows each through its preparatory stage, including formatting, design and layout, to scrutiny of the drafts by the Professional Standards Committee and final approval by Council, ultimately to printing and distribution. Edwina and Mandie both thrive on the creative process this work entails.

Edwina’s interests include cooking (especially the tasting), EastEnders and shopping!

13:00 hours: The PSD Manager, Bob Williams, goes to lunch. He always takes lunch at this time, unless of course there are overriding issues. He has developed a reputation for trying out new coffee shops within the local area – if you need a recommendation just ask when you next visit the College. Bob leaves the office after spending most of the morning recruiting temporary staff for the new position of Patient Safety Administrator within the PSD. He is currently dealing with a variety of topics, including the next meeting of the Physicians’ Assistant (Anaesthesia) (PA(A)) Committee, to which he acts as secretary. The PA(A) is a relatively new concept supporting anaesthetists, and it is pleasing to say that, due to the work of the Committee, they may soon be registered formally with the Health Professions Council. It is also that time of year when staff appraisals, and reviews of departmental job descriptions, are required – actually not too difficult with a team of loyal and dedicated staff who support each other and the Director admirably. Although the College seems to be getting busier with new projects, their dedication is unstinting. It is a pleasure to work with such a dedicated and cohesive team, a view shared by Council, the Senior Management Team, professionals and the public alike.

Bob’s interests include Tottenham Football Club, shopping (now I am joking, I leave the shopping and EastEnders to the others) and travel – having returned recently from Transylvania which, yes, does exist!

14:00 hours: Christiana Coker, working temporarily as the Patient Safety Administrator, is our newest member of the PSD, and is getting to grips with the administration of the Safe Anaesthesia Liaison Group. This is a body of specialists representing patient safety for the College, the AAGBI and the National Patient Safety Agency (NPSA). This new position has been established through close collaboration between the College and the NPSA. This is a developing role, and we are pleased to have Christiana on board.

Thus, a snapshot of the staff and a working day in the Professional Standards Directorate, and to reassure you that we are trying continuously to improve the service we provide for patients, anaesthetists, related professionals and the wider public audience.

The Professional Standards Directorate:
L–R: David Hatch, Shirani Nadarajah, Jane Griggs, Anita Mattis, Mandie Kelly, Christiana Coker, Charlie McLaughlan, Amanda Regan, Edwina Jones, Clara Ogunmilade, Bob Williams
At a meeting of Council on 
Wednesday, 19 November 2008, 
Mr Jim Wardrope was presented with 
a silver salver to commemorate the 
College of Emergency Medicine’s 
receipt of a Royal Charter.

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

**College Tutors**

**North Thames Central**
Dr S J Eckeroll, Lister Hospital  
(in succession to Dr S Gowrie Mohan)

Dr C Venkataprasad, Lister Hospital  
(due to the establishment of a second 
Tutorship at Lister Hospital)

**Mersey**
*Dr S Mallaiah, Liverpool Women’s Hospital

**Wessex**
Dr S Maternik, St Mary’s Hospital, Isle of Wight  
(acting Tutor covering maternity leave)

**South Thames East**
*Dr M J Coupe, Kent and Canterbury Hospital

**West Midlands North**
Dr J C John, The Robert Jones and 
Agnes Hunt Hospital NHS Trust  
(in succession to Dr E O Hughes)

**West Midlands South**
Dr C A Stevenson, Hereford Hospital  
(in succession to Dr N J Bywater)

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.

**South East**
Dr Peter Gordon Anderson*
Dr Annesul Islam Shakir

**North Central**
Dr Robert Charles Meredith Stephens
Dr Oma Omesh Dulan
Dr George Grenville Hallward
Dr Rachel Jane Pegg
Dr James Nicholas Carrannante
Dr Sarah Louise Stirling*
Dr Tanya Louise Jones
Dr Juliet Marie Dunn
Dr Huw Brian Watcyn Thomas
Dr Senthil Kutramal Nadarajan
Dr Clare Narina Melikian
Dr Avinash Gobindram
Dr John Anthony Orr

