Inside this issue

The General Medical Council
Friend or foe?

WHO checklist
Saving lives in surgery

ICU on the move
Retrieval medicine in Australia

A year at the Institute for Healthcare Improvement
Visit the News and Media section of the website for the latest news items at:
www.rcoa.ac.uk/news

Download this and back issues of the Bulletin at:
www.rcoa.ac.uk/bulletin

The rapid response section is now open for articles published in this issue. Please make your views known to the Editor.
www.rcoa.ac.uk/letters

THE PRESIDENT’S STATEMENT: Maintaining a high profile

Page 4

GUEST EDITORIAL: The General Medical Council Friend or foe?

Page 7

TRAINEE’S TOPICS IN ANAESTHESIA: Moonlighting Training in medical ethics and law in the Oxford Deanery

Page 11 Page 14

AS WE WERE

Page 13

THE PATIENT LIASION GROUP DEBATES

Page 17

STAFF AND ASSOCIATE SPECIALIST COMMITTEE

Page 19

FACULTY OF PAIN MEDICINE

Page 20

WHO CHECKLIST: SAVING LIVES IN SURGERY

Page 21

ICU ON THE MOVE: RETRIEVAL MEDICINE IN AUSTRALIA

Page 24

THE EVENTS PROGRAMME

Page 27

A YEAR AT THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

Page 35

PRIMARY FRCA EXAM: WHEN IS THE APPROPRIATE TIME?

Page 39

TRAINING AND EXAMINATIONS DIRECTORATE The Examinations Department

Page 41

MAINTAINING ESSENTIAL SKILLS AND KNOWLEDGE FOR PAEDIATRIC ANAESTHESIA IN DISTRICT GENERAL HOSPITALS

Page 44

REPORT OF THE SENIOR FELLOWS CLUB

Page 47

e-LEARNING ANAESTHESIA

Page 48

REPORT OF COUNCIL

Page 50

LETTERS TO THE EDITOR

Page 52

NOTICES AND ADVERTISEMENTS

Page 54
This issue of the Bulletin sees us half way through the year already and, once again, we have taken extra pages to fit all the excellent copy that we have received on standards of practice and patient safety.

The editorial by Professor David Hatch and Dr Maria Rollin looks at the role and function of the GMC. The College is very lucky to have had the services of Professor David Hatch as Adviser to the Professional Standards Directorate. David is also a senior figure in the GMC, having developed a number of assessment models for doctors who have got on the wrong side of its Fitness to Practise Committee. We planned to publish a complementary article by a trainee who (very bravely in my opinion) contacted us to say that he had been up before the GMC after an incident in critical care. However, shortly before the submission deadline, his solicitors advised him against publishing – trust lawyers to get in the way of good story!

Standards of practice are very topical, however, especially as we all register with the GMC for revalidation. In this issue, Carol Peden tells us how the approach to improving patient safety is developing in the USA, whilst Ravi Mahajan and Les Gemmell introduce us to the WHO checklist developed to reduce iatrogenic harm during surgery. This must be the way forwards, because Mandie Kelly tells me that it cropped up on ER last week. Holby City will follow suit no doubt. Medical ethics and the law features in an article by Kate Thomas, who has set a course up in the Oxford Deanery, whilst the danger of moonlighting to cover gaps in rotas is also highlighted. The PLG debate concerns itself with the problems and the possibility of an opt-out system for organ donation which may commence in Wales in the near future. This is topical, as developing the best approach to ‘end of life care’ and organ donation often appears on Council agenda as the Department of Health develops guidelines.

On a lighter note, Henrik Reschreiter explains the rather different approach to patient transfers that is necessary in the Australian outback, and makes trainee induction and the transfer of patients around the South East of England seem straightforward by comparison! Deciding when to sit the Primary examination, and a visit behind the scenes to explain the workings of the Examinations Department also appear in this issue. Quite a lot of good reading, then!

We have decided to keep the glossy cover – it seems to have universal approval, and the BJA has one, so why shouldn’t we?

The two remaining issues for 2009 will focus on training and academic anaesthesia, but please submit articles on any other topic that you would like to disseminate. We keep space available for articles on a wide variety of subjects so that, hopefully, each issue has something to interest everyone.

© 2009 Bulletin of The Royal College of Anaesthetists
All Rights Reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any other means, electronic, mechanical, photocopying, recording, or otherwise, without prior permission, in writing, of The Royal College of Anaesthetists.

Fellows, Members and Trainees are asked to send notification of their changes of address direct to Miss Karen Slater, Membership Supervisor, at the College (subs@rcoa.ac.uk).

Articles for submission, together with any declaration of interest, should be sent to the Editor via email to: bulletin@rcoa.ac.uk. All contributions will receive an acknowledgement and the Editor reserves the right to edit articles for reasons of space or clarity.

ISSN (print): 2040-8846
ISSN (online): 2040-8854

The views and opinions expressed in the Bulletin are solely those of the individual authors, and do not necessarily represent the view of The Royal College of Anaesthetists.
Senior Fellows’ Club
As a President who is approaching very rapidly the status of ‘Senior Fellow’, I am delighted to pay tribute this month to the Senior Fellows’ Club of the College, and their retiring Chairman. Dr Brian Williams has led the Club as its Chairman whilst I have been in post as President, and I am enormously grateful for all the time and attention that he has devoted to the task. The Club, which meets twice a year, has flourished under his guidance with healthy attendance figures and what can only be described as a very varied programme.

I’ve had the privilege of attending most of the meetings as President, and have listened to many interesting speakers, at least one of whom reduced me to tears of laughter! Brian and the membership team led by Karen Slater, are to be congratulated on the success of the recent ‘out of town’ meeting in Birmingham. Brian hands the Club over in excellent shape to his successor Dr Hugh Seeley. As a soon to be Senior Fellow, I look forward to its continuing success.

The European Working Time Directive (EWTD)
If ever anything was destined to make anyone and everyone wish they were already ‘Senior Fellows’, it is the increasing anxiety about the EWTD and its full 48-hour implementation on 1 August this year. I make no apology for raising this issue yet again, because I regard it as an issue of legitimate and serious professional concern. The undoubted problems that beset some services are largely confined to those that provide acute 24-hour cover, of which we as anaesthetists and critical care doctors are at the heart.

Over the last few weeks a small team from this College has been working with Strategic Health Authorities (SHAs) in England, the Department of Health (DH), Postgraduate Deans and clinicians in order to assess the scale of the problems, and to offer advice on possible strategies and solutions, whether they are financial or managerial. Our team has been led by Dr Anne Thornberry as Deputy Medical Secretary and EWTD lead and administered by Richard Bryant, Director of Training and Examinations. Teams from other Colleges with acute 24-hour care commitments have also been working in a similar way. I must express my gratitude for the enormous task that this team has completed in a very short time-scale to produce a comprehensive and exceedingly useful report. This work has necessitated their absence from clinical work and the College is very grateful for the support they have had from colleagues and management.

The core of the report can be found on the College website (www.rcoa.ac.uk/ewtd), although the detail from each SHA is only available to the relevant parties. There are, undoubtedly, very serious problems in some areas and although the above work has been carried out in England, we know from information provided to the College from other parts of the UK by our trainer and Clinical Director networks, that the problems are not confined to England. We know that many of you are doing all you can to manage the situation in your own hospitals, whether they affect the service, patient safety or the quality of
training that you deliver, and that often this management involves the senior members of departments working in ways that are not sustainable personally.

We have not joined with others to say that the EWTD is undeliverable, because some hospitals have clearly demonstrated that they have delivered it already, whilst continuing to maintain safe patient care and high quality training. However, it is true that in some hospitals the EWTD has not yet been delivered. Furthermore, there is evidence from recent work that it cannot be delivered without the application of derogation as a short-term measure, with considerable re-organisation of services and by increasing staffing levels to achieve sustainable solutions. It is these hospitals that we must support to maintain safe patient services and the quality of their training. I assure you that the College and I will continue to work to help find solutions that are sustainable.

We have not joined with others to say that the EWTD is undeliverable, because some hospitals have clearly demonstrated that they have already delivered it, while maintaining safe patient care and high quality training.

Quality of training
We have welcomed the Secretary of State’s request to Medical Education England (MEE) that there is a ‘Review of the effect of the EWTD on Junior doctor training’ (www.dh.gov.uk/en/News/Recentstories/DH_099740). The College and others have been asking for this at the highest level for some considerable time. Alan Johnson said: ‘...given the concerns raised by some professional groups, it is important that there is an independent and objective assessment of whether the introduction of the European Working Time Directive fully into the NHS will necessitate changes to the current system of postgraduate medical training.’ We look forward to contributing to this review.

Design
The Professional Standard Directorate has been contacted by the Royal Society of Arts (RSA). They state: ‘The RSA Design Directions student award scheme, (www.rsadesigndirections.org/) frames a series of design briefs within a social context in order to explore the role design can play in response to key challenges in contemporary life. Design Directions is part of the RSA’s Design and Society project’ (www.thersa.org/projects/design).

In 2009, Design Directions posed a set of diverse design challenges to students that included product design, graphic design, technology and service design. Two of the technology project winners were concerned with future developments in anaesthesia. May Wilson (Loughborough University) has developed a graphical display of neck anatomy to aid anaesthesia in obese patients undergoing surgery, and Jonathan Allott (University of Nottingham) illustrated a quick, electronic labelling system, requiring little effort from the anaesthetist, whereby the information from the ampoule is transferred automatically onto e-paper once the syringe begins to fill from it. The Royal College of Anaesthetists and the Bulletin extend its warm congratulations on their success, and no doubt we will benefit from their innovation one day.

We have not joined with others to say that the EWTD is undeliverable, because some hospitals have clearly demonstrated that they have already delivered it, while maintaining safe patient care and high quality training.

Diplomates’ day
As ever Diplomates’ day in May was a very upbeat and enjoyable occasion at Kensington Town Hall for some 300 Diplomates and their families and guests. The Diplomates were addressed by Professor Dame Carol Black who spoke to them about professionalism and leadership. I do always feel more optimistic after ‘Dips Day’, looking at so many young faces with their professional lives before them. This year, we again awarded College Honours and Medals following the Diplomates’ ceremony. I must make mention of one of the awards; the Humphry Davy Certificate was awarded to the Tri-services Anaesthetic Association, in recognition of the courage and skill shown by this group of men and women in this regrettable time of conflict. The award was received on behalf of the Association by Group Captain Neil McGuire, Defence Consultant Adviser, in the presence of Lieutenant General Louis Lillywhite, Surgeon General of the Armed Forces.

Nepal
Traditionally, international relations have not held as high a profile in the College as many would wish. Therefore, a recent success story relates to the Shackleton Department of Anaesthesia’s Southampton–Nepal Anaesthesia Project. Following a proposal by Dr Oliver Ross, the College is paying for consultants from Southampton to make two trips per year to Kathmandu, to give paediatric and intensive care updates for anaesthetists, and to provide critical incident refresher training for nurse anaesthetists. The project has now attracted the support of the Nepalese government. Nepal is one of the poorest countries in the world, and I am proud that Fellows of the College are working to alleviate some of its problems.

Revalidation
Through the Academy of Medical Royal Colleges Revalidation Development Group, this College has been working with others to produce guidance on standards, multi-source feedback, remediation, non-clinical work
undertaken by many doctors, and other aspects of the revalidation process. Much of this work is coming to a conclusion, and all of it has been carried out in the closest consultation with the GMC and other stakeholders. During the summer, Fellows of all the Colleges will see the publication of draft documentation. Although there will be a rigorous consultation process later in the year, we in this College are very keen to talk to Fellows and Members in their places of work to impart information, and to test with you some of the standards and processes about which we will be consulting formally. If you would like a visit to your department so that you can learn more and give us the benefit of your views, then please contact cmclaughlan@rcoa.ac.uk. We are most anxious to start these ‘roadshows’ at the earliest opportunity.

Sedation
As many of you will be aware the use of sedation for procedures outside of anaesthesia, such as in endoscopy suites and interventional radiology, has been established for many years and indeed we have joint guidelines for these in many areas of practice. As the frontiers of such specialist practice expand there is a growing need for more sophisticated (or advanced) techniques of sedation. Especially as some procedures may take some hours in elderly ill and frail patients and single agent techniques are usually unsuitable.

Following our very successful meeting for all Colleges and Societies involved in sedation we are planning to review current and predicted future developments in these clinical areas to see where anaesthesia can offer our expertise and skills. It is likely that this will become an increasingly common role for anaesthetists in the future and one where we can, as for the surgeons, enable technical and procedural innovation with increased patient safety.

And finally
At the end of my statement, you will see the annual advertisement for the ACCEA process and the timetable for 2010. All of you in England and Wales should by now have received a request from your regional assessor for submission of your ACCEA forms to the local process, run as a preliminary to the College process that will conclude in the autumn.

Please note that you need to act very soon. The closing date of December is misleading because in order to meet the deadlines, you will need to produce your finely honed form before you depart for the summer holidays. We are very anxious to help, but we can only do so if you produce forms that reflect accurately the excellence of your activities. Please, please make sure that we receive them.

<table>
<thead>
<tr>
<th><strong>Timetable for ACCEA 2010</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline for CVQs to be submitted to Regional Assessors</td>
</tr>
<tr>
<td>2010 Guide available on the ACCEA website</td>
</tr>
<tr>
<td>Letters to be sent to successful 2009 round candidates</td>
</tr>
<tr>
<td>Full 2009 round results posted on ACCEA website</td>
</tr>
<tr>
<td>Deadline for each Region to submit CVQs to the College</td>
</tr>
<tr>
<td>Online system for 2010 round available on ACCEA website</td>
</tr>
<tr>
<td>College ranking meeting</td>
</tr>
<tr>
<td>Closing date for receipt of all applications, ranked lists and citations</td>
</tr>
</tbody>
</table>

*Approximate dates provided by ACCEA
The General Medical Council

Friend or foe?

Regulators are seldom universally popular, and the General Medical Council (GMC) is no exception. In recent years, however, there have been many changes in its constitution and modus operandi, and new Fitness to Practise Rules introduced in 2004 allow it to work more effectively under the legal framework set out in the Medical Act 1983. In this brief article we outline the GMC’s purpose and the processes by which it functions, and discuss some of the practical issues which arise in the assessment of individual doctors’ performance.

What does the GMC do?
Doctors who practise medicine in the UK must be registered with the GMC. By administering systems for the registration and licensing of doctors to control their entry to, and continuation in, medical practice in the UK the GMC aims to ensure that all registered doctors maintain the standards the public and the profession expect. Patients need to have confidence that doctors are competent in their field and abide by high ethical standards, and it is the GMC’s duty to protect this public interest, which is wider than the interest of individual patients. It achieves this in a number of ways. First, it assures the quality of undergraduate medical education in the UK and, when the Postgraduate Medical Education and Training Board (PMETB) is subsumed into the GMC, will in future have overall responsibility for postgraduate and continuing medical education. Secondly, it provides guidance to the profession on the standards expected of all doctors throughout their working lives in its publication ‘Good Medical Practice’ (GMP)¹ and other supporting ethical guidance documents. Thirdly, it deals firmly and fairly with doctors whose fitness to practise is questioned. It relies on complaints and enquiries from others reporting such doctors to the GMC before it initiates any investigation. Following recent high-profile cases, parliament and the public (at least as represented by the media) no longer have confidence in this approach. From the second half of 2009, with the introduction of the licence to practise the first step will be in place for a proactive system of revalidation, requiring doctors to demonstrate positively that they are up to date and fit to practise.

What powers does it have?
The GMC has powers to enforce undertakings agreed by doctors, to apply conditions to their registration and to suspend or erase doctors from the register, thus preventing them from practising medicine anywhere within the UK. It will only apply these restrictions on registration, however, if it finds evidence that the doctor’s fitness to practise is impaired to such an extent that sanctions are necessary in the interests of patient safety or to preserve the public’s trust in the profession. This degree of impairment might arise because a doctor has been found guilty of a criminal offence or serious misdemeanour, has taken advantage of his or her role as a doctor, has not...
kept his or her medical knowledge and skills up to date, is not competent or performing to an acceptable standard or is too ill to work safely. The GMC can also issue a warning to a doctor whose fitness to practise is not impaired but where there has been a significant departure from the principles set out in GMP. A warning, which will not be appropriate where the concerns relate exclusively to a doctor's physical or mental health, will be disclosed to a doctor's employer and to any other enquirer during a five-year period.

How many doctors does the GMC investigate?
The number of doctors about whom information received by the GMC led to a fitness to practise enquiry over the last five years is shown in Figure 1. Approximately 80% of these referrals are made by members of the public, with the remainder being made by someone acting in a public capacity. Whilst the number of enquiries has risen by 32% since 2002, the rate of increase has slowed down considerably in recent years.

How does it deal with them?
Contrary to popular perception, all enquiries are triaged within a week of receipt, and those that could never raise a question of impaired fitness to practise are normally closed without delay. When the information received would only be of concern if part of a wider pattern, the GMC will make enquiries of the doctor’s employer or contractor to establish if they have any wider concerns about the doctor’s practice. 39% of all enquiries in 2008 were immediately closed at the initial stage and 32% were closed after further enquiries. 29% proceeded to a full investigation by trained medical and non-medical Case Examiners, who work two to three days per week for the GMC, and whose work is regularly reviewed and audited. Where health is an issue, the doctor can be invited to undergo initial health assessment and possible ongoing supervision by appointed doctors (usually psychiatrists). Doctors whose performance is questioned may be required to undertake a performance assessment, normally carried out by two trained assessors from the same specialty as the doctor under investigation together with a trained non-medical assessor. It involves a two- to three-day visit to the doctor’s place of work, with observation of actual practice where possible, record review, case based discussions and interviews with the doctor and relevant third parties, as well as a separate competence test of knowledge and skills. These assessments have been developed as a result of close co-operation between the GMC and the medical Royal Colleges, and are continually reviewed and updated. The test of competence is tailored to the doctor’s actual practice and standard setting is carried out by the Angoff method.

Both medical and non-medical Case Examiners must agree before a case can be concluded at this stage, and where disagreement arises will refer the case to the Investigation Committee. Doctors also have the right to an appeal before the Investigation Committee when, for example, Case Examiners offer a warning at the conclusion of their investigations. Doctors exercised this right in 22 out of 169 warning decisions in 2008, and in 45% of these the warning was not issued. Case Examiner decisions in 2008 are shown in Table 1.

<table>
<thead>
<tr>
<th>Decision outcome</th>
<th>Total 2008 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to Hearing</td>
<td>28%</td>
</tr>
<tr>
<td>Undertakings</td>
<td>8%</td>
</tr>
<tr>
<td>Warning</td>
<td>13%</td>
</tr>
<tr>
<td>Conclude with Advice</td>
<td>25%</td>
</tr>
<tr>
<td>Conclude</td>
<td>26%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

The number of Fitness to Practise panel hearings per annum fell from 256 in 2007 to 204 in 2008, though the hearings are becoming more complex and longer. The outcomes of the 2007 and 2008 hearings are shown in Table 2.
This is primarily, of course, for the sake of the patient, to track the course of the anaesthetic, display trends, and provide information for future use. However, it is also the most valuable document an anaesthetist can produce for self-protection, which is, unfortunately in these litigious times, essential. If a mishap does occur, the anaesthetist writing the expert report for the GMC will need to rely on the anaesthetic record. ‘Experts’ are working anaesthetists. They understand clearly that things can and do go wrong, so don’t try to cover up any mistakes you may have made. It is the way these untoward events are handled that will determine the tone of the report. Your anaesthetic record can give the expert something with which to defend you – or not.