**Imperial**
Dr Sarah Ann Ranson
Dr Nicole Anne Richards
Dr Victoria Alexandra Heaviside*

**Barts/Royal London**
Dr Elena Fernandez Garcia
Dr Manisha Dinesh Sahni

**St George’s**
Dr Martin Rowlands

**Leicester**
Dr Anjum Ahmed

**Mersey**
Dr Seshapillai Swaraj

**Northern Ireland**
Dr Jacqueline Mary Faith McAlinden
Dr Ahmed Elashry Mohamed

**Nottingham**
Dr Subramanyam Subbarayudu Mahankali
Dr Aravindan Kathirgamanathan
Dr James Lawrence Hepburn French
Dr Jaime John Greenwood
Dr Srikanth Narra

**East Midlands**
Dr Alison Gillian Wemyss Chalmers
Dr Stuart Howard McClelland

**North West**
Dr Katharine Philippa Boothroyd
Dr Susan Joan Fox

**Northern**
Dr Julian Dimech
Dr Elke Kothmann

**Oxford**
Dr Sarah Akol Aturia
Dr Charles Rudolph Swart

**Bristol**
Dr Hannah Jane Blanshard
Dr Rakhee Hindocha*

**Peninsula**
Dr William Thomas Adam Fox

**Sheffield**
Dr Philip Christopher Jackson*

**Wessex**
Dr Henry Frank Akerman
Dr Kenwyn Meyrick James*
Dr Stewart Gunn Southey
Dr Alan Jeffrey Stedman

**West Midlands**
Dr Ayngara Thillaivasan
Dr Vijay Kumar Gund
Dr David Peter Stanley*
Dr Stephen Merron
Dr Anil Kumar Bhuvanagiri
At a meeting of Council on 
Wednesday, 10 December 2008, 
the following appointments/ re-appointments were made 
(re-appointments are marked with an asterisk):

**Deputy Regional Advisers**

**North Thames West**
Dr Michelle Hayes, Chelsea and Westminster Hospital

**Yorkshire**
Dr J A Horn, Bradford Royal Infirmary  
(in succession to Dr G Oldroyd)
Dr K Robins, York Hospital (in succession to Dr S Old)

**North Thames West**
Dr S-M Lim, St Mary’s Hospital  
(in succession to Dr R W Bacon)

**Regional Advisers**

**Mersey**
Dr E J Fazackerley, Warrington District Hospital (in succession to Dr A Bowhay)

**West of Scotland**
Dr M D Smith, Royal Alexandra Hospital (in succession to Dr N O’Donnell)

**College Tutors**

**Anglia**
Dr E A Bright, West Suffolk Hospital  
(in succession to Dr M I Palmer)

**Oxford**
Dr D Wilkinson, Churchill Hospital,  
(acting Tutor covering maternity leave)

**Northern**
Dr E M E Rodger, Sunderland Royal Hospital (in succession to Dr A S Orwin)
Dr M K Varma, Newcastle General Hospital, (in succession to Dr J S Stanley)

At a meeting of Council on, 
**Wednesday 21 January 2009**, the following appointments/ re-appointments were made 
(re-appointments are marked with an asterisk):

**Regional Advisers**

**Mersey**
Dr E A Hoskins, Bromley Hospital

**Wales**
Dr B John, Nevill Hall Hospital  
(in succession to Dr R Rouse)

At a meeting of Council on, 
**Wednesday, 10 December 2008**, the following appointments/ re-appointments were made 
(re-appointments are marked with an asterisk):

**Deputy Regional Advisers**

**North Thames West**
Dr A K Koomson, Watford General Hospital, (in succession to Dr R Makker,  
Hemel Hempstead General Hospital and Dr M A Soskin, Watford General Hospital  
(Hemel Hempstead and Watford Anaesthetic Departments are merging, 
this change takes effect in March 2009)

**North West**
*Dr A D Haughton, Chorley District Hospital

**West of Scotland**
Dr F J Burns, Royal Alexandra Hospital (in succession to Dr M D Smith)

**South West Peninsula**
Dr E Hartsliver, Royal Devon and Exeter Hospital (in succession to Dr J A L Pittman)  
**change over to take effect in April 2009**

**South Thames East**
Dr M Howells, Maidstone Hospital (in succession to Dr R C Williams)

**Sheffield and North Trent**
*Dr A M Dixon, Bassett Law Hospital  
3rd Term granted 1 year renewable yearly

**North Thames West**
Dr M Howells, Maidstone Hospital (in succession to Dr R C Williams)

**Sheffield and North Trent**
*Dr A M Dixon, Bassett Law Hospital  
3rd Term granted 1 year renewable yearly

The following list of Fellows by Examination was approved (University of Primary Medical qualification in brackets):

ABDUL Sajith (Kerala)
ABELL Daniel James (Birmingham)
AHMED Inas (Alexandria)
AHMED Khalil (Mosul)
AIREY Nicholas William (Liverpool)
AL Aloussi Mohammed Abdulrazaq Abdulwahab (Baghdad)
ALDORY Mutasim Madhi Wees (Baghdad)
Before this idea is confined to the bin, it is perhaps worth remembering that our nautical colleagues have been running 4 am shift changeovers (from the ‘Middle Watch’ to the ‘Morning Watch’) from time immemorial. My understanding is that it’s called a ‘watch’ because it’s about ‘watching’ to make sure that the ship does not hit a rock, or another vessel: the system of ‘watches’ and their changeover times is all about optimising performance and safety. Aren’t both of these attributes what we’re about?

Perhaps a re-think of the time of shift changeover would lead to better teaching, more alert trainees (and, with Dr Price and myself in mind, more alert consultants) and, as a result, better patient care. If ‘Hospital at Night’ statistics on workload are correct, then I think there might also be more time for ‘quality’, detailed and unrushed handovers at 4 am ensuring that nothing was forgotten and patients were well prepared for when the hospital woke up or colleagues came to work at 8 am. Of course, those coming off the ‘Middle Watch’ at 4 am might just want a bed, not a hammock, in the hospital – and this might be the biggest obstacle to the introduction of such a radical system.

Dr P Lawler, Retired Medical Director and Consultant in Critical Care Medicine

I read with interest the articles by Dr Price and Dr Patel on the implications and challenges of the August 2009 implementation of the full provisions of European Working Time Directive (after working a weekend of nights, of course!). Whilst I wholeheartedly agree with everything that Dr Patel had to say, I couldn’t help but feel that he had perhaps missed a trick when pondering ways to rethink our night shift work.

I suspect that many other anaesthetists will agree with me when I say that in every hospital I have worked in, emergency surgery seems to be very much the poor relation of elective surgery. This is in no small part due to the will and targets imposed by our political masters. Whilst every effort is made to ensure that patients who are about to breach are not cancelled and extra waiting list initiative lists are put on to get through the elective workload, the emergency list stops and starts without the extra resource and urgency that seems to be associated with elective work. At times, I have even seen elective patients placed on the emergency list such are the pressures to not postpone elective work. In a number of trusts that I’ve worked in, the emergency list is often interrupted in the early evening, in order to staff overrunning elective lists. As a consequence, patients are operated on far later into the night than necessary, with all the attendant risks, or may have their operation postponed till the following day. Furthermore, I suspect with better planning and more resources many more emergency patients could be operated on in daytime hours and not at night. I think

We are now only accepting letters which are in response to articles published in the previous issue of the Bulletin. Letters will be posted on the College website in unlimited numbers and will be moderated for content but otherwise remain unedited. A representative sample of letters have been selected and edited and are included below. Please make your views known to the Editor via email including your full name, grade and address.

bulletin@rcoa.ac.uk  www.rcoa.ac.uk/letters
we’ve all seen the extremely unwell patient who requires a laparotomy appear on the emergency list in the evening who had been seen on the consultant ward round in the morning and who has been waiting all day for the CT scan of their abdomen.