Be nice to your colleagues
Doctors are not especially good at spotting or taking action on doctors in difficulty. Although we all have an obligation under Good Medical Practice to take appropriate steps when a fellow doctor’s conduct, health or performance may pose a risk to patients, there is a natural tendency to be more supportive to colleagues we respect, especially those who are struggling with alcohol or drug abuse, or depression. Lists can be adjusted, CPD and clinical help provided, duty rosters modified. Many doctors approaching retirement are offered easier workloads than those they previously carried.

From experience, those who end up in front of the GMC are often those who have been unco-operative and difficult for years and have lost the respect, trust and affection of their colleagues.

If you are reported to the GMC
For better or worse, this is a fate increasingly likely to befall doctors. The GMC itself publishes guidance.2 Follow it. Do not ignore the letters

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number (%) 2007</th>
<th>Number (%) 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erasure</td>
<td>60 (23.4%)</td>
<td>42 (20.6%)</td>
</tr>
<tr>
<td>Suspension</td>
<td>79 (30.9%)</td>
<td>75 (36.8%)</td>
</tr>
<tr>
<td>Conditions</td>
<td>55 (21.5%)</td>
<td>30 (14.7%)</td>
</tr>
<tr>
<td>Undertakings</td>
<td>4 (1.6%)</td>
<td>3 (1.5%)</td>
</tr>
<tr>
<td>Warning</td>
<td>8 (3.1%)</td>
<td>22 (10.8%)</td>
</tr>
<tr>
<td>Reprimand</td>
<td>1 (0.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Impairment (no action)</td>
<td>13 (5.1%)</td>
<td>4 (2.0%)</td>
</tr>
<tr>
<td>No Impairment</td>
<td>34 (13.3%)</td>
<td>28 (13.7%)</td>
</tr>
<tr>
<td>Voluntary Erasure</td>
<td>2 (0.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>256 (100%)</strong></td>
<td><strong>204 (100%)</strong></td>
</tr>
</tbody>
</table>

The proportion of doctors erased has fallen from 2007 to 2008 though the proportion of suspensions has increased. The number of warnings issued has risen considerably, possibly reflecting an increase in the number of allegations that reveal a breach of the principles set out in GMP that in themselves would not lead to a finding of impairment.

What follows is a personal view, based on our combined experience of the GMC performance procedures over the past 12 years.

Avoiding the GMC
It is not, of course, possible to avoid the GMC entirely if you wish to remain in medical practice. However, most of us manage to restrict our contact to paying the annual retention fee and reading GMC Today at present, and, in due course, to complying with the requirements for revalidation when they are published.

Be competent
The simplest way to avoid unwelcome attention from the regulator is to maintain professional competence. You are required to be competent in the work which you actually do, and it is the personal responsibility of each individual, with the collaboration of his/her clinical director, to undertake appropriate continuing professional development (CPD).

There is an explicit requirement to make the care of your patients your first concern.1 This includes not only keeping knowledge and skills up to date, but treating patients with respect and involving them, to the extent they wish and are able, in decision making. The overwhelming majority of complaints against doctors are made by patients or their relatives. Not all of these are sensible, but many are clearly the result of impatience, inadequate communication or plain rudeness on the part of the doctor.

Recognise your limitations
In these days of flexible working and performance targets you may be put under pressure to undertake clinical duties with which you are unfamiliar. Never let anyone, whether clinician or manager, persuade you to do something you are unhappy about, and always be prepared to ask for help when necessary, however senior you are.

Make notes
GMP requires that you ‘keep clear, accurate and legible records – at the same time as the events you are recording or as soon as possible afterwards.’

Guest Editorial

in the hope that the whole thing will fade away. It won’t. And join a medical defence organisation. They are very familiar with GMC procedures and can take some of the personal hurt out of the process, as well as dealing professionally and dispassionately with the correspondence.

If it comes to a hearing

There is a very real desire and requirement to be fair (even if it doesn’t feel like it) and a real understanding that human beings make mistakes and doctors are human beings.

Unlike a civil case, which may be about compensation, this is about performance. In a civil case, an unblemished record does not protect you from the consequences of a single error. At the GMC, evidence presented in mitigation can be considered in relation to the sanction to be applied but not to the decision as to whether or not a doctor’s fitness to practise is impaired. If you have indeed made an error, or a series of errors, be truthful, show insight and be willing to acknowledge your mistake. The function of the regulator is not to strike off expensively trained doctors, but to try to ensure that they are safe to practise.

References


Footnote

The authors are grateful to staff at the GMC for providing data for this article, but wish to make it clear that the views expressed are those of the authors and not of the GMC.

THE ROYAL COLLEGE OF ANAESTHETISTS
EDUCATION PROGRAMME ADVISER

The Royal College of Anaesthetists will have a vacancy for the position of Education Programme Adviser from September 2009.

The post holder will work in collaboration with the Education Committee, the CPD Development Group, the Director of Education and the Events team to develop and deliver an educational strategy and programme which are responsive to the future training and continuing professional development needs of anaesthetists. Responsibilities will include sourcing new events and reviewing existing events to ensure they remain current and relevant, in addition to considering how new ways of learning should influence the future design of our education programme. The post holder will also be expected to advise on CPD policy.

The role requires the provision of up to date clinical and educational advice to the Education Directorate of the College, individual event organisers and speakers. We are looking for a senior consultant anaesthetist who has experience of developing and organising anaesthesia related conferences, courses and events. The successful applicant will be able to demonstrate a commitment to CPD and life-long learning, and also be able to implement change to ensure that our education programme remains fit for purpose in the light of revalidation requirements. Additionally, recent experience as a College officer, Council member and/or Regional Adviser would be of benefit.

The College seeks a highly organised individual who has a proven commitment to the College. The position is a fixed-term post of one year, with the possibility to extend. The role requires the post holder to attend and work at the College for two sessions per week. Specific hours and days of working are flexible and should reflect the ongoing needs of the post. Further details, the job description, the person specification, terms and conditions and an application form are available from the College website at www.rcoa.ac.uk/vacancies or upon request from Ms Sharon Drake, Director of Education (sdrake@rcoa.ac.uk).

Applications should be submitted by Tuesday, 8 September 2009 to:

Ms Sharon Drake
Director of Education
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
LONDON WC1R 4SG

Interviews will be held on Tuesday, 22 September 2009.
The effect of the reduction of junior doctors’ hours imposed by the European Working Time Directive (EWTD) on the quality and quantity of training is widely debated, whereas its effect on salaries is much clearer. Most posts attract a lower New Deal pay banding supplementation in line with the reduction of duty hours. EWTD and New Deal compliant rotas either require more personnel, or increase the demand for ad-hoc locum staff. External locums are recruited from agencies or pools of hospital ‘bank’ staff, but internal cover may be provided by medical staff currently working in the same department. The final EWTD limits apply from August 2009, with the maximum working week of all junior doctors reduced from 56 to 48 hours, exacerbating the staffing problems of on-call rotas and further reducing pay banding. An increasing need for locum anaesthetists might be matched by the temptation for doctors-in-training with reduced pay banding to undertake these extra shifts.

Money, money, money

In October 2008 we audited the amount of locum work undertaken by trainees in the Imperial School of Anaesthesia. We performed an online survey of trainees at or above their third year of specialist training (ST3/SpR1). The response rate was 50% (57/113). Most responders were working in a standard clinical training post, and out-of-hours commitments varied. 12% of respondents were in posts banded 2A (x1.8 banding supplement), 77% were in posts banded 1A or 2B (x1.5 banding supplement) and the remaining 11% were in posts attracting a salary multiplier x1.4 or less.

Regarding their locum activity over the previous six months, 61% (35/57) of respondents had undertaken at least one locum shift per month, and 16% had undertaken three or more shifts per month. Approximately half of the trainees only undertook ad-hoc internal shifts at their base hospital. The results, concerning adequate rest and EWTD constraints, showed that much of the locum work was associated with a breach of the 56-hour maximum working week. Only 26% (9/35) of respondents reported that their locum activities had rarely (<25% of shifts), or never, broken the 56-hour weekly limit. However, over half of respondents (20/35) felt that most of their locum shifts did permit adequate rest before and after each shift, defined by the EWTD as an 11-hour period of rest between duty shifts. Motivation for undertaking locum work was either financial or to ‘help out’. 60% (21/35) of respondents stated that over half of their locum work was undertaken to supplement income,
whilst 31% (11/35) did most of their shifts to assist their department.

**Changes**

Various strategies have been proposed to enable a reduction of junior doctors’ hours whilst minimising the impact on patient care and medical training.1 These include:

- expanding both the career-grade and trainee workforce (short- and long-term)
- reforming out-of-hours services (hospital at night, reducing tiers of cover), and allocating some duties to non-medical personnel (such as anaesthetic assistants)
- re-configuring services within a trust or region (for example, separate sites for emergency and elective work, twilight sessions for NCEPOD work).

With the 48-hour working week fast approaching, there is a degree of urgency to achieve EWTD compliance. Fundamentally changing service configuration takes time, and may not be achievable by August. The implications for clinicians, managers and patients suggest a bleak outlook for the summer.

For trainees, training opportunities may be further reduced. The financial implications of down-banding posts will encourage further ad-hoc locum work to supplement income, which risks breaches of EWTD constraints. Career-grade staff will work alone more frequently, have less teaching opportunity, and will be the main providers of the continuity of care. Hospital trusts will be required to bridge the service gap in the short-term by engaging locum staff, with consequent expense and organisational challenges. Some shifts are likely to remain unfilled, requiring internal cover to the detriment of the department’s daytime staffing. The influence of locums on the quality of patient care has been discussed previously in the Bulletin.2

**Going underground**

The EWTD changes assume that junior doctors are content to work fewer hours for less money. From this small survey of London trainees it seems that this is not the case. While many locum shifts are undertaken internally to ‘help out’, with a secondary financial benefit, many others are sought externally, primarily for financial gain. The financial motive is strong and reflects the ever-increasing cost of living, particularly in London. The recent global economic crisis has ensured that financial concerns are likely to be experienced country-wide. An unhealthy situation is developing. Trainees, constrained by limited working hours at their normal place of work, are supplementing their income with unregulated service provision during additional out-of-hours shifts, which may have implications for the EWTD, employment contracts and even patient safety. Trusts, unable to cover shifts with routine staff, have to attract external locum staff with high hourly rates and agency fees, or may even have to sacrifice daytime staff to employ them as locums out-of-hours.

**The times, they are a-changing**

Trainee locum activity is one symptom of a wider problem resulting from fundamental changes to doctors’ working practice. Unfortunately, there is no single solution.

Individual doctors registered in the UK are expected to follow the Good Medical Practice guidance of the General Medical Council. This includes a responsibility to prevent their own health endangering patients. A doctor fatigued by extra locum work, resulting in inadequate rest, may fail in that responsibility. Additional work that breaches inter-shift rest requirements and causes excessive fatigue should not be undertaken. From a legal perspective any problem with the delivery of clinical care in this situation makes that individual vulnerable to a clinical negligence claim. There are also contractual restraints; most trainee employment contracts do not permit extra work if this results in a breach of the maximum duty hours, or adequate rest periods of the permanent post. This could account for the low response rate in our survey.

Applying a blanket ban on locum work would be heavy-handed. Accepting that staff will continue to want to supplement their income would encourage trusts to develop novel ways to permit this activity, whilst discouraging fatiguing working patterns. In the longer term, expansion of junior and career-grade doctors is required. Meanwhile, a possible solution is the reorganisation of rota to concentrate work and training in certain periods, and have other periods of less intensive work with periods of time off, to permit extra work if required. This would not only allow individuals time to supplement their income, but would also increase the pool of staff available to trusts to cover locum shifts. It would also provide time for work-related activities away from direct clinical care, similar to the supporting professional activity framework used by career-grade staff.

There has been an entirely appropriate drive to maintain high quality training with the huge changes to junior doctors’ working lives.
an intrinsic tendency to resist change. This is a good example; the keenness of doctors to supplement their salaries together with the increased locum staffing requirements of departments produce a powerful combination to resist the very changes that the EWTD is trying to achieve. Worryingly, it also de-regulates the system. It would be very easy for a doctor with a strong financial incentive to work excessively and jeopardise patient safety. To avoid this, staff and their trusts must find ways of organising working patterns to achieve both their goals. It is a joint responsibility of both parties to discourage the fatigue inducing extra shifts that may compromise the quality of care delivered to patients. Sometimes the extra cash is just not worth it…

References

AS WE WERE ...

Although Cadge Road, Norwich, is now described as ‘a street of shame, where families are living in terror of gangs of yobs running riot,’ it is not named to reflect the propensities of the inhabitants, but to perpetuate the memory of a local surgeon, William Cadge. Cadge was one of a number of East Anglians who became eminent in the Victorian medical world; among others were James Paget, Joseph Clover, and Elizabeth Garrett (Anderson), whose father established The Maltings at Snape.

William Cadge is remembered by anaesthetists as Robert Liston’s assistant at the amputation of Frederick Churchill’s leg at UCH on 21 December 1846, when ether anaesthesia was used for a surgical operation for the first time in England. He was born in 1822 into a Norfolk family of farmers, studied at UCH, and was appointed Assistant Surgeon in 1850, but had to relinquish the post because of poor health. Returning to Norfolk he was appointed to the staff of the Norfolk and Norwich Hospital in 1854, and became full surgeon three years later. During his career he specialised in the surgery of bladder stones, acquiring an international reputation, and was elected to the Council of the Royal College of Surgeons.

In Norwich he became a great public figure, Sheriff, and a magistrate. Between 1879 and 1883 he was the driving force behind the rebuilding of the old hospital, raising a staggering £20,000 himself towards it, and leaving more in his Will. He received the Freedom of the City in 1890, the year in which he retired from clinical work. He died, aged 80, in 1903, and is remembered by a stained glass window in the North Transept of Norwich Cathedral; and by Cadge Road, where, Derek James, Features Editor of the Norwich Evening News, hopes, ‘conditions will improve soon so that residents can live their lives in peaceful harmony, which is what the good doctor would have wanted.’

Is Cadge Road unique in being named after a doctor? Does anyone know of any other?

Acknowledgement to Derek James, for permission to quote from the article in his series, ‘The stories behind our street names,’ published in the Norwich Evening News, 9 February 2009.

Dr David Zuck, History of Anaesthesia Society
The balancing acts that we undertake in clinical anaesthesia do not just relate to decisions about pharmacological agents or physiological parameters, but also to the broader aspects of our work, such as ethics and the law. The scales of anaesthesia that balance benefit with harm need to be used carefully, if we ourselves are to escape the ‘scales of justice’.

This article outlines the results of an audit of training in Medical Ethics and Law that we have undertaken in the Oxford Deanery, and the benefits of the regional course that has developed as a result.

The case facts
The RCoA publication entitled ‘The CCT in Anaesthesia’ includes a section entitled ‘Professional Knowledge and Skills’. Under this heading appear ‘broader professional competencies’ such as information technology, health care management, medical education, responsibilities of professional life, as well as medical ethics and law. Knowledge of these areas enables consultants and other medical staff to play a fuller part in the running of the NHS. There is a variation in the manner and the degree to which trainees gain their experience in these areas, which appear more relevant as they approach the final two years of training, when the FRCA exams are behind them, and they are looking for new directions and interests within their working lives. We decided to undertake an audit of training in the Oxford Deanery, focusing upon one of these competencies, medical ethics and law.

Counting the cost
Since the time of Hippocrates, it has been the duty of a doctor to ‘first do no harm’. This is pertinent to anaesthesia especially, where inappropriate actions may lead ultimately to serious morbidity or mortality. This ‘harm’ can have profound physical, psychological or financial implications for patients, medical staff or NHS trusts. It has been suggested that failure of the medical profession to resolve ethical and medical issues has resulted in a diminution of trust in the profession by the public and politicians, and a correspondingly rapid evolution of medical law. Both on a personal and a professional level, the impact of medical litigation is considerable. The average time taken to deal with a claim under the Clinical Negligence Scheme for Trusts (CNST) is 1.46 years. This is a long period of uncertainty and stress for an individual. On a public level, if we consider that each million pounds paid in damages is a million pounds that otherwise could be spent on clinical care, our duty to ‘first do no harm’ assumes even greater importance. However, the financial implications are clear. Anaesthesia
represents a small proportion of the total number of claims. Data accessed on 31 March 2009 show the number of claims, since the scheme began in 1997, to be £1,121 in anaesthesia, compared with £17,817 for surgery, and £9,477 for obstetrics and gynaecology. Indeed, the same is true for the total compensation paid (£137 million for anaesthesia, compared with no less than £3.3 billion in obstetrics and gynaecology, and £1.2 billion in surgery [these figures exclude 'below excess' claims]).

A need for training?
A discussion in theatre about a complex anaesthetic case raised certain ethical and legal questions. A few opinions were canvassed and it appeared that, whilst we had a reasonable amount of anecdotal experience, we had little formal training in medical ethics and law as relevant to anaesthesia. From this chance conversation arose a plan: to audit all the trainees in the Oxford Region and ascertain what training they had undergone in medical ethics and law, and to find out whether they were confident in various ethical and legal topics. We turned to the CCT manual to review the knowledge that trainees require to gain their CCT. The main areas include the Bolam principle, informed consent, consent in children, the Coroner and when to refer, end of life decisions, the Mental Capacity Act, as well as more time to discuss clinically relevant cases.

The evidence
Using the topics mentioned above as our gold standard, we contacted trainees in the Oxford Deanery. A response rate of 60% (54 trainees) was achieved, and completed forms were received from a range of grades. We were concerned that only 19% had received any training in medical law, and that only 8% had received any training in medical ethics. We asked trainees for their views on the importance of training in ethics and law, and 90% recognised a need for formal training in this area. More than 70% of trainees knew that Advanced Directives are legally binding. However, only 18% of trainees knew that a birth plan was not a legally binding document. Fewer than 60% of responders knew when it was acceptable to breach patient confidentiality. Such disclosure of personal information without consent may be justified in the public interest where failure to do so may expose the patient or others to risk of death or serious harm, or in cases where the doctor believes a patient to be a victim of neglect, physical, sexual or emotional abuse, and where disclosure is in the patient’s best interests. Clearly, there was a gap in knowledge. In an attempt to build up a portfolio of expertise within the region, we asked trainees whether there was a consultant within their department who had a declared interest in medical ethics and law, but only five trainees were aware of such a consultant.