I would suggest that there needs to be a change of priority so that emergency patients can receive the care they warrant more expeditiously and in daytime hours. We are the people that need to voice this change of priority, armed as Dr Price points out, with a powerful piece of legislation which our political leaders and managers have to pay due regard. I would emphasize that the European Working Directive is a piece of law, whilst politically motivated targets are not. So perhaps we should regard August 2009, as an opportunity, and not a burden, to achieve what the European Working Time Directive is there for, to safeguard our health and that of our patients.

Dr K Madon, SpR, Portsmouth

EXTENDING TRAINING

Bullitin 53;January 2009:13–15

I read with interest the article written by Dr C Bradbury. As a final year specialist registrar, I am well aware of the reduction in overall training time and an over-commitment to service which may be compromising training in anaesthesia. However, I have reservations about lengthening the overall training time in anaesthesia in this country.

Anaesthesia in the UK already has one of the longest training times in the world. In countries where decreased working hours are already in place, e.g. Australia, New Zealand, Denmark and the Netherlands, training apparently takes place satisfactorily within shift systems. As Dr Bradbury correctly pointed out, the problem is the imbalance between service and training. As intensive care grows as a specialty, both in terms of trainees and consultants, the contribution required from anaesthesia will reduce. In Australia, for example, anaesthetic trainees need only complete three months of intensive care medicine during a total training period of five years in anaesthesia. I am sure many trainees will share my experience in post-fellowship years, in that much of my service time has been spent in intensive care – an area in which I have decided not to specialize and will not be gaining CCT in. As a general anaeasthetist, I would have welcomed more time in the emergency theatre, but most district general hospitals have a junior anaesthetist in this role; the primary role of the senior anaesthetist in a DGH seems to be to cover intensive care and obstetric analgesia/anaesthesia.

What we need to do is to improve the quality of training within EWTD. Underwood and McIndoe looked at the influence of changing working patterns on training in a teaching hospital between 1996 and 2004. Despite an overall reduction in caseload experienced by SHOs and SpRs, they found that teaching and close supervision of trainees had survived following the introduction of the New Deal and EWTD.

Service commitment will never go away, but with further consultant expansion, we can at least expect it to reduce. I suspect that consultants will be resident more of the time in the future, and this will provide extra training opportunities to trainees. Workforce planning has been made more difficult since the advent of MMC and an exodus of doctors abroad, but to go back to the peri-Calman era is thinking the unthinkable in my mind.

Dr S Quasim, SpR Anaesthesia, Warwickshire School of Anaesthesia

References
APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

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

**Associate Fellows**
- December 2008
  - Dr Peter Bernard Maguire
  - Dr Tomasz Torlinski
- January 2009
  - Dr Anargyros Skalimis
  - Dr Dominika Marta
  - Dabrowska

**Members**
- December 2008
  - Dr Shanti Ramasami
  - Dr Manishi Purohit
  - Dr Narendra Purohit
  - Laxminarayan
  - Dr Anand Gore
  - Dr Aparna Bharatkumar Trivedi
  - Dr Sukhpreet Singh Sihota
- January 2009
  - Dr Narendrasinh Padhiyar
  - Dr Jaison Thattarukunnel Paul
  - Dr Manish Gupta

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**THE MAURICE P HUDSON PRIZE**

The late Dr Maurice Hudson’s daughter generously donated money to the College in memory of her father and asked that the interest on the capital sum be used for an annual prize for the best paper on his favourite subject – resuscitation.

Dr Hudson was a consultant anaesthetist in London, took the DA in 1936, was awarded the FFARCS in 1948 and had a particular interest in dental anaesthesia. The Hudson Harness was one of his innovations.

Council decided that this prize would be awarded to the anaesthetic trainee who is the principal author of the best paper relating to resuscitation published, or accepted for publication, in a peer reviewed journal. If you are such a trainee, would like to apply for the prize, and have published such an article since 1 August 2008, please forward a copy of your paper to the Royal College of Anaesthetists by 31 July 2009.

Applications should be sent to:

Morgan Cenan
Administrative Officer
National Institute for Academic Anaesthesia
The Royal College of Anaesthetists
Churchill House,
35 Red Lion Square
LONDON WC1R 4SG

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**61ST ANNIVERSARY DINNER**

**Wednesday, 18 March 2009**
**Renaissance Chancery Court**
**252 High Holborn, WC1**

The 61st Anniversary Dinner will be held on the evening of Wednesday, 18 March 2009. The dinner will be at 7.00 pm for 7.30 pm and is expected to finish at approximately 11.00 pm. Dress will be black tie. Spaces are limited but if you would like to attend, please contact Clara Ogunmilade on cogunmilade@rcoa.ac.uk.
SOCIETY FOR EDUCATION IN ANAESTHESIA (UK)

ANNUAL SCIENTIFIC MEETING

TRAINING, EDUCATION AND ASSESSMENT OF ANAESTHETISTS – AN UPDATE

Monday, 16 March 2009
The Sage, Newcastle–Gateshead
Fee: £125 for Members/£150 for non-Members
(including one year membership)

- Length of training – do competencies change anything?
- Update on trainee assessment tools.
- Departmental teaching in the era of e-learning.
- The changing role of the College Tutor.
- Setting case numbers for training.
- The NIAA.

For further details/registration form, please contact: Barbara Sladdin,
Administrator, Northern School of Anaesthesia, Royal Victoria
Infirmary, Newcastle upon Tyne NE1 4LP tel: 0191 282 5081
e-mail: Barbara.sladdin@nuth.nhs.uk or visit www.seauk.org

Registration Fees
Early Booking Rate*: 1 Day £160 / 2 Day £230 / 3 Day £280
Late Booking Rate**: 1 Day £210 / 2 Day £280 / 3 Day £330
Non-Member: 1 Day £300 / 2 Day £370 / 3 Day £430
* (members booking up to 04/05/09)
** (members booking after 04/05/09) These rates apply to both GAT and SAS doctors.

For complete information and online booking please visit
www.aagbi.org/events/gatasm.htm

“Excellent speakers, big names, fantastic social events…
GAT Cambridge has it all. The GAT Committee look forward to welcoming you this summer”
Chris Meadows, GAT Chairman
**XXIIIrd EDINBURGH ANAESTHESIA FESTIVAL**

19th–21st August 2009

The Edinburgh Anaesthesia Festival is organised by the University Department of Anaesthesia, Critical Care and Pain Medicine at the Royal Infirmary of Edinburgh to coincide with the 2009 Edinburgh International Festival of the Arts. The three-day programme will consist of lectures and discussion on current topics in anaesthesia. The lecturers are from all parts of the United Kingdom and represent leading opinions in their field.

**Contact details:**
Mrs C Middleton, University Dept of Anaesthesia, Critical Care and Pain Medicine, Royal Infirmary, Little France, Edinburgh EH16 4SA
Tel: 0131 242 3292  Fax: 0131 242 3138
Email: cindy.middleton@ed.ac.uk  Web: www.eafonline.co.uk

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**THE EUROPEAN SOCIETY OF REGIONAL ANAESTHESIA & PAIN THERAPY (UK & I)**

**ANNUAL MEETING**

Including cadaver, landmark and ultrasound regional anaesthesia workshops

**Monday 11 May–Tuesday 12 May 2009**

The Anatomy Department, University of Liverpool and
The Mersey Maritime Museum, Albert Dock, Liverpool

Call for Abstracts for Poster Competition

Scientific meeting sessions include RA and outcome, courtroom drama, ultrasound for central/paravertebral blocks, clinical implications of the NAP3 study, and Bruce Scott Lecture by Prof Alain Delbos

For more details/registration/abstract form go to www.ragbi.org

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**BULLETIN ADVERTISING**

The Royal College of Anaesthetists’ *Bulletin* is published bi-monthly and distributed to over 14,000 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 Editorial Board.

Text, images, logos or crests should be submitted to bulletin@rcoa.ac.uk. Images should be at least 300dpi in resolution and sent as separate graphic files (i.e. high-quality pdf, tiff, jpg or eps). We are unable to use images embedded within a Word document.