Medical ethics and law in anaesthesia
Driven by the need for training in our region we created a regional course. Using the information from the audit forms, we designed a one-day course, ensuring that we included lectures based upon the areas of least knowledge, namely, end of life decisions, the Mental Capacity Act and patient autonomy. The panel of speakers consisted of regional and national experts. In recruiting the help of consultants and speakers from within the Oxford Region, we hoped to raise the profile of our local expertise. The regional training day consisted of six interactive lectures, and was recognised for 5 CPD points. The lectures included topics such as medical negligence, the Mental Capacity Act, ethical decision making (using the four principles: respect for autonomy, beneficence, non-maleficence and justice), consent and competence in children, ethics in obstetric anaesthesia, and end of life decision making. The feedback was very positive and all trainees felt that they had benefited from the course, with 89% feeling that information learnt on the course would change their practice. Trainees wanted more discussion on end of life decisions and the Mental Capacity Act, as well as more time to discuss clinically relevant cases.

Ether, ethics and the law
A revised and improved version of the course was held in November 2008. The ‘Ethics and Law in Anaesthesia’ course addressed all of the competencies outlined in the CCT manual. We audited pre- and post-course knowledge and training. This time, only two out of the 24 trainees (8%) attending had received any training in ethics and law. This second course took place over one and a half days, and included both lectures and workshops. It was awarded 9 CPD points. We included additional topics on confidentiality, the legal right to healthcare, research ethics, resource allocation, organ transplantation and definitions of death.

In conclusion, M’Lud...
‘The first step to moral action is moral perception, since an ethical problem can seldom be resolved if not first spotted’.

---

The average time taken to deal with a claim under the Clinical Negligence Scheme for Trusts (CNST) is 1.46 years.
In auditing the level of training and the self-rated knowledge in medical ethics and law of trainees in the Oxford Deanery, we identified an important area that lacked exposure and structured teaching in the region. It is likely that this lack of training is reflected in some other anaesthetic training programmes. As a result of this work, we believe we have motivated trainees and improved their recognition of the importance of ethics and law in their everyday clinical practice. We also feel that we have improved the knowledge base of trainees in the key areas of medical ethics and law as defined within the competencies in the CCT manual. We are aware that the course we have provided to trainees in our region is only a small step in the right direction with regard to training in ethics and law for anaesthetists. However, we hope that the increased awareness gained from this course will benefit trainees above and beyond the competencies defined in the CCT manual.

It is easy to attend a course, but it is another thing to practise what you have learnt, build upon it, and maintain the standards expected as future consultants, rather than to treat it as a tick box exercise for achieving the CCT. These competencies, professional skills and knowledge are important for trainees. Perhaps they appear to carry less importance than clinical competencies, but the value of training in medical ethics and law, for example, will become only too apparent when presented with a difficult case (typically on the first day as a consultant) that demands an immediate decision, and all eyes are on you – waiting for your words of wisdom.

Acknowledgement
I would like to acknowledge the role of Dr Sarah Muddle in the audit of training in medical ethics and law, and for her help in development of the Ethics and Law in Anaesthesia course. Also, thank you to Professor John Sear (Nuffield Department of Anaesthesia, Oxford) and Kim Beaumont (from the MPS) for their continued support and encouragement with the course.

References
As Wales celebrates a decade of devolution, it may become the first country in the UK to pioneer presumed consent for organ donation. Members of the RCoA’s Patient Liaison Group (PLG) heard earlier this year that Wales could press ahead with an opt-out system.

When the PLG met in March, it was informed that the controversial concept of presumed consent had been shelved in England, and that the current opt-in system will remain. However, the Chairman of the RCoA Advisory Board for Wales, Dr Hywel Jones, and lay member Viv Stoddart, told their PLG colleagues that presumed consent was still being debated in Wales.

Need for more donors
The momentum for change in Wales arose from a petition from Kidney Foundation Wales, which sought Welsh Assembly support for a campaign to increase awareness of the need for more donors. Kidney Foundation Wales specifically highlighted the issue of presumed consent when they presented their case.

The Assembly’s Health, Wellbeing and Local Government Committee (HWLGC) set up an inquiry, with a brief to look at presumed consent as a way of improving the number of donors. The Committee heard evidence and considered written submissions in Spring 2008, and produced their report the following July.

Welsh Health Minister favours presumed consent
Welsh Health Minister Edwina Hart had declared herself in favour of presumed consent, together with the Assembly’s First Minister, and the Chief Medical Officer for Wales. In January 2008, she said: ‘I have already made my views on organ donation clear and am already on the organ donation register along with my family. I do recognise, though, that this is a sensitive and emotive issue, and would need wide-ranging consultation.’

Can Wales go it alone?
The Health, Wellbeing and Local Government Committee considered a series of questions on the ‘Welsh perspective.’

Could presumed consent be introduced in Wales alone? Did the Assembly have the power to legislate such a change, independently of the UK Government?

The Committee concluded that, despite the complexities, there appeared to be...
attention was paid to the needs of Welsh-speaking families. The UK Transplant Co-ordinators Association said that the only literature that was produced in Welsh was the organ donor card.

Now, the registration form, posters and the UK Transplant website are also available bilingually, as is the Donate Wales Campaign website and literature. The consent form for organ donation is not yet available in Welsh, but translation is under way.

Following the HWLGC’s report published in July 2008, the Welsh Health Minister launched a series of grass roots, all-Wales debates on presumed consent. Public meetings were facilitated by Welsh community health councils, the last session being held in January this year. Additionally, there was an inter-faith meeting, written views were invited, and a telephone survey was conducted.

The outcome of the public debate was published in May 2009. It confirmed support for increasing organ donation numbers, and changing the consent system.

According to the conclusions published by the Assembly, there is ‘clearly a public preference for either an opt-out system, or for a mandated choice system’ with a preference for a soft, rather than a hard, opt-out system.

The Assembly is now inviting views on options for changes to the organ donation system in Wales.

Since anaesthetists play a key role in maintaining the donor’s organs prior to transplantation, this will be an opportunity for the specialty to contribute to the Welsh debate, should the College and the Advisory Board for Wales choose to do so. The consultation closes on 3 August.

no fundamental legal reason why the Assembly could not seek the power to legislate to introduce presumed consent. However, they were reluctant to take the step from ‘could’ to ‘should.’

There were also issues about ‘cross border’ situations. The Committee was concerned for the bereaved families of those who died whilst they were visiting or working in Wales. This also concerned the BMA, who voiced the need for safeguards in place to protect non-Welsh visitors who happened to die whilst on Welsh soil.

Devolution is about difference
However, despite its reservations about an opt-out scheme, the HWLGC did not feel that cross border differences should be the decisive issue, arguing that the whole point of devolution was that, where appropriate, different laws could apply in different parts of the UK, and that this should be welcomed.

Joyce Robins, Co-director of Patient Concern was supportive of devolved governments legislating on the controversial issue, saying: ‘We [Patient Concern] are not familiar with the legislative powers in Wales, but it seems reasonable that each country should make its own decision on such an emotive issue.’ She was robust, however, on her patient organisation’s view on presumed consent, adding: ‘We suspect that, after ministers in Wales have supported presumed consent so vigorously, it is probably a done deal. We hope this is not so, because Wales has a proud tradition of doing what is right for patients, e.g. free prescriptions, free parking… We consider that presumed consent is unethical and unjustifiable.’

The needs of Welsh speakers
The ‘Welsh perspective’ also includes the issue of bilingualism. Kidney Foundation Wales told the HWLGC of the Foundation’s concerns that insufficient
It has been rather heartening to note that many of you are using the College website to access information, be it on us as SAS anaesthetists, or for information on courses and meetings being held by the College. I would encourage you to tell us what you think, please, as the SAS pages are a work in progress, with modifications and adaptations being made as information changes and comes to us. A gentle reminder, however, dear readers, that as a Medical Royal College, we have no remit to get involved in contractual issues, something which I am sure, looming large in many of your working lives at present, with the new contract and the prospect of fewer trainees’ hours available for the ‘on-call’ commitments. Our colleagues at the Association of Anaesthetists of Great Britain and Ireland (AAGBI) Staff and Associate Specialist Committee, however, will be more than happy to help with contractual and employment issues that you may have.

Judging by the number of approved to teach certificates I have signed off, teaching is something in which many of you are interested and take part. Teaching and training are one of the remits of the College, and it may be of interest to you that the current stand on SAS anaesthetists as trainers is as follows. I have also included the codicils for those of you who work in foundation trusts or independent sector treatment centres.

Trainers in NHS foundation hospitals and the independent sector

NHS consultants and SASGs who have been recognised as trainers, as described above, carry their personal recognition when working outside their NHS base.

Consultants and SASGs appointed to posts in foundation trusts that do not use College representation for AACs, to independent sector treatment centres or to independent hospitals do not have automatic recognition as trainers. In such instances the College will offer recognition in a personal capacity.

<table>
<thead>
<tr>
<th>Foundation trusts.</th>
<th>In the case of foundation trusts when no College representation has been used during selection, the College delegates its authority to the local CT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISTCs.</td>
<td>In ISTCs, private hospitals or any other institution without a CT, the College delegates this authority to the local RA or Deputy.</td>
</tr>
<tr>
<td>Local education provider (LEP).</td>
<td>This encompasses all NHS trusts, health boards, the independent sector and any service provider that hosts and supports trainees.</td>
</tr>
<tr>
<td>Trainer.</td>
<td>This is an experienced practitioner who is involved in teaching, training and supervision in the workplace, particularly for trainee doctors.</td>
</tr>
</tbody>
</table>

The vast majority of us are going to be classified as a trainer; and having possession of the approved to teach certificate identifies us as a ‘local workplace trainer’ as defined by PMETB. There is going to be an added hurdle to pass, though, as PMETB has mandated that, from 16 January 2010, the currently desirable criteria of having successfully completed a Training the Trainers course is going to become mandatory. Don’t let this added hurdle put you off teaching, though. As doctors we do have much to offer to trainees, many of us having developed particular skills in anaesthesia that can be passed on to future generations.
Two new committees established by the Faculty Board have embarked upon substantial work programmes that deal with a broad range of subjects. The Training and Assessment Committee is chaired by Dr Kate Grady, and the Professional Standards Committee is chaired by Dr Karen Simpson. Assessment of advanced training and revalidation are high on the respective agendas.

Routes of entry to Fellowship
When the Faculty of Pain Medicine (FPMRCA) was established, Council of the Royal College of Anaesthetists emphasised that this was a Faculty of the RCoA and that full Fellowship of the Faculty was to be restricted to anaesthetists who were Fellows of the RCoA. This meant that established pain medicine specialists working in the UK who were not Fellows of the RCoA were ineligible to apply for full Fellowship of the FPMRCA. Many were Fellows of the Irish College of Anaesthetists and it transpired that they were eligible to apply for Fellowship of their own Irish College, or to apply for Associate Fellowship of the FPMRCA. Some have done the latter, and the Faculty Board has been delighted to welcome them.

Enquiries that have been received by the Faculty suggest that there is still some uncertainty with regard to current trainees in the UK who are Fellows of the Irish College (FCARCSI) and do not hold the FRCA, and who are undertaking advanced training in pain medicine. The situation for these trainees is summarised below

1. Award of FCARCSI does not lead to reciprocal award of FRCA (and vice versa).
2. Possession of FCARCSI plus satisfactory completion of the UK training programme leads to award of the CCT in the UK.
3. Possession of FCARCSI counts towards the CCT in the UK because, in the main, it substitutes for the final test of knowledge which is just one part of the whole UK CCT training programme (i.e. it exempts the holder from having to pass the Final FRCA). The reason for this concession is to allow trainees in Northern Ireland to choose whether they join the Irish or the UK College.
4. FCARCSI is not equivalent to an end of training exit qualification in the UK. It is the successful completion of the whole PMETB approved training programme that leads to the award of the CCT.
5. Holders of the FCARCSI who are registered with the RCoA can complete advanced pain training in the UK, be signed off for the relevant competencies and describe these achievements in their CV.
6. Holders of the FCARCSI can apply for Fellowship of their own Faculty of Pain Medicine within the Irish College. This is outside the jurisdiction of the FPMRCA.
7. A holder of FCARCSI who obtains a CCT in the UK and is appointed to a substantive NHS consultant post in the UK with a contracted clinical commitment in pain medicine can apply for Associate Fellowship of the FPMRCA.
8. A holder of FCARCSI who is appointed to a substantive non-consultant career grade post in the UK with a contracted clinical commitment in pain medicine can apply for Membership of the FPMRCA.
9. A holder of FCARCSI who is training in the UK and who also passes the Final FRCA would be eligible to apply for Fellowship by assessment of the FPMRCA after satisfactory completion of advanced training in pain medicine.
10. Conclusion: FCARCSI is not a direct route to FFPMRCA.

Educational events
A very successful and well attended study day for advanced pain trainees was held on 14 May 2009. Professor Clifford Woolf from Harvard Medical School will deliver the Patrick Wall Lecture at the First Annual Fellows Meeting on 16 November 2009. The full programme is on the website at: www.rcoa.ac.uk/index.asp?PageID=40&MeetingID=345
By the time this article reaches your desk, you will have at least heard of, if not already been involved in, implementing the World Health Organization (WHO) checklist to improve surgical safety. The checklist has been adapted by the National Patient Safety Agency (NPSA) for use in England and Wales, and was released on 15 January 2009 as a Patient Safety Alert.

Why this matters

Every year, more than eight million surgical procedures are performed in the UK. In the year 2007, 129,419 surgical incidents in England and Wales were reported to NPSA; over 1,000 resulted in severe harm and 271 resulted in the death of the patient. Recently, we have started using the term ‘Never Events’; these events can have catastrophic consequences and are generally preventable. Examples include wrong-side surgery, or intrathecal injection of medications that are intended for intravenous use. Global literature and anecdotes suggest that, in most circumstances, there was at least one member of staff who could have raised an alert, but felt too intimidated to ‘speak up’.

The checklist aims to bring the full operating team together at critical points during surgery and, encouraged by the results of the pilot study, it is envisaged that this will reduce the chances of ‘Never Events,’ and improve patient safety in its wider context.

WHO safer surgery checklist

The checklist (Figure 1) details three good practice stages:

1. Sign in: before the anaesthetic is administered.
2. Time out: immediately before the surgical incision is made.
3. Sign out: before the patient is removed from the operating theatre.

The checklist comes with a supporting document which details how each stage should be implemented. Since
the release of the NPSA alert, a number of initiatives have been introduced to guide managers and clinicians implementing the checklist in their trusts. The WHO states: ‘This checklist is not intended to be comprehensive. Additions and modifications to fit the local practice are encouraged.’

The key elements of the checklist, related to anaesthesia, will not come as a surprise to most practising anaesthetists because this information is routinely checked and recorded in everyday anaesthetic practice. The difference in the use of the checklist is that we ‘must’ now share this information with the rest of the team. In addition, the checklist will provide us with an opportunity to share with surgical and nursing colleagues the elements of their concerns for the patient as a matter of routine, and on a ‘must do’ basis. Bringing the team together, to share and own the responsibility for some critical elements of the surgical procedure, is the key feature of the checklist.

Learning from aviation and human factors
In 1935, after the crash of Boeing’s new aeroplane (299), with the most experienced test pilot in the cockpit, the press described: ‘too much aeroplane for one man to fly.’ Later it was realised that it was not ‘too much aeroplane for one man to fly’, rather it was simply ‘too complex for one man’s memory’. Consequently, four checklists were developed for the pilot and co-pilot, to make sure that nothing was forgotten.

Operating theatre activities are complex, and they require standardisation. Clinicians, though highly intelligent, are prone to human factors. It is well known that our short-term memory can store around seven facts at one time. The checklist is designed to support human memory with useful and simple tools.

Evidence that the checklist ‘works’
In January 2009, the New England Journal of Medicine published results from a year-long global study.4 The authors hypothesised that a programme to implement a 19-item checklist, designed to improve team communication and consistency of care, would reduce complications and deaths due to surgery. Over a 12-month period, eight hospitals in eight cities, representing a variety of economic circumstances and diverse patient populations, participated in the study. The most spectacular result of the study was a 40% reduction in the death rate after introduction of the checklist. The number of complications also decreased by more than a third. It was felt that the overall improvement in patient safety in these pilot sites exceeded that which could be expected from the bare elements of the checklist. The authors believe that this could be because the use of the checklist underpins certain behaviour, and enforces teamwork. This, in return, can have consequences on patient safety which would reach much further than the intended effects.

No doubt, more data will become available in the future. However, the facts of the pilot study are impressive and they speak for themselves. For a health service, that aspires to be consistently excellent, not to implement these findings as soon as possible could not have been an option. However, the overwhelming case that has been made for using the checklist should not be confused with the ease of its implementation.

Implementing the checklist
After a high profile national launch of the Safety Alert by the NPSA, and support and endorsements from all the relevant national bodies as well as the Department of Health, the huge task of implementation at local level remains to be achieved. The challenges are widely recognised – the main one being that the introduction of the checklist would demand a ‘cultural change’. The results of the pilot study clearly indicate that gaps in teamwork and safety practices are substantial in healthcare systems all over the world. Sophia Christie has articulated why, unlike the airline industry, the quality (and safety) movement in the NHS is not still embedded.5

‘Culturally, we continue to resist systematisation at a local level. We acknowledge the existence of variation, whether in incident definition and reporting, investigations, prescribing or performance management, but remain reluctant to acknowledge the link between differential approaches and variable outcomes for patients.’

However, as a specialty, anaesthesia is far ahead in embracing and embedding the culture of safety in its practice. No wonder the present checklist makes references to well recommended and established safety practices such as minimal monitoring standards, and the management of difficult airways, as per AAGBI and Difficult Airway Society (DAS) guidelines. In keeping up with the tradition of promoting safety, it will not be surprising if many anaesthetists lead the implementation of the checklist at local, regional and national levels.

It is well acknowledged that implementation of the checklist will require strong and visible leadership.

However, a specialty, anaesthesia is far ahead in embracing and embedding the culture of safety in its practice. No wonder the present checklist makes references to well recommended and established safety practices such as minimal monitoring standards, and the management of difficult airways, as per AAGBI and Difficult Airway Society (DAS) guidelines. In keeping up with the tradition of promoting safety, it will not be surprising if many anaesthetists lead the implementation of the checklist at local, regional and national levels.

It is well acknowledged that implementation of the checklist will require strong and visible leadership. There will be issues around motivating people and educating in the correct use of the checklist. Mechanisms will be needed to monitor how effectively the
checklist is being used. Most crucially, demonstration of its effect on patient safety at local and national level will be the main motivating factor. Dr Alex Haynes, who led the pilot study, states: 

‘Even many clinicians who were initially sceptical of the idea became advocates once they saw the benefits to safety and consistency of care.’

We believe that implementation of the checklist, in addition to providing an opportunity to make a real difference to patient outcome, will also provide a huge opportunity for the anaesthetists to take a lead role in managing its implementation, auditing its effectiveness and researching the impacts it may have on human factors, team working and patient outcome.

In conclusion

‘The beauty of the surgical safety checklist is its simplicity and – as a practising surgeon – I would urge surgical teams across the country to use it. Operating theatres are high-risk environments. By using the checklist for every operation we are improving team communication, saving lives and helping ensure the highest standard of care for our patients. The amazing results from the pilot put this beyond any doubt.’

Health Minister Lord Darzi

References
5. www.hsj.co.uk/sophia-christie.
ICU on the move
Retrieval medicine in Australia

Dr H Reschreiter,
Specialist Registrar (SpR 5) in Anaesthesia and Intensive Care Medicine,
Oxford Radcliffe NHS Trust

The sheer distances and remoteness of Australia make the support and transfer of patients paramount in delivering a good standard of healthcare. What we in Europe take for granted – CT and MRI scanners, access to specialist services, even routine blood testing – is not readily available in large areas of Australia.

Dream job
It was the dream of the Reverend John Flynn to establish a crucial link to the outback. Set up in 1928, the Royal Flying Doctor Service (RFDS) paved the way for the concept of aero medical retrieval medicine, which is well established in Australia today.

As an advanced trainee in intensive care medicine, I jumped at the chance to further my pre-hospital experience by working for Mediflight™, a critical care retrieval service based at the Royal Adelaide Hospital. The main purpose of the service is to attend primary roadside scenes, retrieve critically ill patients from rural areas, and occasionally undertake inter-hospital transfers in the metropolitan area.

The mode of transfer is determined by the location and the specific circumstances of the patient, the destination, and the availability of assets. We used road ambulances, helicopters, or fixed-wing aircraft borrowed from the RFDS. Furthermore, we provided rural hospitals with the possibility of consults and advice, even via telemedicine in selected places.

Referrals are made by ambulance control, local hospital doctors, GPs or other healthcare workers. As always, obtaining a detailed history is paramount. However, frequently this proved to be a significant challenge due to language barrier, remoteness, or the availability of only second- or third-hand information. Sometimes misconception resulted in very surprising situations once one eye-balled the patient; for example, the meaning and values of the Glasgow Coma Scale – talking and walking patients with a reported GCS of 3! Frequently, even establishing the number of patients at the scene was incorrect. Combining sometimes scanty information with the necessity to bring everything you might need with you, without access to specialised drugs or equipment if required, was an interesting challenge at times. It had resulted in the creation of a number of different, yet comprehensive, pre-made bags of kit – we rapidly became very familiar with the content of these.

The obtained information would then be discussed with the aero medical consultant on-call (usually either an ICU or A+E consultant with a dedicated on-call commitment) to agree a plan for the subsequent management of the patient, with a decision to retrieve if necessary.

The core retrieval team consists of a doctor and a nurse, with an additional paramedic for primary roadside attendances, and an RFDS nurse when using their aircraft. All nurses are
...yes, you truly are alone, 
...no-one is going to come and, 
if you forgot the satellite 
phone, you sometimes can’t even 
call for help...

immobilisation for what appeared to be 
a broken pelvis and femur, we returned 
the way we had come – padded with as 
much soft clothing and sleeping bags 
on a pick-up truck, trying to find the plane again…

The return flight would see another first 
for me; the pilot needed a few extra 
hands in refuelling the plane, and my 
lack of any knowledge or training in 
refuelling planes meant very little. The 
job had to be done! We finally returned 
home 13 hours later. Of course, 
everyone was tired and my dinner was 
cold, but there was no place I would 
have rather been that night.

I did not have to wait long for a further 
example of how the vast size of this 
country matters. Many a registrar 
has bailed out a junior colleague. In the UK 
that colleague is, at least, in the same 
hospital. In a rural hospital located 
60km away, a nurse and volunteer 
paramedic were struggling with a failed 
intubation, with no doctor available. 
This scenario added a new dimension 
to the failed-intubation-drill that we all 
know by heart. Neither were thrilled 
by the concept of cutting someone’s 
throat with instructions via a telephone 
(there was no LMA available at that rural 
hospital) but, thankfully, the patient had 
just enough returning respiratory effort 
with a reasonably patent airway, to allow 
us to scramble a helicopter and attend 
the patient ourselves.

---

A typical transfer from a plane of the Royal Flying Doctor Service (RFDS) to a road ambulance on a landing strip in the middle of nowhere
Lessons learnt

It certainly was a unique experience. It was a very different kind of medicine, one I would not want to miss. I can only strongly recommend this kind of work to anyone seeking a personal challenge or anyone who wants to work outside their comfort zone for a while.

New techniques learnt and the great experiences made make me feel now much better prepared for challenging situations in these more unfamiliar out-of-hospital situations. Particularly, ketamine has a special place in my heart now.

On day one in anaesthesia, we were taught that (1) you are never alone, (2) calling for help is essential, and (3) in trouble, you give 100% oxygen. In the outback this translates into: (1) yes, you truly are alone, (2) no-one is going to come and, if you forgot the satellite phone, you sometimes can’t even call for help, and (3) then you might not have enough…

Further reading

The 2009 AAGBI guideline
www.aagbi.org/publications/guidelines/docs/interhospital09.pdf

Guideline of the UK Intensive Care Society

A survey in 2008 in the Wessex region highlighting problems in the UK transfer training
http://journal.ics.ac.uk/pdf/0902145.pdf


Comparison to the UK

The difference compared with the ad hoc performed transfers in the UK was immense. All too often junior medical staff, with little or no formal training and little transfer experience, are taken from the ‘shop-floor’ to perform a transfer. Equipment used for transfer is often not rigorously checked and maintained, and is not necessarily standardised. In contrast, the daily meticulous checking of the transfer kit was part of the morning routine in Mediflight™. Weekly audit meetings would address any significant events, and a review of the last week’s missions would serve as a basis for teaching and reflection.

As a result, I cannot remember a single instance where a monitor or pump battery died mid-mission, or where crucial pieces of equipment were not functional or missing – such problems in UK transfers occurring frequently enough for many doctors to have tales to tell.

With a streamlined process of reliable communication to an emergency department, trauma and surgical staff – as well as a relationship between all parties that comes only from frequent co-operation, good knowledge of protocols and familiarity with equipment – crucial time could be saved especially in trauma situations, leading to better outcomes.

It is not surprising that the AAGBI has just published recommendations addressing these issues in February of this year. Given the likely increase in overall number of transfers in the UK, and the substantial potential for harm if executed in a sub-standard way, the drive for a dedicated transfer service for adults is logical – echoing that which already exists for paediatric patients.
**SEPTEMBER**

- 21 September 2009 (code: B63)  
  **NIAA DMA&CC ACADEMIA AND ARMED CONFLICT**  
  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: £200  
  (£150 for registered Trainees)

- 22–23 September 2009 (code: A37)  
  **ANAESTHETISTS AS EDUCATORS – DELIVERING IN THE WORKPLACE**  
  **Limited availability**  
  Royal College of Anaesthetists, London  
  Registration fee: £385  
  (£290 for registered Trainees)

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

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

**OCTOBER**

- 5 October 2009 (code: C40)  
  **AIRWAY WORKSHOP – GLASGOW**  
  **Limited availability**  
  University of Glasgow  
  Registration fee: £240  
  (£180 for registered Trainees)

- 7 October 2009 (code: C97)  
  **CORE TOPICS DAY – BELFAST**  
  Waterfront Hall, Belfast  
  Registration fee: £160  
  (£120 for registered Trainees)

- 14 October 2009 (code: D09)  
  **ULTRASOUND WORKSHOP**  
  **Limited availability**  
  Royal College of Anaesthetists, London  
  Registration fee: £220  
  (£165 for registered Trainees)

- 27 October 2009 (code: C79)  
  **CORE TOPICS DAY**  
  Royal College of Anaesthetists, London  
  Registration fee: £200  
  (£150 for registered Trainees)

- 28 October 2009 (code: A69)  
  **NATIONAL ACCS DAY**  
  Royal College of Anaesthetists, London  
  Registration fee: £75  
  (£50 for applications received by 31 August 2009)

**NOVEMBER**

- 3 November 2009 (code: C49)  
  **A CAREER IN ANAESTHESIA**  
  Royal College of Anaesthetists, London  
  Registration fee: £25

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

- 7 November 2009 (code: A76)  
  **CME DAY**  
  A joint meeting with the AAGBI  
  Royal College of Anaesthetists, London  
  Registration fee: £220  
  (£165 for registered Trainees)

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

- 13 November 2009 (code: A12)  
  **ANAESTHETISTS AS EDUCATORS – AN INTRODUCTION**  
  Royal College of Anaesthetists, London  
  Registration fee: £200  
  (£150 for registered Trainees)

- 16 November 2009 (code: B08)  
  **FIRST ANNUAL MEETING OF THE FACULTY OF PAIN MEDICINE**  
  For Fellows and Members of the FPM  
  Royal College of Anaesthetists, London  
  Registration fee: £150

---

**New Event Ideas**

Would you like to organise an event with the RCoA? If so, please visit our website and click on the new event ideas link on the Meetings and Events page to complete a proposal form.
Events Programme 2009

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

30 Nov – 1 Dec 2009 (code: C80)
ANAESTHETISTS AS EDUCATORS – DELIVERING IN THE WORKPLACE
Limited availability
Royal College of Anaesthetists, London
Registration fee: £385
(£290 for registered Trainees)

2010
FEBRUARY
1–3 February 2010 (code: C68)
CURRENT TOPICS MEETING
Royal College of Anaesthetists, London
Registration fee: £450

3 February 2010 (code: B53)
AIRWAY WORKSHOP
Limited availability
Royal College of Anaesthetists, London
Registration fee: £240
(£180 for registered Trainees)

15–26 February 2010 (code: A82)
FINAL FRCA COURSE
Royal College of Anaesthetists, London
Registration fee: £650

ADVANCED AIRWAY WORKSHOP
Registration fee: £230
Approved for 5 CPD points

LIMITED AVAILABILITY
PLEASE NOTE THAT THIS IS AN ANNUAL EVENT ONLY
The Advanced Airway Workshop is an opportunity for senior trainees and Consultants to cover areas of airway management in more depth than the standard Airway Workshop. Teaching is from experienced consultants and takes place in small groups. The emphasis for this workshop is on hands-on practice and group discussion. Topics covered include:
- Fibreoptic intubation handling skills and use of airway catheters
- Jet ventilation
- Video laryngoscopy
- New supraglottic devices
- Case scenario discussion

WORKSHOP ORGANISER: DR R BHAGRATH

MARCH
17–18 March 2010 (code: A03)
ANNIVERSARY MEETING – HUMAN FACTORS IN ANAESTHESIA AND CRITICAL CARE
Royal Institute of British Architects, London
Registration fee: £410
(£310 for registered Trainees)

FACULTY OF PAIN MEDICINE – FIRST ANNUAL MEETING
16 November 2009 (code: B08)
The Royal College of Anaesthetists, London
Registration fee: £150
Approved for 5 CPD points

APPLICATIONS TO BE RECEIVED BY FELLOWS, ASSOCIATE FELLOWS AND MEMBERS OF THE FACULTY ONLY

- What are the prospects for acute pain services?
  Dr D Counsell, Wrexham
- Pain and gender: is there really a difference?
  Dr S Derbyshire, Birmingham
- Getting patients back to work: Are we making progress?
  Speaker to be advised
- Faculty of Pain Medicine Patrick Wall Lecture
  From local anaesthesia to local analgesia – developing pain-specific blockers
  Professor C Woolf, Neuropasticity Research Group, Harvard Medical School, USA
- Guidelines in pain management: are they fit for purpose?
  Professor H McQuay, Oxford
- World class commissioning: what does this mean for pain services?
  Speaker to be confirmed
- Faculty of Pain Medicine: where are we now?
  Professional Standards Committee, Dr K Simpson, Chair
  Training and examinations, Dr K McGrady, Chair
  The future, Dr D Justins, Dean

MEETING ORGANISER: PROFESSOR D J ROWBOTHAM
CME Day
7 November 2009 (code: A76)
The Royal College of Anaesthetists, London

Registration fee: £220 (£165 for registered Trainees)
Approved for 5 CPD points

A joint meeting with the Association of Anaesthetists of Great Britain and Ireland

CME Day will comprise of 18 lectures, allowing participants to choose a total of six different lectures to attend.

**Session 1**

**a** Perioperative dysrhythmias and implantable devices
Speaker to be advised

**b** What makes patients different – generic variability of anaesthesia
Professor P Hopkins, Leeds

**c** Improving outcome in elective abdominal surgery
Speaker to be advised

**Session 2**

**a** Anaesthesia for fractured neck of femur
Dr M Cox, London

**b** Paediatric emergencies for non-paediatric anaesthetists
Dr M Tremlett, Middlesbrough

**c** What is difficult in the airway?
Dr A Pearce, London

**Session 3**

**a** Neuromuscular blockade and reversal
Professor R Mirakhur, Belfast

**b** Managing admission and discharge to ICU
Dr C Waldmann, Reading

**c** Obstetric anaesthesia for the non-obstetric anaesthetist
Dr T Meek, Middlesbrough

**Session 4**

**a** Safe and effective peripheral anaesthesia
Dr J Picard, London

**b** Effective communication with patients
Speaker to be advised

**c** Anaesthesia for the aged
Professor C Dodds, Middlesbrough

**Session 5**

**a** Managing eclampsia and pre-eclampsia
Dr M Dresner, Leeds

**b** Basic and current concepts in fluid therapy
Professor M Bellamy, Leeds

**c** Anaesthesia for maxillofacial trauma and sepsis
Dr J Curran, East Grinstead

**Session 6**

**a** Needle stick injuries
Dr A Hartle, London

**b** Avoiding medico-legal problems in obstetrics
Dr F Plaat, London

**c** Dilemmas in managing the elderly undergoing orthopaedic surgery
Dr R Griffiths, Peterborough

Meeting Organiser: Professor C Kumar

Please note that the programme is subject to change.

---

NATIONAL ACCS DAY 2009
28 October 2009 (code: A69)
The Royal College of Anaesthetists, London

Registration fee: £75
(£50 for applications received by 31 August 2009)
Approved for 5 CPD points

The Intercollegiate Committee for Acute Care Common Stem Training (ICACCST) will be holding a national ACCS day at the Royal College of Anaesthetists. The day is aimed at current ACCS trainees and trainers and Foundation Year trainees who are considering applying for ACCS.

The day will include panel discussion of different clinical scenarios within the emergency department, medical ward and intensive care unit. Non-clinical topics such as team work, communication and leadership will also be discussed.

For further information, please email accs@rcoa.ac.uk

---

COMING SOON!
RISK MANAGEMENT – SERIOUS ADVERSE EVENTS

Registration fee to be advised
Check website for further details

The day aims to explore the generation and prevention of serious adverse events and will include a case study, followed by rotational workshops on:

- Negligence and the law
- Root cause analysis of adverse events
- Use of human factors training to reduce the risk

WWW.RCOA.AC.UK/EVENTS
## CURRENT CONCEPTS SYMPOSIUM: ANAESTHESIA AND CRITICAL CARE 2009

5–6 November 2009 (code: B05)
The Royal College of Anaesthetists, London

Registration fee: £410 (£310 for registered trainees)
Approved for 10 CPD points

### DAY 1

#### SESSION 1
PREOPERATIVE ASSESSMENT IN THE 21ST CENTURY
- Current preoperative assessment – what and when
  Speaker to be advised
- Which examinations and tests
  Dr M Swart, Torbay
- Informing patients; risks and complications of anaesthesia
  Dr L White, Southampton

#### SESSION 2
WHY, WHEN AND HOW TO OPTIMISE PATIENTS
- Is preoptimisation of patients undergoing major surgery justified?
  Professor M Mythen, London
- Can you optimise the multi-trauma patient with a head injury?
  Dr P Oakley, Stoke-on-Trent

#### SESSION 3
NEWER CONCEPTS AND DRUGS
- Hunting for hypnotics
  Professor R Sneyd, Plymouth
- Miniaturisation: the final frontier
  Professor J Hall, Wales
- Substance abuse, risk and anaesthesia
  Dr I Moppett, Nottingham

#### SESSION 4
PATIENT SAFETY – MOVING FORWARDS
- National reporting and learning centre – safer surgery
  Professor R Mahajan, Nottingham
- Recent innovations in medical technology
  Dr T Clutton-Brock, Birmingham

### DAY 2

#### SESSION 5
ENVIRONMENT AND ANAESTHESIA
- Climate change and health
  Dr F Godlee, London
- Anaesthesia's part in the problem
  Dr A McGlennan, London
- Combatting climate change due to anaesthesia/energy reduction in anaesthesia
  Mr D Pencheon, Cambridge

#### SESSION 6
RESEARCH AND INNOVATIONS
- The role of the NIAA – research is not just for the ‘boffins’
  Professor D J Rowbotham, Leicester
- Systematic review – bees knees or dogs dinner
  Dr D Bogod, Nottingham

#### SESSION 7
CHANGING GOALS IN CRITICAL CARE
- Surviving sepsis – how should the sceptic treat the sepsis?
  Professor M Singer, London
- Controversy in outreach
  Professor J Bion, Birmingham
- Whose body is it?
  Dr P Murphy, Leeds

#### SESSION 8
PEDIATRIC ANAESTHESIA
- Managing acute pain in children
  Dr G Bell, Glasgow
- Airway management in children
  Dr R Walker, Manchester

**Please note that the programme is subject to change**

---

## ULTRASOUND WORKSHOP

14 October 2009 (code: D09)
The Royal College of Anaesthetists, London

Registration fee: £220 (£165 for registered trainees)
Approved for 5 CPD points

**LIMITED AVAILABILITY**
With a focus on clinical scenarios, 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.

**WORKSHOP ORGANISER:**
Dr A Gaur

---

## A CAREER IN ANAESTHESIA

3 November 2009 (code: C49)
The Royal College of Anaesthetists, London

Registration fee: £25
Approved for 2 CPD points

The Royal College of Anaesthetists is holding two informal sessions for Foundation Year two Trainees who are considering a career in anaesthesia. The day is not intended to provide personal career guidance, but instead will focus on the general aspects of the specialty. Trainees are invited to the College to attend either a morning (10.00 am–12.30 pm) or afternoon session (2.00 pm– 4.30 pm).

The day will provide an insight into life as a trainee and consultant anaesthetist. There will also be plenty of time for questions.
## FINAL FRCA COURSE

20–31 July 2009 (code: A79)
15–26 February 2010 (code: A82)
The Royal College of Anaesthetists, London

**Registration fee:** £650  
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 course, which run from 4.30 pm to 6.00 pm.