Adverts are in portrait and can be in full colour. 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. Prices below are per issue and are subject to VAT:

<table>
<thead>
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<th>Advert Size</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Quarter page</td>
<td>£220.00</td>
</tr>
<tr>
<td>Half page</td>
<td>£432.50</td>
</tr>
<tr>
<td>Full page</td>
<td>£702.50</td>
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A 20% discount is available if advertisements are placed in six consecutive issues and are paid for in advance. Please supply a contact name, email and full address for the invoice.

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**The Royal College of Anaesthetists**

**4TH NATIONAL AUDIT PROJECT (NAP4)**

**Major Complications of Airway Management in the UK**

**NAP4** will run from 1 September 2008 – 31 August 2009

**A one year prospective audit to determine the frequency of major airway complications in all NHS hospitals.**

**PHASE 1:** a snapshot audit in September 2008 of all anaesthetic activity.

**PHASE 2:** a year-long case reporting period (1 September 2008 – 31 August 2009).

**Please report all relevant complications of airway management during anaesthesia and in ICU or the Emergency Department.**

**Inclusion criteria:**
- Death or brain damage
- Emergency surgical airway or needle cricothyroidotomy
- Unanticipated ICU admissions: only where the complications of airway management are the cause of admission, or lead to an adverse outcome.

More detailed information can be found on the DAS website (www.das.uk.com/natauditproject) or RCoA website (www.rcoa.ac.uk/NAP4), or directly from Tim Cook (tcnock@rcoa.ac.uk) or Nick Woodall (nicholas.woodall@nnuh.nhs.uk) co-leads for the project.
Mersey
Final FRCA & FCARCSI Examinations
SAQ and E&SAQ Papers

Learn & Practise
THE MERSEY METHOD
by joining

The London Writers Club
The Dublin Writers Club

Clubs Opening 8th June
Candidates are invited to an essential Four Hour Introduction Session
No Charge – No Obligation
April & May
Venues

London – Liverpool – Edinburgh – Dublin
31 Members sat the October 2008 RCoA SAQ Paper
27 were successful
2 of those who failed have admitted they did not use
The Mersey Method
throughout.

For full details, venues, dates and information please see our website at: www.msoa.org.uk
### The Mersey Weeks

<table>
<thead>
<tr>
<th>Course</th>
<th>Dates</th>
<th>Details</th>
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| Final FRCA MCQ              | MARCH 14.00 Sun 15th – 16.00 Fri 20th | An Intense (10 hours per day) Course of MCQ Analysis  
No limit to places |
| Final FCRA Crammer (Booker) | MARCH 14.00 Sun 29th – 16.00 Fri 3rd (APRIL) | Limited places – Course closed |
| Primary OSCE/Orals          | MAY 14.00 Fri 1st – 16.00 Fri 8th | Limited places |
| Primary MCQ                 | MAY 14.00 Sun 10th – 16.00 Fri 15th | An Intense (10 hours per day) Course of MCQ Analysis  
No limit to places |

### The Mersey (Aintree Way) Weekends

<table>
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<tr>
<th>Course</th>
<th>Dates</th>
<th>Details</th>
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<tbody>
<tr>
<td>Final FRCA SAQ weekend</td>
<td>MARCH 14.00 Fri 13th – 16.00 Sun 15th</td>
<td>Places limited*</td>
</tr>
<tr>
<td>Primary OSCE weekend</td>
<td>APRIL 14.00 Fri 17th – 16.00 Sun 19th</td>
<td>Places limited*</td>
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<tr>
<td>Final FCARCSI Viva weekend</td>
<td>APRIL 14.00 Fri 17th – 16.00 Sun 19th</td>
<td>No Limit to Places</td>
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<tr>
<td>Primary Viva weekend</td>
<td>APRIL 14.00 Fri 24th – 16.00 Sun 26th</td>
<td>No limit to places</td>
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<tr>
<td>Final FRCA Viva weekend</td>
<td>JUNE 14.00 Fri 12th – 16.00 Sun 14th</td>
<td>Places limited*</td>
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*Originally advertised as Unlimited Places but, because of the current popularity of these courses and the resulting pressure on the venue, it has become necessary to put a limit to the number of candidates.

For further information, details and applications see our website at: www.msoa.org.uk

“If you feed the children with a spoon, they will never learn to use the chopsticks”
DEATHS
It is with regret that the College records the deaths of those listed below.