The programme covers various subjects and will include topics such as:
- Applied pharmacology in anaesthesia
- Management of trauma
- Respiratory failure and ventilatory support
- Paediatric anaesthesia
- Thoracic anaesthesia

**Course organiser:** Dr J Cashman

## CORE TOPICS DAY

7 October 2009 (code: C97)  
Waterfront Hall, Belfast

**Registration fee:** £160 (£120 for registered Trainees)  
Approved for 5 CPD points

**A JOINT MEETING WITH THE COLLEGE OF ANAESTHETISTS OF IRELAND**

**Chair:** Dr J Johnston, Belfast  
- Human factors in patient safety  
  Professor R Mahajan, Nottingham
- Transfer of the critically ill adult – principles and practicalities  
  Dr G Lavery, Belfast

**Chair:** Dr J Tracey, Dublin  
- Chest radiology – perils and pitfalls  
  Dr B Kelly, Belfast

**College of Anaesthetists of Ireland Autumn College Lecture**

- Pulmonary function  
  Professor B Madden, London

**Chair:** Professor J P H Fee, Belfast

- Mechanisms of anaesthesia  
  Professor N Franks, London
- Patient awareness  
  Dr I Russell, Hull
- Climate change  
  Professor H Montgomery, London
- Close of meeting  
  President, College of Anaesthetists of Ireland

**Meeting organiser:** Professor J P H Fee

## UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE

24–25 September 2009 (code: D29)  
The Royal College of Anaesthetists, London

**Registration fee:** £380  
Approved for 10 CPD points

**LIMITED AVAILABILITY.**

The UK TEAM Course is a two day simulator-based course designed to teach the foundation of the knowledge, skills and attitudes required to safely manage the airway in an emergency situation outside the operating theatre. This applies principally to the Emergency Department, but also to inpatient wards, radiology and pre-hospital care.

The course is taught by an experienced faculty using small groups and high fidelity patient simulators. It is aimed at doctors three to four years after qualification who have six to 12 months experience in anaesthesia and intensive care (typically those completing an ‘acute care common stem’ programme), and who are intending to pursue a career in anaesthesia, critical care, emergency medicine or acute medicine.

**Course organiser:** Professor J Benger
The concept of the Core Topics Day is based on the need for a list of topics that would be sufficient to ensure a core knowledge base for all qualified anaesthetists. The knowledge contained within the core topics programme would allow any anaesthetist to manage a typical range of clinical situations that could be encountered undertaking emergency cover for a hospital. Evidence of completion of core topics will also be a requirement for revalidation.

CoRE ToPICs dAy
27 October 2009 (code: C79)
The Royal College of Anaesthetists, London
Registration fee: £200 (£150 for registered Trainees)
Approved for 5 CPD points

The concept of the Core Topics Day is based on the need for a list of topics that would be sufficient to ensure a core knowledge base for all qualified anaesthetists.

The knowledge contained within the core topics programme would allow any anaesthetist to manage a typical range of clinical situations that could be encountered undertaking emergency cover for a hospital.

Evidence of completion of core topics will also be a requirement for revalidation.

ANAESTHETISTS AS EDUCATORS – AN INTRODUCTION
 FORMERLY KNOWN AS AN INTRODUCTION TO TEACHING
13 November 2009 (code: A12)
The Royal College of Anaesthetists, London
Registration fee: £200 (£150 for registered Trainees)
Approved for 5 CPD points

'Anaesthetists as Educators – An introduction' provides an introduction to post graduate medical education in anaesthesia. The course replaces an ‘Introduction to Teaching’ and is suitable for trainees and consultants who have had no previous training in teaching or medical education. The course will provide:

- An overview of the educational landscape as it is today: regulatory bodies and the relationship between them, governance of medical education, where anaesthetists delivering training fit in
- An introduction to how adults learn
- How to teach: in theatre and giving lectures
- An introduction to clinical and educational supervision from the trainees point of view, including appraisal
- Overview of assessment in anaesthesia, including workplace based assessment and where it fits in
- Principles of recognition and dealing with the trainee with problems.

This course provides the ground work for the ‘Anaesthetists as Educators – Delivering in the Workplace’ course, which is a natural follow on.

Course organisers: Dr A Cooper and Dr S Edgar

NATIONAL INSTITUTE OF ACADEMIC ANAESTHESIA AND THE DEPARTMENT OF MILITARY ANAESTHESIA AND CRITICAL CARE
ACADEMIA AND ARMED CONFLICT
21 September 2009 (code: B63)
The Royal College of Anaesthetists, London
Registration fee: £150
Approved for 5 CPD points

This is a joint meeting organised by the National Institute of Academic Anaesthesia (NIAA) and the Department of Military Anaesthesia and Critical Care (DMA&CC). Please note the change of title from: 'Military Showcase' to 'Academia and Armed Conflict'.

Armed conflict continues to provide the stimulus responsible for the advances made in combat casualty care, which is delivered by the Defence Medical Services (DMS). The aim of this showcase event is to provide an understanding of the key projects that are likely to influence both current and future treatment protocols and improve casualty survival. The presentations are appropriate for academics, clinicians and scientists from a Military or civilian background and topics include: Sepsis, Analgesia, Coagulation, Acute lung injury and Simulation.

- Combat casualty data capture
  Lt Col R Russell
- Combat casualty care research - overview
  Dr E Kirkman
- Sepsis study
  Dr R Lukaszewski
- Analgesia study
  Dr S Watts
- Coagulation study
  Lt Col T Woolley
- DMS simulation training
  Professor R Stone
- The role of damage control Surgery in damage control resuscitation
  Surg Capt M Midwinter
- Abstract presentations – Research in progress
  Wg Cdr S Turner
- Acute lung injury
  Dr B Jugg
- Resuscitation after blast injury and haemorrhage
  Sqn Ldr N Jacobs
- Researching opportunities for military/civilian co-operation and closing address
  Professor D J Rowbotham and Col P Mahoney

Course organisers: Wg Cdr S Turner and Professor D Rowbotham

CORE TOPICS DAY
27 October 2009 (code: C79)
The Royal College of Anaesthetists, London
Registration fee: £200 (£150 for registered Trainees)
Approved for 5 CPD points

The concept of the Core Topics Day is based on the need for a list of topics that would be sufficient to ensure a core knowledge base for all qualified anaesthetists.

The knowledge contained within the core topics programme would allow any anaesthetist to manage a typical range of clinical situations that could be encountered undertaking emergency cover for a hospital.

Evidence of completion of core topics will also be a requirement for revalidation.
### Events Programme 2009

#### Airway Workshops
- **5 October 2009, Glasgow (code: C40)**
- **19 November 2009, London (code: C65)**
- **3 February 2010, London (code: B53)**
- **3 March 2010, Cardiff (code: C96)**
- **14 April 2010, London (code: C12)**

**Registration fee:** £240 (£180 for registered Trainees)
Approved for 5 CPD points

**Limited Availability.**

**Previous Workshops Have Proved To Be Very Popular – Early Booking Is Advised.**

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 in London, Cardiff, Edinburgh and Glasgow.

**Workshop Organisers:** Dr R Bhagrath, Dr T Turley, Dr T Ireland and Dr A McNarry

#### Core Topic Meeting – Fluid Management

- **22 September 2009 (code: C63)**
The Royal College of Anaesthetists, London

**Registration fee:** £200 (£150 for registered Trainees)
Approved for 5 CPD points

**Topics Include:**
- Blood transfusion
- Bad blood research: overview of literature on stored RBC
- Platelets FFP and other sticky agents: when and why
- Fast track surgery
- Bariatric surgery
- Modern management of renal failure
- Which Anions matter
- Fluids and inotropes

#### Anaesthetists as Educators – Delivering in the Workplace

**Formerly Known as Teaching Methods Workshop**
- **22–23 September 2009 (code: A37)**
- **30 November – 1 December 2009 (code: C80)**
The Royal College of Anaesthetists, London

**Registration fee:** £385 (£290 for registered Trainees)
Approved for 10 CPD points

**Limited Availability**

A follow on course for those who have participated in ‘Anaesthetists as Educators – An Introduction’, or for those who already have some experience of medical education in the roles of teaching, assessment, educational supervision and dealing with the trainee in difficulty. It is aimed at promoting a commitment to good educational practice.

This course is aimed at career grade anaesthetists (but trainees with a special interest are also welcome). It looks at their roles in the education and assessment of trainee anaesthetists, and raises awareness of some of the key concepts associated with education. Topics to be covered are:

- Teaching styles (including small group teaching)
- How to identify learning needs and learning opportunities in the clinical workplace
- Supervision
- Importance of non-technical skills in effective professional practice
- Work placed based assessment and feedback features
- How appraisal fits into revalidation
- The place of audiovisual aids
- Videobox session with an actor to talk about your presentation skills

The course will give learners the knowledge and skills that they can apply to their own teaching and assessment.
**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:** [Enter name]  
- **Please use BLOCK CAPITALS.**

- **College Reference Number (CRN):** [Enter CRN]  
- **GMC Number:** [Enter GMC number]

- **Address:** [Enter address]

- **Postcode:** [Enter postcode]

- **Please ensure you complete your full postal address.**

- **Telephone:** [Enter telephone number]

- **Email:** [Enter email]

- **This address is (tick one only):**  
  - Temporary
  - Permanent

- **Date of Birth:** [DD MM YYYY]

- **Present appointment and hospital:** [Enter details]

### Event details

- **(members of the Senior Fellows Club can attend meetings at half price)**

- **Date:** [DD MM YYYY]  
  - **Code:** [Enter code]

- **Event Title:** [Enter title]

- **Registration fee:** £ [Enter fee]

- **How did you hear about this event?** [Enter method]

### 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):** [Card type]  
  - [ ] Visa
  - [ ] American Express
  - [ ] MasterCard
  - [ ] Access

- **Cardholder’s name:** [Enter name]

- **Signature:** [Sign]

- **Please use BLOCK CAPITALS.**

- **Card number:** [Enter card number]

- **Valid from:** [Enter valid from date]

- **Expiry Date:** [Enter expiry date]

- **Issue number (if applicable):** [Enter issue number]

- **Security Code:** [Enter security code]
A year at the Institute for Healthcare Improvement

Dr C J Peden, Consultant in Anaesthesia and Intensive Care, Royal United Hospital, Bath

The growing patient safety movement in the UK, of which the Royal College of Anaesthetists is a leading supporter, has a transatlantic ally, the Institute for Healthcare Improvement (IHI) in Boston. In this article I will explain IHI’s global role in the drive for better quality and safety in patient care, explain how IHI is involved in current British programmes and policy, and comment on my year’s experience at IHI in Boston as a Health Foundation Quality Improvement Fellow.

The Health Foundation Quality Improvement Fellowships
I first became aware of this Fellowship programme, which began in 2004, when I saw it advertised on the RCoA website. The Health Foundation is an independent charity working to improve the quality of care across the UK and beyond, which has a number of leadership and fellowship programmes. The opportunity appeared very exciting; a year based in Boston at the Institute for Healthcare Improvement learning about quality and improvement in healthcare, including seven weeks on the Clinical Effectiveness course at Harvard School of Public Health. I had reached a point in my career where I wanted to work more broadly to influence change in healthcare. As an Intensive Care Consultant I see (as do we all) patients who have passed through a flawed system where there have been many opportunities for care to have been performed better.

As well as caring for those individual patients in a highly focused way, as occurs in ICU, I wanted to learn more about how to effect change and improvement in the upstream processes that lead our patients to ICU. In addition, my experience as Chair of the Hospital Drug and Therapeutics Committee for a number of years had led me to look at the way drug policy is evaluated for a whole community, not just the hospital, and the decision-making processes involved in high-cost drug applications. With these thoughts as drivers, I applied in October 2007 for the Fellowship, and after a long application and interview process was very fortunate to be accepted as one of the 2008–2009 Fellows.

The Institute for Healthcare Improvement, Cambridge, Massachusetts
IHI is an independent not-for-profit organisation, formed in 1991 when a group of committed individuals came together with the idea of improving the flawed healthcare system they found in the US. The IHI has now grown into an organisation with international influence which has the aim of leading healthcare
improvement throughout the world by building the will for change, cultivating promising concepts for improving patient care, and helping healthcare systems put those ideas into action. It achieves this through a philosophy of collaboration and ‘all teach, all learn’ with three key areas of development: innovation, strategic relationships, and learning opportunities. IHI Fellows become deeply integrated into the day-to-day workings of the organisation and participate in the three key areas noted above.

One of the values IHI promotes is transparency, and that is very evident whilst working there. The offices are designed so that no-one is hidden. The Chief Executive and President of IHI, the inspirational Don Berwick, shares a glass office with the visiting Fellows. Around the walls are painted quotes such as ‘What can you do by next Tuesday?’, ‘Hope is not a plan’, and ‘Some is not a number. Soon is not a time’ – key philosophies of IHI’s action-centred approach. The pillars of the main corridor carry the six aims of the Institute of Medicine’s (IOM) report, Crossing the Quality Chasm:¹ care that is safe, efficient, patient centered, timely, effective and equitable. While at IHI, Fellows have a structured learning programme which includes weekly seminars with leading healthcare experts; I have been privileged to spend time with individuals such as Lucian Leape, the father of the patient safety movement, and David Blumenthal, Harvard Medical Professor and the Obama Administration’s new National Co-ordinator for Health Information Technology.

Harm and IHI’s campaigns

Working in the US, learning about the US healthcare system and, indeed, experiencing US healthcare have given me a fresh, positive perspective on the NHS. Anyone seeking inspiration for the ideals of the NHS should read the speech Don Berwick gave at the 60th Anniversary celebrations of the NHS.² The US is currently on track to spend 18–19% of GDP on healthcare to achieve the worst outcomes in the western world (see Figure 1).³–⁷ The IOM estimated that as many as 98,000 people die each year in US hospitals due to medical injuries⁸ and the Centers for Disease Control and Prevention estimate that two million patients suffer hospital-acquired infections each year.⁹ These problems are not unique to the US and, as the Commonwealth Fund¹⁰ rankings show, the UK could do better. However, at least we have a system that can be changed, unlike the multiple fragmented providers that exist in the US.

We need not just to be clever doctors and know what drug is best for a particular condition; we need to understand how that drug will be given to the patient safely, effectively, and in a timely fashion.

With awareness of US healthcare problems at its core, IHI launched the 100,000 Lives Campaign¹¹ in January 2005 which ran for 18 months. This campaign aimed to introduce proven best practices across the US to help participating hospitals extend or save as many as 100,000 lives. The following practices were implemented in participating hospitals

1. Deploy Rapid Response Teams…at the first sign of patient decline.
2. Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction…to prevent deaths from heart attack.
3. Prevent Adverse Drug Events (ADEs)…by implementing medication reconciliation.

4. Prevent Central Line Infections…by implementing a series of interdependent, scientifically grounded steps called the ‘Central Line Bundle.’
5. Prevent Surgical Site Infections…by reliably delivering the correct peri-operative antibiotics at the proper time.
6. Prevent Ventilator-Associated Pneumonia…by implementing a series of interdependent, scientifically grounded steps including the ‘Ventilator Bundle.’

The key statement that follows the adoption of these practices is ‘when reliably implemented, these interventions should greatly reduce morbidity and mortality.’ One of the main learning points of my year has been that we are not very good at translational science in medicine (although anaesthetists are probably a notable exception here). Consider the huge amount of research that goes into the development of new medical knowledge, and then consider how good we are at ensuring that new knowledge is reliably delivered to our patients (Table 1). Reliability here means at least 95% of the time. Most hospital systems work at 50–80% reliability.¹²

The 100,000 Lives Campaign was followed in 2006 by a two-year campaign called the Five Million Lives Campaign. This was designed to prevent five million episodes of patient harm; as a measure of IHI’s influence in the US, this campaign was adopted by over 4,000 (more than 90%) of US hospitals, from the major academic teaching centres to small rural clinics. These campaigns have given IHI a tremendous knowledge of how to spread information and change concepts in healthcare – a tactic which is now being used to promote adoption of the WHO surgical safety checklist.”¹³
Strategic partnerships
Although many of you reading this will not have heard of IHI, you do know its work. IHI has a Strategic Partnership with the Health Foundation in London, through which it provided advice and support to help develop the Patient Safety First Programme. IHI also provided technical support to ‘The Safer Patients Initiative’ (SPI) which began with four UK hospitals, one in each of the four UK countries, and then developed with a further group of 20 partnered hospitals. This is continuing with a further safer patient initiative, the Safer Patients Network; Annette Bartley a previous IHI fellow will be the Director. The Scottish Patient Safety Programme, which has the bold aim of reducing mortality by 15% in five years in Scottish hospitals, has as its National Clinical Lead, Jason Leitch, a previous IHI Fellow. IHI also has a Strategic Partnership with the NHS Institute for Innovation and Improvement.

Learning and the Open School
Another initiative from IHI that is taking hold in the UK is the IHI Open School for Health Professions. The Open School is designed to harness the energy of students in medicine, nursing, and other allied health professions, before they are steeped in the cultural norms of their future profession, and therefore less able to see areas of patient care which could be changed and improved. It also encourages individuals to meet before they go into their own professional silos. Have a look at the Open School on the IHI website; there are some great learning modules on quality and safety relevant to all doctors, not just medical students.

My learning and the science of improvement
I have learned that doing medicine well is about putting the patient at the centre of what we do. We need not just to be clever doctors and know what drug is best for a particular condition; we need to understand how that drug will be given to the patient safely, effectively, and in a timely fashion. We need not to be scared of measurement, but to understand that unless we measure what we do, we cannot improve. I have also re-learned the power of patient stories; a well known recent anaesthetic example is that of Elaine and Martin Bromiley, which could not fail to touch us all. I am trained as a medical researcher and have an MD, but this year has been truly transformational in my ability to understand the failings of modern medicine and how far we have to go to get it right. The mainstream journals now understand that there is a new medical science, that of Quality Improvement, e.g. the BMJ, JAMA, and the NEJM have adopted the Standards for Quality Improvement Reporting Excellence (SQUIRE) guidelines for quality improvement studies. As we are all aware with the Darzi report, quality is the way forward for the NHS. Thinking about delivering

Table 1
Evidence Base to Delivery Base

<table>
<thead>
<tr>
<th>Evidence base</th>
<th>Delivery base</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCT is gold standard</td>
<td>Delivery and reliability</td>
</tr>
<tr>
<td>Excellence = knowledge</td>
<td>Excellence in application</td>
</tr>
<tr>
<td>Context not an issue</td>
<td>Context is key</td>
</tr>
<tr>
<td>One patient at a time</td>
<td>Patients and populations</td>
</tr>
<tr>
<td>Individual based</td>
<td>System based</td>
</tr>
<tr>
<td>MI = give drugs X and Y</td>
<td>MI = do X and Y reliably</td>
</tr>
</tbody>
</table>

quality care to our patients energises front-line staff in a way that many other directives have failed to do.

I have been very privileged to have a tremendous year of learning, grounded in understanding the very real problems that face patients in the NHS. I am proud to have been the first Anaesthetic/Intensive Care Fellow in an organization which bases many of its key goals in the work we do on a daily basis. I know that the RCoA has been at the forefront of the safety movement for many years, and I hope that I am now better able to help continue that work.

‘The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.’

DONALD BERWICK MD MPP KBE, PRESIDENT AND CEO, IHI

References

1. www.ihi.org/ihi.
2. www.health.org.uk/.
5. www.commonwealthfund.org/.
Primary FRCA exam: when is the appropriate time?

In the past, most trainees sat the Primary examination at the end of year one, or during year two. Recently, much concern has been expressed by year one anaesthetic trainees (CT1) with regard to the need to sit the Primary FRCA examination during their first year of core training.

Royal College regulations require the Primary FRCA examination to be passed by the end of the first two years of core training, conferring eligibility to proceed to specialty training from year three. However, due to the timing of the selection process by Deaneries, many trainees feel the need to sit the examination after ten months of experience in the specialty, which may be just too early. After six months’ experience most, if not all, have gained only just enough of the knowledge, skills and, most important, confidence to attend to basic emergency calls and anaesthetise ASA grade 1 and 2 patients.

In this context, we conducted a survey of opinion regarding the necessary timing of sitting the Primary FRCA examination amongst the CT1 trainees in the Mersey Deanery, with the aim of identifying the reasons for their concerns. Twenty year one trainees completed the questionnaire. Most of the trainees (90%) felt that appearing for the examination with less than 12 months’ experience in the specialty was too early. 60% had no previous experience in anaesthesia or critical care as postgraduates. There was some difference in opinion between graduates from medical schools where teaching was based upon a traditional medical course – providing a grounding in medical science prior to clinical tuition, and those from medical schools which had adopted the problem based learning method. Whilst 25% of the former group felt that it was not too early to sit the examination, 100% of latter group disagreed. However, 17 of the 20 surveyed felt that competition for specialty training posts put them under pressure to sit an examination which, otherwise, they might not have attempted at that stage.

Only one attempt

The current year one core trainees in anaesthesia are the first cohort to pass through since the uncoupling of core and specialty training programmes. They are required to apply for a specialty training programme, equivalent to the previous specialty registrar (SpR) training programme, after 18 months.
of experience. Although eligibility to apply does not include prior success in the Primary FRCA examination as a pre-requisite, it is desirable and, almost certainly, gives trainees a better chance of being shortlisted. As mentioned above, under the previous system, prior to the introduction of Modernising Medical Careers (MMC), senior house officers (SHOs) took the first part of the examination after ten months’ experience and were expected to have passed the whole examination before the end of 24 months. ‘Stand alone’ SHO posts were available as a ‘fall back’, if they failed to achieve a pass prior to applying for SpR rotation. As is the case now, specialty training numbers became available throughout the year but, at that time, interviews were held at regular intervals during the year in order to replace those trainees who had completed their training. Since the advent of MMC, trainees have a single attempt to secure a specialty training post by interview, about six months into their second year of core training. Their career progression is not guaranteed if they fail to pass the Primary FRCA within that 18-month time frame. Therefore, trainees are in a dilemma with regard to the optimal timing of their Primary FRCA Examination application. In our region, the majority of the CT1s have decided to sit the examination after ten months’ of experience to give themselves two chances of passing (June and September), before the application process for specialty training begins.

Examinations are set to ensure trainees meet appropriate standards of knowledge and skills so that they may practise competent and safe anaesthesia. The Primary FRCA examination assesses a wide breadth of clinical and basic science knowledge and, whilst most trainees find examinations stressful, the current cohort of trainees may feel unduly burdened by the general lack of basic science teaching at those medical schools that have adopted the problem based learning curriculum. This is in addition to their aforementioned employment concerns.

The new undergraduate curriculum
In fact, most of our core trainees are from medical schools that have adopted the problem based learning curriculum. They acknowledge their general lack of basic science knowledge at the start of their anaesthetic careers, and attribute it to the medical curriculum that they have covered. They are of the opinion that inclusion of basic science in their undergraduate programmes would have been of great value to them. There may well be an advantage in anaesthetists, with their solid grounding in basic science, playing a larger part in the education of medical undergraduates in the UK. Of course, whilst we acknowledge that this argument is not new, we do know that placements in anaesthesia, whether as a medical student or as a foundation trainee, are considered to be of great educational value by those who manage to secure them. Perhaps these learning opportunities should be extended to benefit as many undergraduates as possible. It would be interesting to hear comments from trainees who have attended medical schools both with traditional and with problem based learning curricula, as well as from their trainers.

Furthermore, it is a basic fact that trainees are unable to attend all of their weekly tutorial sessions due to the demands of the current shift working patterns. In our hospital, we try to conduct tutorial sessions twice a week to help trainees maximise their attendance. The drive to implement the European Working Time Directive (EWTD) has contributed to a major reduction in the clinical experience of trainees by decreasing working hours, and this may also be contributing to a feeling of anxiety amongst junior trainees.

Our survey showed that the application process for specialty training rotations with only 18 months of experience was the main factor contributing to anxiety amongst trainees about choosing when to sit the Primary examination. Other important factors included basic science teaching at undergraduate level, as well as the pressures of the EWTD.

Ideas for the future
This raises a number of interesting questions. Would more emphasis on basic science teaching at medical school improve the confidence of trainees? If this were the case, then how would this teaching be provided, and to what end would further involvement of anaesthetists in medical school teaching and curriculum design add value? Can we bridge medical schooling, foundation training, CT and ST rotations more smoothly and effectively? Should some sort of specialty doctor post be created to act as a bridge between core training and the specialty training system in the event of failure to achieve the Primary FRCA examination within 24 months of experience? If so, would such a trainee be able to get back into specialty training? Would it be advantageous to have the ST3–7 application process commencing at 21 months and would this allow adequate time for the process?

The issues raised here are open to debate, and comments are welcome. Perhaps any ensuing discussion will initiate a process of finding solutions that would be of great benefit to the upcoming generation of trainees, as well as to the specialty.
Training and Examinations Directorate

The Examinations Department

The team that provides administration and support to the FRCA examinations

Mr G Clissett, Manager, Examinations Directorate

The Examinations Department is committed to maintaining the highest standards possible for the Royal College examinations. In order to maintain this position, the department and the FRCA examiners not only manage and maintain the examination needs on a day-to-day basis, but rigorously quality assure all its processes. They actively engage in research and ongoing development work to ensure the pre-eminence of the FRCA examination.

The young doctor walks urgently along the hospital corridor, his examination application held firmly in his hand. The countdown clock on the College website said there were five hours 24 minutes and 37 seconds before the closing date. He needs his College Tutor's signature. There is plenty of time, the College is only eight miles or so away, he can deliver it by hand in time to be booked on with the other applications…

The Examinations Department processes around 3,500 applications per year. With the Final examination written and structured oral examination (SOE) sections becoming stand-alone from September 2009, this number is likely to increase by another 1,000–1,300 applications. Although the Examinations Department works as a team to ensure timely processing of applications, Beth Doyle, Examination Assistant Administrator, handles the majority of the forms received, ensuring each form is thoroughly checked against the College records, and that the applicants are eligible in accordance with the ‘Examination Regulations’. As an assistant administrator, Beth plays an active part in many of the roles within the examination remit, and is especially involved in assisting the preparation of the objective structured clinical examination (OSCE).

The College Tutor signs the form, along with a copy of the doctor’s Initial Assessment of Competency in Anaesthesia. They presume the latter must be a new requirement, as neither remembers having to provide a copy of this the last time they submitted an application for the OSCE/SOE examination...

The award of the Initial Assessment of Clinical Competency in Anaesthesia has been one of the criteria to sit the Primary examination since September 2007, when the College moved from time based to competency based eligibility. Because the FRCA examinations are woven into the Certificate of Completion of Training (CCT) programme, the Examinations and Training Departments work in close liaison to ensure that competency awards are recorded, and that the College records are maintained as accurately as possible. The examination application form is an ideal tool for acquiring copies of competency certificates and, in some cases, acts as a gentle reminder to the College Tutor to ensure that certificates are issued. Therefore, the requirement to include competency certificates, along with other relevant documents, not only assists in quickly identifying an applicant’s eligibility, but ensures that a trainee’s records are correctly maintained both locally and at the College.

Three hours 20 minutes and 15 seconds left. The young doctor heads for the station, he is ready for the exam, although he wasn’t looking forward to the OSCE…

There’s a saying on the examination floor: ‘a day not in OSCE is a day wasted’. Maddy Blair, the Lead Administrator for the OSCE, never lets a day go to waste. Being responsible to the OSCE Chairman and the Working Party for providing administrative support to the examination, there isn’t much time to
waste. After all, there are 18 stations to manage, covering resuscitation, technical skills, anatomy, history-taking, physical examination, communication skills, anaesthetic equipment, monitoring equipment, measuring equipment, anaesthetic hazards, and the interpretation of x-rays. All the equipment and materials used in these stations must be checked, re-ordered where necessary and maintained. Every question is reviewed by the OSCE Working Party after each examination, and revised if required. The Question Bank is constantly scrutinised for errors and updates. The RCoA pioneered the use of OSCEs in postgraduate medicine in the UK, and Maddy, Beth, the Working Party and, of course, every member of the Examinations Department are committed to maintaining the high standards introduced at its conception.

The structured oral examinations, in both the Primary and Final parts of the FRCA examinations, are in the reliable hands of John Greenburgh, who has more than 30 years of experience in examination administration. In common with all FRCA questions, SOE topics are cross referenced to the examination syllabus. Well before each exam, John liaises closely with the examiner core groups, to ensure the examination is fully prepared, and that the subject areas chosen for each and every question are selected from the full width of the published syllabus. He reproduces question papers and artifacts to ensure sufficient material is available to the examiners and candidates attending the SOEs. The knowledge and expertise John has gained over the years are also put to good use in other areas of the examination processes. Anyone who has attended the examination ceremony at the end of a Final FRCA examination is certain to recall the rich tones and well rounded pronunciation of John’s voice, as he carried out the role of master of ceremonies.

Lindsay Troubridge is the Lead Administrator for both the Primary and Final MCQs. Lindsay has nine years of experience in this role and has been the sole administrator responsible for ensuring the Primary and Final examinations are set, marked and recorded accurately. Lindsay has seen the MCQs go through a number of changes, most recently the removal of negative marking. She is very aware that one of the greatest advantages in removing negative marking is that all candidates now answer the five stems in the anchor questions, which are used to set the pass mark. Safe anaesthetic practice is based upon a thorough knowledge of basic science and the MCQs remain an excellent examination in which to assess that factual knowledge. With 90 stems, each with five true/false answers, the accurate marking and recording of each candidate’s results are of paramount importance. The department relies not only on the best technology available, but the continued commitment and professionalism of the examiners and staff who run and administer it. With venues from Edinburgh to London, and applicants in Wales and Ireland, it would be impossible to manage these examinations without the many part-time invigilators who consistently oversee the written sections in examination rooms that range from great halls to university refectories, and libraries to hotel conference centres.

0 hours, 40 minutes and 14 seconds. The bus sits in traffic. He starts to worry about the exam ahead, what if he fails – he’d have to attend a guidance interview...

Since November 1990, guidance sessions for unsuccessful examination candidates have been an integral part of the College’s approach to candidates experiencing difficulties. Chloe Scrivener is the Lead Administrator for this essential task, having recently taken over the position from Lindsay. Chloe canvasses and schedules experienced examiners to undertake the 30 to 45 minute sessions, which must be attended by any candidate who does not pass the Primary FRCA OSCE or SOE examination after two attempts, or the Final FRCA written or SOE examinations after three attempts. Sessions are offered as soon as possible after the relevant failed attempt, and Chloe will send out letters to candidates and prepare their examination history packs prior to the guidance session. During guidance, the candidate’s performance in both attempts is discussed in detail, based upon the careful records that have been made during the examination itself. Candidates are encouraged to attend with their College Tutor, so that both benefit from understanding where improvement is needed. Chloe also plays a lead role in examiner administration, and is responsible for managing hotel bookings for examiners during examination week.
In the November 2008 issue of the RCoA Bulletin, Dr Andy Tomlinson, Chairman of the Examinations Committee, gave a comprehensive report on the changes to the examinations, both those introduced recently and those soon to come. They have also been published on the examination pages of the College website for over 12 months. Mr Richard Bryant, Director of Training and Examinations, continues to work closely with the Examinations Committee to ensure that final details are agreed and brought to fruition. The Examinations Department has also been putting in place the administration systems required to implement the changes. There will be further changes to the application forms and applicants are always advised to ensure that they read the instructions at the back of the forms fully before completing them, especially when applying for any examination commencing after 31 August.

The application form was filled in correctly and the doctor was booked into the examination. There is a notice at the top of the application page for the examinations on the College website which states: ‘early application saves stress’. Timely submission of applications allows the department time to liaise with applicants if there is a problem, either with the information submitted on the form or with the examination fee. Our working ethic revolves around treating each and every candidate consistently and fairly, and firm adherence to the examination regulations in regard to all aspects of FRCA examinations ensures that no-one is disadvantaged.

References
1 Primary and Final FRCA Examination Regulations. RCoA, August 2009.
Maintaining essential skills and knowledge for paediatric anaesthesia in district general hospitals

Feedback from a ‘break-out’ session at the 3rd National Association of Paediatric Anaesthetists (APA) Linkman Meeting, 3 November 2008

Dr J Peutrell, Consultant Paediatric Anaesthetist, Royal Hospital for Sick Children, Glasgow
Dr T Dorman, Consultant Paediatric Anaesthetist, Sheffield Children’s Hospital
Dr M Entwistle, Consultant Anaesthetist, Royal Lancaster Infirmary
Dr T Howell, Consultant Paediatric Anaesthetist, Manchester Children’s Hospital
Dr R Lawson, Consultant Paediatric Anaesthetist, Royal Hospital for Sick Children, Glasgow
Dr I Locker, Consultant Paediatric Anaesthetist, Hull Royal Infirmary

The programme for the National APA Linkman Meeting in November 2008 included a session on how consultants covering children’s anaesthetic services in non-specialist hospitals can keep up to date. These consultants anaesthetise children on elective lists and/or for emergency or urgent procedures when on-call and/or manage sick or injured children admitted through the Emergency Department.

Two thirds of the delegates at this session came from district general hospitals (DGHs) and one third from specialist paediatric centres. The organisers had recommended several publications1–4 in advance as useful background reading. The APA subsequently used the feedback obtained as part of its response to a request from the Royal College of Anaesthetists for recommendations on criteria for re-certification. There were several key themes which are summarised in Tables 1 and 2.

Priorities
Delegates gave the highest priority to having appropriate skills and knowledge to recognise and manage a sick child, including the skills for resuscitation and stabilisation. As topics, ‘resuscitation’ and ‘the sick child’ were universally cited ahead of ‘paediatric anaesthesia’. Delegates considered vascular access and tracheal intubation for all age groups essential skills for any anaesthetist expected to manage a sick child, observing that local anaesthetists often have better airways skills than transport staff. These skills were particularly important for those in very remote areas, where weather and distance can delay the transport team for hours (or even days) and the local team has to cope.

Delegates also valued easy access to information and advice (for example, written local policies for managing common conditions in childhood; telephone advice from paediatric intensivists) to complement their core skills. Other topics listed as important included: child protection; medico-legal aspects (consent and competence); deciding what you can and cannot do (according to age, procedures, co-morbidity); communication skills; pain management; drug doses and equipment and fluid management.

Paediatric life support
Completing a ‘branded’ course in paediatric life support (such as ‘APLS’ or ‘EPLS’) was not thought to be essential and delegates thought that local courses should be recognised as equally (or perhaps even more) appropriate. Delegates saw significant advantage to local courses, which are cheaper, can be tailored to the needs of the local service or individual, can train the ‘whole team’, and may achieve greater compliance. Both the cost and duration of external courses were seen as significant impediments, particularly for those needing to maintain competence in several other sub-specialties. If national bodies recognised only external courses, local provision may be jeopardised because anaesthetists might decline to manage children rather than comply with a standard they considered unreasonable.

Simulation and in-house scenario-based updates were popular, especially for practising emergency drills. Delegates thought that this approach would be especially useful for training the whole clinical team together and practising drills for clinical emergencies.
Delegates gave a high priority to obtaining additional experience in the care of sick children and advocated spending time in both neonatal and paediatric intensive care units. There was also strong support for ‘outreach’ teaching by staff from the regional paediatric intensive care unit, which was considered especially good for whole teams working together, although recognised as ‘resource intensive’ for the regional centre. Constructive feedback about any cases transferred was welcomed.

Relationships
There was a clear desire to foster better links between DGHs and their local specialist centres. This could be achieved by having a designated paediatric anaesthetist to contact for advice and better telephone access to paediatric intensivists, whenever necessary. Some delegates wanted the APA to provide clear guidance about the different types of clinical work that could reasonably be undertaken in different categories of hospital. They also asked national bodies, including the APA, to disseminate published guidelines, policies and reports more effectively.

Traditional education through courses
This seemed to have a lower priority than teaching in simulated situations (high-fidelity simulation, scenarios), especially those devised to meet local needs and include the whole team. However, there was support for comprehensive one-day updates to include resuscitation, common skills, child protection, pain management etc. Delegates also supported e-learning for some topics.

Obstacles
Delegates reported many actual or perceived obstacles, particularly in arranging clinical attachments to specialist centres. These included: time (loss of service at base); cost (limited study

Table 1
The consultant who is expected to resuscitate and stabilise sick children: essential knowledge and skills

<table>
<thead>
<tr>
<th>Essential knowledge and skills</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core skills include:</td>
<td>Basic anaesthetic skills for adults can be applied to children (i.e. applying the ‘A, B, C’ approach):</td>
</tr>
<tr>
<td>■ Recognition of the sick child</td>
<td>■ Additional competencies can be obtained through external or local courses in advanced life support for children</td>
</tr>
<tr>
<td>■ Tracheal intubation</td>
<td>■ There should be ready access to additional information and advice (for example, written local policies for managing common conditions in childhood; telephone advice from a paediatric intensivist) when needed</td>
</tr>
<tr>
<td>■ Vascular access (intravenous and intraosseous)</td>
<td>■ Anaesthetists often have better airways skills than other staff in the transport team</td>
</tr>
<tr>
<td></td>
<td>■ Some district hospitals are situated a long way from the specialist centre</td>
</tr>
<tr>
<td></td>
<td>■ In remote and rural areas, the transport team may be delayed for hours or days because of the weather</td>
</tr>
</tbody>
</table>

Clinical experience
Delegates from DGHs were very keen to obtain additional clinical experience. There were many suggestions for how to do this. Local solutions included jointly managing challenging cases (for example, two consultants to anaesthetise a baby) and attending a colleague’s list as part of continuing professional development.

Visiting specialist centres was also popular, either as an observer (to obtain reassurance about personal approach and build links with specialist colleague) or for ‘hands-on’ practice. A one-week attachment each year (or one day every couple of months) was thought to be about right. Delegates suggested tailoring the programmes for these specifically to the needs of the visitor. Programmes could include, for example, practical experience or updates in anaesthesia, pain management, resuscitation or critical care depending on the individual. Visitors were clearly thought to have a responsibility to take any new skills or knowledge back to their base hospitals.