Dr R G Cole  
*Melbourne, Australia*

Dr P C Ghosh  
*Beaconsfield*

Dr E A Hoult,  
*Worcestershire*

Admiral D Lammiman,  
*London*

Dr P K Sowa  
*Suffolk*

Dr A L Stead  
*Anglesey, Wales*

The College is able to receive brief obituaries (of no more than 500 words), with a photo if desired, of Fellows, Members or Trainees.

The obituaries will be published on the College website for a period of three months, after which they will be moved to a permanent archive. Please email your text and any photo to website@rcoa.ac.uk.

www.rcoa.ac.uk/obituaries

<table>
<thead>
<tr>
<th>APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS</th>
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<tbody>
<tr>
<td>The College congratulates the following Fellows on their consultant appointments:</td>
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</table>
| Dr Harry Akerman  
*Southampton University Hospitals Trust* |
| Dr Catherine Ben  
*Nelson Hospital, New Zealand* |
| Dr Karen Butler  
*East Lancashire NHS Trust* |
| Dr Yogita Ashish Chikermame  
*Heart of England NHS Foundation Trust* |
| Dr Jennifer Cuthill  
*Stobhill Hospital, Glasgow* |
| Dr Elizabeth Duff  
*Royal Gwent Hospital, Newport* |
| Dr Frances Emerantia Jacintha  
*Queen’s Hospital, Burton-on-Trent* |
| Dr Steven John Joseph Golding  
*Orthopaedic Hospital, Shropshire* |
| Dr Helene Patricia Lindsay  
*Musgrave Park Hospital, Belfast* |
| Dr Jon McCormack  
*Royal Hospital for Sick Children, Edinburgh* |
| Dr Rita Singh  
*Freeman Hospital, Newcastle-upon-Tyne* |
| Dr Stephanie Strachan  
*King’s College Hospital, London* |
| Dr Jacob Nicholas Francois Taljard  
*Monklands District General Hospital, Airdrie, Scotland* |
| Dr Pallipalayam Venkatesan  
*Hull & East Yorkshire Hospitals NHS Trust* |
| Dr Leigh Willoughby  
*Salford Royal Hospitals NHS Foundation Trust* |

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<th>COLLEGE CONTACTS</th>
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<tr>
<td><strong>Chief Executive</strong></td>
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<tr>
<td>Kevin Storey</td>
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| **Directors**  |
| David Bowman, Training and Examinations  |
| Sharon Drake, Education  |
| Charlie McLaughlan, Professional Standards |

| **Managers**  |
| Martin Bennetts, Facilities  |
| Graham Clissett, Examinations  |
| Richard Cooke, IT  |
| Roger Smith, Financial Controller  |
| Bob Williams, Professional Standards  |
| Craig Williamson, Training  |

| **Advisory Appointment Committees**  |
| Anita Mattis: 020 7092 1571  |
| Jane Griggs: 020 7092 1572 |

| **Courses and Meetings/Events**  |
| Ekaterina Boyd: 020 7092 1670  |
| fax: 020 7092 1735  |
| events@rcoa.ac.uk |

| **Examinations**  |
| Chloe Scrivener: 020 7092 1525  |
| Beth Doyle: 020 7092 1526 |

| **Finance**  |
| Sarah Bishop: 020 7092 1583  |
| Alison Clark: 020 7092 1585 |

| **Quality Assurance**  |
| Afsha Choudhury: 020 7092 1652 |

| **Individual Trainees A–La**  |
| Claire Higgins: 020 7092 1553 |

| **Individual Trainees Le–Z**  |
| Carly Melbourne: 020 7092 1552 |

| **Membership**  |
| Karen Slater: 020 7092 1701  |
| Craig Miller: 020 7092 1702 |

| **Venue Hire**  |
| Manja Krech or Karoline Streicher: 020 7092 1510  |
| roombookings@rcoa.ac.uk |

| **Website and Bulletin**  |
| Edwina Jones: 020 7092 1692  |
| Mandie Kelly: 020 7092 1693 |