Another suggestion, for hospitals that were not too far apart, was to offer a DGH anaesthetist a contract to cover appropriate elective work at the regional specialist centre (‘anaesthetic in-reach’). This would be a good way to increase case-load, maintain experience and improve relationships between specialist centres and referring hospitals. However, clear governance arrangements are essential and this may lead to difficulties. One delegate described his experience of ‘anaesthetic in-reach’ as rather negative: ‘I always felt like an outsider,’ he said.
leave budgets); bureaucracy; arranging temporary contracts (often necessary for hands-on practice); clearance from the Criminal Records Bureau (CRB) and similar bodies; occupational health checks; and limited capacity in specialist centres (training opportunities taken by trainees). Delegates made a specific plea for honorary contracts to be more easily arranged and for occupational health checks and CRB clearance by the base hospital to be accepted by other NHS organisations.

Maintaining competence
Overall, the most important factor in persuading colleagues to maintain their competence seemed to be to ensure that training was ‘fit for purpose’ and appropriate to both the needs of individuals and the local service.

Acknowledgement
The authors would like to thank Dr Anna-Maria Rollin for her helpful editorial review during the preparation of this article.

Declaration of interest
Dr Jane Peutrell is Honorary Secretary to the APA.

References

Table 2
Opportunities for anaesthetists working in district hospitals to maintain their competence

<table>
<thead>
<tr>
<th>Methods</th>
<th>Category</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching/practice in simulated clinical situations</td>
<td>In-house scenario-based updates/practice</td>
<td>Good for whole team together. Allows teams to practice ‘drills’</td>
</tr>
<tr>
<td></td>
<td>High fidelity simulators</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Outreach’ teaching by staff from the regional PICU</td>
<td>Good for whole team together. Resource intensive for the regional centre</td>
</tr>
<tr>
<td>Resuscitation courses</td>
<td>External courses, for example, APLS (ALSG), EPLS (European Resuscitation Council)</td>
<td>These should not be considered the only courses acceptable to national bodies</td>
</tr>
<tr>
<td>Local courses</td>
<td></td>
<td>Strongly advocated: ▪ Appropriate for the whole local team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Tailored to local and personal needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Cheaper and shorter</td>
</tr>
<tr>
<td>Obtaining additional clinical experience</td>
<td>‘Shared lists’</td>
<td>Especially for babies</td>
</tr>
<tr>
<td></td>
<td>Attending a colleague’s list</td>
<td>As part of CPD</td>
</tr>
<tr>
<td></td>
<td>Attachment to a specialist centre</td>
<td>▪ One week a year generally thought appropriate (or perhaps one day every two months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ The programme should be based on the needs of the visitor; likely to comprise both anaesthesia and resuscitation/transfer medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ The visitor should bring the skills and knowledge acquired back to colleagues at base</td>
</tr>
<tr>
<td>Access to new information</td>
<td>National guidelines, policies and reports etc</td>
<td>Request for better dissemination from national bodies, including the APA</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Networking telemedicine</td>
<td></td>
</tr>
</tbody>
</table>
Report of the Senior Fellows Club
14 May 2009
Dr B Williams, Chairman

The third ‘away meeting’ in the history of the Club was held in Birmingham City’s Grade II listed Council House, a building designed following the theme of a Venetian palace in classical Renaissance style. Over 70 members were able to enjoy the excellent facilities of the ornate ‘banqueting suite’, and it was particularly pleasing to see such good support for a meeting held outside London.

The Chairman’s introductory remarks reminded members that his term of office would end following the meeting. He reviewed some of the Club’s features over the past three years, and demonstrated that it was ‘in good health’, and that it continued to enjoy successful meetings.

A warm welcome was extended to the College President, Dr Judith Hulf, no stranger to her ‘home’ city. The Chairman thanked her for her College ‘hot off the press’ news concerning the building itself. She also gave an update on the Faculty of Pain Medicine, the EWTD (European Working Time Directive), and the College’s e-learning facility, the latter now involving the College in a partnership with the Department of Health. The President concluded with a tribute to the outgoing Chairman for his industry in maintaining the success of the Club, and was pleased to announce the appointment of Dr Hugh Seeley as incoming Chairman, wishing him success in the role.

The Chairman welcomed the guest speaker, past-President Professor Peter Hutton, Head of the Academic Department of Anaesthesia at the University of Birmingham. Despite his busy schedule, Professor Hutton had kindly agreed to provide the Guest Lecture ‘2000 years of human rights: their impact on medicine’. In typical style, he delivered an erudite, interesting and entertaining lecture. He covered an extensive period beginning with the development of the concept of human rights from the Hammurabic Code of Babylonian times, across landmarks of Roman times, the Middle Ages and the Renaissance, ultimately leading to the UN’s declaration of Human Rights in 1948. He ended with a reference to the ‘Right to life’, and the issues impacting on medicine which embraced degrading treatment, assisted suicide, freedom of belief, and freedom from discrimination. Had there been the remotest possibility of anyone tiring of the wealth of information presented, it would have been prevented by the cleverly selected and interposed newspaper cuttings, with their own brand of ‘take’ on the topic.

In drawing the meeting to a close, the Chairman thanked all members who had supported the Club meetings during his term of office, the College President for her diligence in attending as many meetings as possible to provide the College News and, not least, Karen Slater and her team for their invaluable assistance, not only in organising meetings but also in making the role of Chairman such an enjoyable one.

Date of next meeting
The next Senior Fellows Club Meeting will be held at the College in Red Lion Square on Tuesday, 17 November 2009 when past-President Professor Leo Strunin will provide the Guest Lecture.
Introduction

The recent arrival of the GMC’s document ‘Licensing. It’s time to decide’ reminds us that the ‘Licence to practise’ will be introduced in autumn of this year as the first step towards the introduction of the revalidation process. A registered doctor will be required to undertake periodic renewal of that licence by demonstrating that they are up to date and fit to practise. It remains an individual’s responsibility to be familiar with Good Medical Practice and to follow the guidance contained within.

Revalidation is not being introduced at the same time as licensing. Although we do not yet know the detailed components and requirements that will comprise full revalidation and recertification, it is known that the processes are likely to involve a retrospective analysis of the previous five years of professional activity. The elements within recertification are to include:

- CPD activity and performance of individual doctors
- departmental accreditation
- individual professional performance review.

The article ‘Revalidation: where are we now?’ by Professor Dodds in the March 2008 issue of the Bulletin summarises what is currently known about what is going to be reviewed and by whom. A key element of the whole process will be the presentation of evidence that CPD has not just been performed but that it has also been effective. Examples could include the completion of e-Learning sessions, reading of CPD journal articles and a record of MCQ activity. Integral to all this is the need to ensure that both core and specialist knowledge/skills relevant to an individual’s job plan are maintained and covered by an effective rolling programme of self-directed revision.

e-LA and CEACCP/BJA

Over the past 12 months e-LA has been working with Oxford University Press and the BJA Board to make available articles published in both the British Journal of Anaesthesia (BJA) and Continuing Education in Anaesthesia, Critical Care, and Pain (CEACCP) via the e-LA learning management system (LMS). All articles from CEACCP are now accessible in the e-Library section of the LMS. Users can browse the table of contents by year/month or search for specific articles using key words. No additional passwords are required to view, print or download the full text pdf of each article. Articles are also being indexed by reference to the anaesthetic curriculum, specific sub-specialties and the appropriate level of training or practice. For example all CEACCP articles relating to obstetric anaesthesia and appropriate for ST1/2 trainees will appear under the e-Library Block 4 section which covers obstetrics, paediatrics and anaesthesia for the elderly (Figure 1). Access to and time spent reading an article are recorded on the LMS and can be used as evidence of appropriate CPD activity for appraisal and revalidation.

e-LA and on-line MCQs

Following agreement reached with the BJA Board and OUP in January of this year, e-Learning Anaesthesia also now hosts the MCQ questions drawn from CEACCP that accompany each CPD article (Figure 2).

For each edition of the journal, users of e-LA will be able to access and review each article followed by the set of related questions (Figure 3). The MCQs are initially presented as they would be in an assessment – without answers, explanation or feedback (Figure 4). Once the user is satisfied with the responses

Figure 1

12 July 2014

Dear Dr X,

Thank you for submitting your online portfolio. I can confirm that all documents required for the recertification process have now been received electronically.

The College is required to confirm, for both relicensing and recertification, that relevant CPD has been performed in line with the GMC’s guidelines on Maintaining Good Medical Practice. Whilst there are several ways that evidence to support this may be presented, you may wish to make use of the online e-learning resources and assessments available on e-LA which will record these automatically for you.

Yours sincerely,
they have made, the entire question set is submitted electronically for marking. As is currently the case in the journal, the pass mark is set at 80%. Answers and explanations are then available for review and reflection. The score achieved is recorded and the LMS can provide a certificate of performance for the individual as evidence of successful Specialist CPD activity. Combined with a log of e-Learning activity on the LMS this information can be used as formal evidence of an individual’s commitment to maintaining good medical practice.

Articles and MCQs from each issue of 2009 are being made available at the same time as their release in the printed edition of CEACCP. Over the next six to 12 months the entire back catalogue of articles and related MCQs (2001–2008) will be available through e-LA to support CPD for consultants and SAS anaesthetists. Additional CPD articles and MCQs from the BJA will also be available. The articles and related MCQs can be found in the e-Library section of e-LA under the heading ‘e-Library CEACCP’.

**e-LA and Core Topics**

In line with the ‘Core Topics’ section in the RCoA CPD guidelines, we are developing this concept further by creating collections of articles relevant to core revision topics such as obstetrics, paediatrics, critical care and other sub-specialties and linking them to an online self-assessment session that combines all the MCQs from those articles (Figure 5). This will allow anaesthetists to undertake further on-line CPD and assessment on the ‘core topics’ most relevant to their everyday clinical practice and on-call commitments as part of their ongoing programme of self-directed revision.

**Phase 2 and CPD**

The plans for phase 2 of e-LA covering intermediate and higher training in anaesthesia were released in June 2009. The curriculum is being expanded into a further 12 clinical blocks to cover the key six sub-specialty units and the remaining general/additional units of training. The e-Library is being extended in parallel and articles relating to sub-specialties at these higher training levels will be indexed and made available in these e-Library blocks.

**Summary**

In summary, e-Learning Anaesthesia was conceived as a Learning Portal to support both training and continuing professional development for ALL anaesthetists. The online CPD sessions being built into e-LA are designed to deliver the following tools to support specialist appraisal and recertification.

- Mandatory modules of training (e.g. child protection material for ‘Safeguarding Children’).
- e-Library access to expert CPD material published by CEACCP and BJA.
- Sub-specialty collections of relevant CPD articles and related self-assessment MCQs.
- A personal record of Specialist CPD activity and performance on College approved MCQ questions.

e-Learning in the NHS continues to develop, expand and be accepted as the way forward. As we discover new ways that e-Learning can and should be used, further resources to support consultants in their role as trainers and for revalidation are being added.

e-Learning Anaesthesia has been available to all UK anaesthetists from January 2009.

If you are a consultant, an SAS anaesthetist, or a trainee and you have not already done so, please register for access to e-LA at [www.e-LA.org.uk](http://www.e-LA.org.uk).

---

**Figure 3**

CEACCP (April 2009) showing articles and linked MCQs

**Figure 4**

Example question related to the article in Figure 2

**Figure 5**

Core Topic MCQs: obstetric anaesthesia
At a meeting of Council on Wednesday, 22 April 2009, the following appointments were made:

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

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

College Tutors
Re-appointments are marked with an asterisk:

Anglia
Dr A A Klein, Papworth Hospital (in succession to Dr J Arrowsmith)
*Dr M A Stevens, Hillingdon Hospital

From September 2009

North Thames West
*Dr M A Stevens, Hillingdon Hospital

North Thames Central
Dr M Sivararajaratnam, North Middlesex Hospital (in succession to Dr R Lo)

Mersey
Dr O Al-Rawi, Liverpool Heart and Chest Hospital, formerly Cardiothoracic Centre (in succession to Dr S M Gilby)

North West
Dr D A Watson, Burnley General Hospital (in succession to Dr S R Price)

South East Scotland
Dr L M Carragher, St John’s Hospital (in succession to Dr D W Galloway)

West of Scotland
Dr P W Bolton, Royal Hospital for Sick Children (in succession to Dr L A McKee)
*Dr L Chee, Inverclyde Royal Hospital
*Dr C H Whymark, Crosshouse Hospital

Severn
*Dr S Shinde, Frenchay Hospital
*Dr J S Wills, Southmead Hospital

Nottingham and Mid Trent
*Dr R A Caranza, Derby Hospitals

Sheffield and North Trent
Dr J A Short, Sheffield Children’s Hospital

Acting Tutor for Dr C M Wilson
who is on maternity leave

Heads of School
There were no appointments to note.

At a meeting of Council on Wednesday, 13 May 2009, the following were all admitted to the Board of Examiners:

Dr T S H Armstrong (Wales)
Dr A Bedi (Belfast)
Dr R Bhagrath (London)
Dr S I Chadwick (Manchester)
Dr R K Correa (Coventry)
Dr J E Dinsmore (London)
Dr F F A Donald (Bristol)
Dr D F Doyle (Sheffield)
Dr K Hasan (Birmingham)

The following appointments were made:

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

Deputy Regional Adviser
North West
Dr I C Brocklehurst, Royal Oldham Hospital (in succession to Dr C B W Till)

College Tutors
Anglia
Dr N J Curry, Luton and Dunstable Hospital (in succession to Dr F D Spears)

Yorkshire
Dr G Parkin, Harrogate District Hospital (in succession to Dr P Y A Poon)

Mersey
Dr P M Mullen, Countess of Chester Hospital (in succession to Dr N M Robin)

Wessex
Dr R M Heames, Southampton General Hospital (in succession to Dr I M Mettam)

Head of School
Dr P Spargo, Wessex School

---

EXAMINERS ADMITTED TO THE BOARD

LEFT TO RIGHT: DR KHALID HASAN, DR TREVOR ARMSTRONG, DR FIONA DONALD, DR DAMIAN DOYLE, DR SIMON CHADWICK, DR AMIT BEDI, DR RAVI BHAGRATH, DR ROBIN CORREA AND DR JUDITH DINSMORE

---

50 Bulletin 56  July 2009
Council noted recommendations made to PMETB for approval, that Certificates of Completion of Training be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. The doctors whose names are marked with an asterisk have been recommended for a joint CCT in Anaesthesia and Intensive Care Medicine.

Anglia
Dr Zahid Waheed
Dr Sau Hsien Yap
Dr Sarah Isabel Yarham

South East
Dr Zahoor-Ul-Huq Mackay
Dr Christopher James Nicholson
Dr Ranjit Kaur Dulai
Dr Karen Elaine Collingwood

North Central
Dr Gareth Lewis Ackland *
Dr Suneetha Ramani Moonesinghe *
Dr Katherine Margaret Heath James
Dr Lucy Hannah Hepburn
Dr Jeremy James Dawson *

Imperial
Dr Veiko Herodes
Dr Guy Nicholas Barrie Jackson
Dr Elizabeth Georgina Emily Thompson
Dr Marcela Paola Vizcaychipi

Barts/Royal London
Dr Mark Nicholas Paul
Dr Thahira Abdul Rashid
Dr Sanjeev Kumar Thunga Harikrishnaiah
Dr Saravanan Rathinam

St George’s
Dr Fariborz Neirami
Dr Fiona Michelle Wrightson

Leicester
Dr Helen Catherine Luis Hann *

Mersey
Dr Saiprasad Annadurai
Dr Sally Jean Hargreaves
Dr Giju Jacob George
Dr Arun Kumar Durairaju
Dr Lindsay Clare Parker *

Northern Ireland
Dr Kanniah Senthil Kumar

Nottingham and East Midlands
Dr Aniruddha Pai
Dr Paul Richard Smith
Dr Asha Nandakumar
Dr Adam Charles March *

North West
Dr Parag Ramesh Desai

Northern
Dr Ian John Whitehead
Dr Alison Marjorie Schofield
Dr Sreedhar Gudipati
Dr Bernhard Frank

Oxford
Dr Claire Louise Frampton

Severn/Bristol
Dr Peter Vassilev Dimitrov
Dr George Mark Haslam *
Dr Daniel King-Wai Low
Dr William Andrew English *
Dr Mathew Keith Molyneux
Dr Jill Harmony Dale
Dr Nicola Katherine Weale

Peninsula
Dr Garry Anderson
Dr Rachel Elizabeth Blackshaw

South Yorkshire and South Humber
Dr Amanda Lesley Nair
Dr Sarah Charlotte Rawlinson

Wessex
Dr Richard Peter Bowers
Dr Michael Girgis
Dr Robert David James Swanton

West Midlands
Dr Richard Anthony Jackson
Dr Balachandran Santhosh
Dr Kevin James Sim *
Dr Jonathan Hulme *
Dr Andrew John Burtenshaw *
Dr Joanna Clare Marriott
Dr Caroline Mary Elizabeth Moody
Dr Mukesh Ramprasad Sharma
Dr Nicole Cecilia Victoria Davis-Gomez

Wales
Dr Felicity Emma Howard

East Scotland
Dr Anand Atchuta Kamat

South East Scotland
Dr Alistair David Milne
Dr Charlotte Helene Rennie Scott

West Scotland
Dr Laura Anne McGarrity
Dr Margaret Ruth Owen

Yorkshire
Dr Chunda Sri-Chandana *

**ELECTION TO COUNCIL 2010**

Details of Council vacancies will be available on the College website from **Tuesday, 1 September 2009** when nominations for candidates will be requested. Please see the College website for further details and to download the appropriate forms from **Tuesday, 1 September 2009**.

An education session for those considering standing for Council will take place at the College on **Tuesday, 15 September 2009** from 4.00 pm to 6.00 pm. Please could those wishing to attend, contact Ms Charley Wainwright via email at: cwainwright@rcoa.ac.uk

**WWW.RCOA.AC.UK/ELECTION**
Dr M Jones makes a persuasive case for the use of ultrasound to improve success with regional anaesthesia. He proposes too that it could improve theatre utilisation by ‘allowing the anaesthetist to block the next patient while surgery is being performed on the previous awake patient.’ If an equally expert anaesthetist is left with the patient then there would be no problem to solve. So that cannot be what is proposed.

This reminds me of my experiences in Sweden and the USA 30 and 40 years ago where this was the practice. I did not like it then; and (at my age) as a prospective patient I want my anaesthetist in the theatre throughout. And the use of ultrasound!

Professor M Rosen, Consultant Anaesthetist (retired), Cardiff

We are delighted that your edition with a theme should focus on regional anaesthesia, recognising that the introduction of ultrasound techniques has driven the most recent increase in interest in this aspect of anaesthesia. Unfortunately, there are those who seem to think that the only requirement for success is access to an ultrasound machine so we were pleased to read Dr Jones’ emphasis on the need for both anatomical knowledge and technical expertise. However, we would dampen some of his subsequent suggestions that both landmark and nerve stimulator guided approaches should be abandoned. With time this may happen, but those who have acquired the skills to use these methods both effectively and safely remain a large majority in both Europe and USA compared to the relatively small body of expert ultrasound users. Caution must be exercised lest it seem that they are being criticised. Further, ultrasound may not necessarily prove to be the ubiquitous guide to success, two points needing to be kept in mind:

1. When peripheral nerve stimulators first became widely available exactly the same claims for their impact on the efficacy and safety of regional anaesthesia were made as are now made for ultrasound.

2. The superiority of ultrasound-guided approaches has yet to be established. While the potential benefits have been widely publicised, definitive data are more limited. A recent systematic review found only 13 randomised trials (933 patients) comparing ultrasound with landmark or peripheral nerve stimulator techniques. While some benefits of ultrasound guidance are demonstrable, enhanced safety is not one of them; temporary neuropraxia was the same in both groups and recent reports of intravascular injections and a significant pneumothorax indicate that ultrasound guidance is subject to the same profile of adverse events as more traditional techniques.

We appreciate that we risk being labelled as ‘Luddites’ in stating these views, but the history of medicine is littered with methods which have been introduced on a wave of enthusiasm, only for time (and sometimes patient harm) to prove that there was no new benefit. The potential of ultrasound is obvious (even to us), but that potential should be evaluated objectively, not assumed.

We are also concerned by the encouragement of block performance in parallel to surgery on the previous awake patient. This can work when the surgery is minor and the whole unit is organised around the practice, but we should never lose sight of one of our key functions: the care of the patient during surgery. Sooner or later in these situations, both patients will develop a complication at the same time, and what then? Dr Hanning’s Guest Editorial in the same issue rightly emphasises the flexibility of a career in anaesthesia, but we refute absolutely his suggestion that ‘the middle of the case’ is boring. It is what the patient has come for, and if we abrogate responsibility for that phase we will have little defence against the accusation that we have become mere ‘block technicians’ with no interest in patient care.

Reference

Dr H B J Fischer, Consultant Anaesthetist, Worcestershire Acute NHS Trust
Professor J A W Wildsmith, University of Dundee
The PLG debates

Bulletin 55; May 2009:13–15

We note with keen interest Professor A R Aitkenhead’s article on the treatment of patients experiencing PTSD as a consequence of awareness under general anaesthesia. We recently had a patient who experienced symptoms after awareness and were frustrated by the lack of clear guidelines and care pathways to follow.

As a consequence, we have conducted a national survey to see if this problem was a common experience. We have collected 600 responses and our preliminary findings suggest that our problem was not unique. Moreover, our findings support Professor Aitkenhead’s call for local plans to be in place to provide appropriate psychological care for these patients. We look forward to publishing our findings shortly.

Dr M Sacks, Consultant Anaesthetist;
Dr M Kenny, Consultant Anaesthetist;
Dr P Bhalla, SpR Anaesthetist; and
Dr G Smith, Clinical Psychologist
St Mary’s Hospital, London

In the May issue Professor A R Aitkenhead sets out the features of PTSD particularly as it might be experienced after an episode of awareness in a patient promised general anaesthesia. Professor Aitkenhead’s advice is timely and wise. Yet its necessity highlights the issue of individual failure to provide general anaesthesia when it has been promised to the patient and the failure of our specialty to address the problem. Awareness during distressing procedures is an entirely preventable event. The vast bulk of cases stem from the abuse of neuro-muscular blocking drugs over more than half a century, a practice whose purported benefits have never to my eye been convincingly demonstrated. Neuromuscular blocking drugs have been consistently used in excessive dosage thus permitting underdosing with anaesthetic agents and simultaneously abolishing many of the signs which might alert the anaesthetist to a problem. Historically, the principal problem which the introduction of neuro-muscular blocking drugs solved was to permit surgeons easier access to the abdomen than could be gained with any other form of general anaesthesia. This was at a time when general anaesthetic agents were few and unsatisfactory. To provide these conditions a fair degree of NM Block was useful, although currently recommended doses are regularly well in excess even of that requirement. Away from intra-abdominal surgery and particularly with the use of modern anaesthetic agents the need for neuro-muscular blockade is minimal and their continued use in high doses is both reckless and lazy. This issue has dogged our specialty. There is no sound case that, say, profound neuro-muscular blockade effectively permits lowering the dose of anaesthetic agents to the patient’s benefit. Of course, with cardiovascular instability providing general anaesthesia becomes more difficult but too often that has resulted to full neuro-muscular blockade and little else. I know of no systematic evidence which would support a defence of knowingly risking/permitting an episode of awareness on the grounds of enhanced patient safety. I appreciate that this is a contentious issue but I believe that it has to be addressed. The College should with some urgency assemble a group to scrutinise the evidence and make clear guidelines for the conduct of general anaesthesia which will remove this problem and end what has been a shameful episode in our history.

Dr W G Anderson, Consultant Anaesthetist (retired), Scotland

Regional block area

Bulletin 55; May 2009:35–37

I would like to congratulate Dr Blunt on an excellent article and the significant administrative achievement of setting up a regional block area in her hospital. There are many advantages of organising such an area not the least of which is an improvement in provision and teaching of regional anaesthesia. At Holland Orthopaedic and Arthritic Centre in Toronto the use of a regional block area has provided similar clinical advantages but also led to reduction in case turnover time, surgical cancellations and the use of nursing overtime due to cases running late (Dr Sue Belo, unpublished data). The increased use of regional anaesthesia has therefore brought both clinical and financial advantages in this specialist orthopaedic surgery centre.

However, the provision of a separate area for regional anaesthesia, whilst having advantages, also incurs costs that often preclude their use in centres where volume of regional procedures is lower. This has been one of the barriers to use of a dedicated area in the majority of North American centres where block areas remain uncommon contrary to the statement in her article.

Although the use of a regional block area has provided significant advantage in our own practice more work on the clinical, academic and economic advantages is required to further justify their introduction in a wider sense in the future.

Dr C McCartney, Sunnybrook Health Sciences Centre, Toronto, Canada
**APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS**

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

**Associate Fellows**

- **March 2009**
  - Dr Fergal John Burns

- **April 2009**
  - Dr Mostafa H Abdel-Hafiz
  - Dr Zaherali Bandali Damani

**Members**

- **March 2009**
  - Dr Muhammad H Chaudhry
  - Dr Michael William O Frow
  - Dr Chitra Ganesan
  - Dr Stanley John
  - Dr Peter Leo Mcloughlin
  - Dr Rohith Ramanath Nayak

- **April 2009**
  - Dr Biju A Peringathara
  - Dr Sunil Gottumukkala Raju
  - Dr Frank Rosemeier
  - Dr Rajesh R Vaddhireddy

<table>
<thead>
<tr>
<th>Year</th>
<th>Course Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td></td>
</tr>
<tr>
<td>27–29 July</td>
<td>MCQ/SAQ</td>
</tr>
<tr>
<td>2–3 November</td>
<td>(Viva)</td>
</tr>
<tr>
<td>2010</td>
<td></td>
</tr>
<tr>
<td>1–3 February</td>
<td>(MCQ/SAQ)</td>
</tr>
<tr>
<td>17–18 May</td>
<td>(Viva)</td>
</tr>
</tbody>
</table>

**MCQ/SAQ course: £250  Viva course: £300**

Programme includes full mock MCQ and SAQ exam plus tutorials. Viva course includes intense and realistic formal Viva practice under exam conditions with consultant mock examiners. Candidates receive personalised one to one feedback on techniques.

Please contact

karen.kendall@stees.nhs.uk

for an application form. PLACES LIMITED.

---

**DEATHS**

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

- Dr A H Kasasian
  - Wigan
- Dr J I M Lawson
  - Dundee, Scotland
- Dr J Walsh
  - Cork, Ireland

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

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

[**WWW.RCOA.AC.UK/OBITUARIES**](https://www.rcoa.ac.uk)

---

**Final FRCA Crammer Courses**

*(NEWLY REVISED STRUCTURE AND CONTENT)*

**Available courses 2009:**
- 27–29 July 2009 (MCQ/SAQ)
- 2–3 November 2009 (Viva)

**Available courses 2010:**
- 1–3 February 2010 (MCQ/SAQ)
- 17–18 May 2010 (Viva)

**Fee:**
- MCQ/SAQ course: £250
- Viva course: £300

Programme includes full mock MCQ and SAQ exam plus tutorials. Viva course includes intense and realistic formal Viva practice under exam conditions with consultant mock examiners. Candidates receive personalised one to one feedback on techniques.

Please contact

karen.kendall@stees.nhs.uk

for an application form. PLACES LIMITED.

---

**Intense 3-day OSCE/Viva Course**

*FOR PRIMARY EXAMINATION*

**Available courses 2009:**
- 23–25 September 2009
- 16–18 December 2009

**Available course 2010:**
- 28–30 April 2010

**Fee:** £395

Candidates will attend nine Viva and 32 OSCE stations. Intense coaching in OSCE and Viva technique via interactive tutorials.

Please contact

karen.kendall@stees.nhs.uk

for an application form. PLACES LIMITED.

---

**The School of Anaesthesia**

James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW

---

**The School of Anaesthesia**

James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW
FRCA EXAMINERSHIPS 2010–2011

The College invites applications for vacancies to the Board of Examiners in the Fellowship of the Royal College of Anaesthetists, for the academic year 2010–2011. Examiners will be recruited to the Primary examination in the first instance. The number of Examiners required will reflect the number of retirements from the current Board of Examiners.

Applicants shall be assessed against the following person specification:

a  Essential
1  Shall normally be a Fellow by Examination, but a Fellow *ad eundem*, or a Fellow by election of the Royal College of Anaesthetists will also be considered.
2  Shall be in good standing with the College.
3  Applicants must be able to demonstrate that they have the competence, confidence and credibility to assess the next generation of consultants.
4  Shall currently be active in clinical practice in the NHS or a comparable post.
5  On 1 September 2010 shall have the expectation of completing ten years as an examiner whilst filling a Specialty Doctor/SAS grade or Consultant appointment in the NHS, or comparable post.
6  Can demonstrate active involvement in the training and assessment of trainees.
7  Good written and verbal communication skills.
8  Ability to work as part of a team.
9  Documentary evidence of satisfactory completion of Equal Opportunities training in the last five years.
10  Able to commit to long-term and active involvement to examiner duties including the ability to devote a minimum of 15 days per academic year to the role. This includes both the delivery and development of the examinations.

b  Desirable
1  Shall demonstrate a special interest(s) directly relevant to the balance of expertise required in the Board of Examiners.
2  Within the past five years shall have visited a Primary or Final FRCA examination.

An application form and further information for applicants can be downloaded from the examinations section of the College website ([www.rcoa.ac.uk/examinerships](http://www.rcoa.ac.uk/examinerships)) or can be obtained from Miss Chloe Scrivener, Training and Examinations Directorate by tel: 020 7092 1525 or email: cscrivener@rcoa.ac.uk.

Please note that the application process will open on Thursday, 30 July 2009 and the closing date for receipt of completed application forms is Friday, 16 October 2009.

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 College 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
ASSOCIATION OF CARDIOTHORACIC ANAESTHETISTS

Autumn Meeting 2009
De Vere Herons’ Reach Hotel, Blackpool

Thursday, 5 November
Thoracic Day
5 CPD Points
Organised by Dr J B Kendall
Liverpool Heart and Chest Hospital NHS Trust

Friday, 6 November
Cardiac Day
5 CPD Points
Organised by Dr C Rozario
Lancashire Cardiac Centre

For further details and an application form, please visit:
www.actablackpool2009.nhs.uk
or contact Ms Andrea Reid at Blackpool, Fylde and Wyre Hospitals Foundation Trust:
andrea.reid@bfwhospitals.nhs.uk
01253 657789
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
- Unplanned ICU admission: 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 (tcook@rcoa.ac.uk) or Nick Woodall (nicholas.woodall@nnuh.nhs.uk) co-leads for the project.

The National Institute for Academic Anaesthesia

Grants and Awards

The National Institute for Academic Anaesthesia has several small grants funded by The Royal College of Anaesthetists for the purpose of supporting research, education or travel connected with the study of anaesthesia. Applications are invited for the following funds:

Nuffield Fund
To meet the research, teaching and lecturing expenses connected with the promotion of the art and science of anaesthesia.
Value up to £2,500.

Foundation Fund
For lectureships, research grants and fellowships.
Value up to £2,000.

Folkard Educational Fund
For educational and other purposes.
Value up to £1,500.

Stanley Rowbotham Fund
For education in anaesthesia.
Value up to £1,500.

Payne-Stafford-Tan Award
An award to honour the medical careers of Professor James P Payne, Dr J A Timothy Stafford and Dr Oon Tan. This award will comprise a grant to be used for educational purposes such as attendance at a major conference or the purchase of educational materials.
Value up to £1,000

Sargant Fund
For education and research purposes.
Value up to £1,500

Eligibility
All Fellows in good standing and registered trainees are eligible to apply for a grant.

To apply
Please visit: www.niaa.org.uk/index.asp?PageID=150 for further details and an application form.

The closing date for all applications is noon on Tuesday, 1 September 2009.
Mersey Notice
For the attention of those who intend sitting the Final FRCA Examination in or beyond September 2010
in anticipation of the intended change to the Final MCQ Paper currently scheduled for September 2010 or later, the MSA is to establish a

Single Best Answer (SBA) Faculty

Trainees who are to face the challenge of the SBA are invited to join The SBA Faculty.

Members of the Faculty will be expected to draft SBA questions from Final FRCA Examination fodder as provided by the MSA and to submit the answers and appropriate explanations to those answers.

All communication will be anonymised and conducted by email.

Ultimately, the SBAs submitted, once refined as necessary, together with their answers and explanations, will be used in a

Private SBA Weekend Course
2.00 pm Friday to 4.00 pm Sunday
August 2010

This course will only be available to those members of the Faculty who have contributed in accordance with the rules of the Faculty.

There will be a registration fee of £100 to join the Faculty and to show commitment. This fee will also cover the cost of attending

The Private SBA Weekend Course

For details, faculty rules and regulations and an application form, please see our website at: www.msoa.org.uk – and go to the SBA Faculty
### The Mersey Autumn Menu

<table>
<thead>
<tr>
<th>Course</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Final FRCA and FCARCSI MCQ Courses</td>
<td>2.00 pm Sunday, 9 August – 12 noon Friday, 14 August 2009</td>
</tr>
<tr>
<td>The Final SAQ and E&amp;SAQ Weekend Courses</td>
<td>2.00 pm Friday, 14 August – 1.00 pm Sunday, 16 August 2009</td>
</tr>
<tr>
<td>The Final Examinations (Booker) Crammer</td>
<td>2.00 pm Sunday, 16 August – 4.00 pm Friday, 21 August 2009</td>
</tr>
<tr>
<td>The Final FCARCSI Viva Weekend Course</td>
<td>2.00 pm Friday, 9 October – 4.00 pm Sunday, 11 October 2009</td>
</tr>
<tr>
<td>The Final FRCA Viva Weekend Course</td>
<td>2.00 pm Friday, 20 November – 4.00 pm Sunday, 22 November 2009</td>
</tr>
<tr>
<td>The Primary FRCA MCQ Course</td>
<td>2.00 pm Sunday, 23 August – 4.00 pm Friday, 28 August 2009</td>
</tr>
<tr>
<td>The Primary FRCA Viva Weekend Course</td>
<td>2.00 pm Friday, 11 September – 1.00 pm Sunday, 13 September 2009</td>
</tr>
<tr>
<td>The Primary FRCA OSCE Weekend Course</td>
<td>2.00 pm Friday, 18 September – 1.00 pm Sunday, 20 September 2009</td>
</tr>
<tr>
<td>The Primary FCARCSI MCQ Course</td>
<td>2.00 pm Sunday, 20 September – 4.00 pm Friday, 25 September 2009</td>
</tr>
<tr>
<td>The Primary FRCA OSCE/Orals Course</td>
<td>2.00 pm Friday, 25 September – 4.00 pm Friday, 2 October 2009</td>
</tr>
<tr>
<td>The Primary FCARCSI OSCE/Orals Course</td>
<td>2.00 pm Friday, 6 November – 4.00 pm Friday, 13 November 2009</td>
</tr>
</tbody>
</table>

For further details on all the above courses, please see our website at: [www.msoa.org.uk](http://www.msoa.org.uk)
APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following Fellows on their consultant appointments:

Dr I Ahmed
Hull Royal Infirmary

Dr A F Bewaji
Surrey and Sussex NHS Trust

Dr A Donaldson
Manchester Royal Infirmary

Dr A D Evans
Glan Clwyd Hospital, North Wales

Dr C T Gillan
Royal Victoria Infirmary, Newcastle

Dr E Halliwell
Salisbury NHS Foundation Trust

Dr A Hare
Chelsea and Westminster Hospital

Dr A Karnat
Aberdeen Royal Infirmary

Dr M Lane
Royal Brompton Hospital

Dr S J Love-Jones
Fenchay Hospital, North Bristol NHS Trust

Dr A J McCheyne
Freeman Hospital, Newcastle upon Tyne

Dr C Moody
Russell’s Hall Hospital, Dudley Group of Hospitals Foundation Trust

Dr R Poddar
East Kent University Hospital

Dr T C Rope
Northwick Park Hospital, Harrow

Dr D Sethi
Darent Valley Hospital, Dartford

Dr A Sharan
University Hospitals Nottingham

Dr R Swanton
Dorset County Hospital

Dr M Trivedi
Christie Hospital, Manchester

Dr M K K Venkata
Down Patrick and Ulster Hospitals, Ireland

Dr S Yarham
Norfolk and Norwich University Hospital

ALTERNATIVE DENTAL CONSCIOUS SEDATION TECHNIQUES
Delivering Training Workshop

12 September 2009 at 10.30 am to 3.30 pm
The Royal College of Surgeons of England
Lincoln’s Inn Fields, WC2

The Standing Committee on Sedation for Dentistry (SCSD) of the Faculty of Dental Surgery of the Royal College of Surgeons of England invites interested dental/medical practitioners who are currently involved in the delivery of training in conscious sedation for dentistry to contribute to a workshop on the delivery of training in the use of ‘Alternative’ conscious sedation techniques as described in Standards for Conscious Sedation in Dentistry: Alternative Techniques (www.rcoa.ac.uk/docs/SCSDAT.pdf).

The SCSD is currently working towards producing model(s) of training programme(s) to facilitate theoretical and hands-on training compliant with contemporary guidance and outcome-based assessment criteria. The aim of this workshop is to explore potential models of training which might be delivered in Dental Schools, General Dental Practice and the Salaried Primary Dental Care Service.

The workshop will include short presentations from SCSD members representing the above areas of practice. It is not designed to accredit training providers in either ‘Standard’ or ‘Alternative’ conscious sedation techniques for dentistry.

If you would like to take part please contact: Anne Mochrie, tel: 020 7869 6801 email: amochrie@rcseng.ac.uk

For more detailed information please contact: Dr David Craig, tel: 020 7188 6067 email: david.craig@kcl.ac.uk

CPD: 4 HOURS

COLLEGE CONTACTS

Chief Executive
Kevin Storey

Directors
Richard Bryant, Training & Examinations
Sharon Drake, Education
Charlie McLaughlan, Professional Standards

Managers
Martin Bennetts, Facilities
Graham Clissett, Examinations
Richard Cooke, Information Technology
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
Daniel Marsden: 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
Afshana 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