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BULLETIN
of The Royal College of Anaesthetists

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Registered Charity No 1013887 Registered Charity in Scotland No SC037737 VAT Registration No GB 927 2364 18

Design and layout by The Royal College of Anaesthetists

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Articles for submission, together with any declaration of interest, should be sent to the Bulletin 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.

Views & 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.

ISSN (print): 2040-8846
ISSN (online): 2040-8854
From the Editor

Welcome to the July issue of the Bulletin, and I hope that you are enjoying the barbeque season, although at the time of writing, the weather has yet to perk up.

This issue looks at the practice of paediatric anaesthesia in the UK in some depth, and contains no less than ten articles about training, consent, and practice. There is no doubt that training in paediatric anaesthesia has become more difficult to obtain over the last ten years, and this is beginning to show in the confidence of the more senior trainees. Primary cleft lip and palate babies were operated upon most weeks in my hospital from post war years until about two years ago. Now they go to London. Although this follows the trend of focusing treatment within dedicated paediatric centres, let us not belie the impact that this is having on training opportunity at all levels, including CPD for consultants. I am sure that the eight post fellowship SpRs attached to our unit each six months now get less ‘hands on’ experience competing with their peers in London, than they would have done with us until recently. I can’t help feeling a bit of ‘if it ain’t broke, don’t fix it’, but such is life. We welcome your views by email on this important subject.

The implication for consultants of this development in district hospital practice is alluded to in the editorial by Dr Philippa Evans and her co-authors, whilst Dr Young deals with arrangements for children requiring neurosurgery. Professor David Hatch relates the changes he has seen in paediatric practice during his career, and Dr Rollin takes a wider look at anaesthesia for children over the course of the last century. Dr Judith Short publicises information for children requiring neurosurgery, whilst Dr Kathy Wilkinson looks at safeguarding children, and Mrs Roff and Dr Norman suggest a new way of teaching the ethics of taking consent for surgery in children.

Paediatric dental anaesthesia, cardiac anaesthesia in Sri Lanka, paediatric resuscitation, and the benefits of the WHO checklist for Great Ormond Street Hospital are also discussed.

I have succeeded Dr Keith Myerson as chairman of the Communications Committee, of which the Bulletin is a subset. One area that we need to develop surrounds the best way of communicating in a timely manner with the 14,500 fellows and members of the College. Obviously, the Bulletin is one way that we will continue to make good use of, but considering that I am writing this in the second week of May, and you are reading it probably no sooner than the end of June, we need to find alternative and updated methods of keeping in touch. Apparently, about 30% of consultants now possess iPhones, whilst Facebook and Twitter are probably the most widely used means of social networking. Should we be looking at these, or yet other methods? Please let us know your views and we will discuss them. Whilst on this subject, don’t miss the latest update on GMC revalidation published on page 16.

September’s issue will focus on obstetrics, and we will examine anaesthesia for transplant surgery in November.

Lastly, on behalf of all her colleagues at the Bulletin and the College, may I send warm congratulations to Edwina Jones, now proud mother of Flora. Both are thriving, and there is picture on page 57.
A new Government; where will it take us?

Following the Parliamentary election on 6 May, and the necessary ‘horse-trading’ behind the scenes, we now have a coalition Government for the first time since World War II. The Coalition published their programme for Government on 20 May, the same day as the Royal College of Physicians (RCP) released its report Future Physicians: changing doctors in changing times; both are required reading.

The RCP report calls upon doctors to take up the challenge of becoming leaders in medical politics, public life and healthcare provision in order to improve outcomes for patients. Section 22 of the Coalition’s programme covers the NHS and, in 30 bullet points, details their programme of change. Taken together, these two papers represent a tremendous challenge to doctors but also an opportunity to shape the future of our health service.

There is no doubt that Andrew Lansley, the new Secretary of State for Health, is extremely well briefed and knowledgeable about the NHS and has clear ideas of what he wishes to achieve. Some of the proposals are to be welcomed but others will no doubt generate much debate. It will be interesting, for example, to see how the medical profession as a whole responds to the statement ‘We will examine the balance of the EU’s existing competences and will, in particular, work to limit the application of the Working Time Directive in the United Kingdom.’ As I write, Professor Sir John Temple’s draft report on the effect of the Directive on the quality of training has just been presented to Medical Education England. The report describes the problems in training that the Working Time Regulations have brought to the fore, particularly for those specialties with high emergency and/or out-of-hours workloads. Sir John also notes the benefits of a 48 hour week. He makes a number of recommendations that would change the way training and service are delivered in the future. He lays great emphasis on a consultant delivered service but states that ‘the implementation of the report’s strategy will be for others to determine’. This will cost money.

The NHS is in a uniquely privileged position in that the Coalition has stated that health spending will increase in real terms each year despite the current dire financial circumstances. We must work with the new Government to deliver the best care for our patients since, as the penultimate page of the report states, ‘The deficit reduction programme takes precedence over any of the other measures in this agreement, and the speed of implementation of any measures that have a cost to the public finances will depend on decisions to be made in the Comprehensive Spending Review’. There are a number of tough decisions to be made in healthcare delivery. We have already seen politicians expressing concern at reconfiguration; it will be up to clinicians to explain to patients how this may actually improve care if done in a considered and appropriate way.

NCEPOD Surgery in Children study

NCEPOD are currently undertaking a study exploring remediable factors in the processes of care of children (aged 17 or younger at the time of procedure) who die within 30 days of a surgical procedure. Data collection is underway and questionnaires are being sent to the relevant clinicians for completion. As usual with NCEPOD studies these, and any extracts from the case notes, are anonymised before peer review by a panel of multidisciplinary advisors. Although it is early days, return rates are low:

➤ 31% completed surgical questionnaires returned
➤ 42% completed anaesthetic questionnaires returned
➤ 19% case notes returned
➤ 7% complete sets (both the surgical and anaesthetic questionnaire and case notes)

I have represented the College on the NCEPOD Steering Group for the last seven years and over that time have noticed a progressive decline in responses to NCEPOD studies. This is a worrying trend and must be reversed; it is a professional responsibility to contribute to audits that can improve the way we practise. There is no doubt that the nature of
The President’s Statement

the way in which national audits are supported will change in the near future. Anaesthetists have been at the fore of such developments and I would urge you to raise this among your colleagues, promote awareness of the study as far as possible, and encourage the returns of questionnaires where applicable. Further information on the work of NCEPOD is on their website www.ncepod.org.uk.

Academy of Medical Royal Colleges and Faculties in Scotland
It is my great pleasure to report that John Colvin has been elected the next Chairman of the Scottish Academy. He will succeed Professor Sir Neil Douglas at the Academy’s meeting on 15 June 2010. For the last two years John has been Chairman of the College’s Advisory Board for Scotland and has a well earned reputation for being an astute advocate for anaesthesia within the Scottish Government and at the Academy. His strengths are many but I have been particularly impressed by his grasp of the intricacies of workforce planning.

Faculty of Intensive Care Medicine
At 12 noon, on Monday, 17 May, a press release announced the establishment of the Faculty of Intensive Care Medicine of the United Kingdom. The timing was perfect; it coincided with the meeting of Council of the Intensive Care Society (ICS) and enabled Bob Winter, President of the ICS, to announce the news at the Society’s Annual General Meeting the next day. In recognition of her contribution to this momentous occasion, it was my great pleasure to read an abbreviated citation for Judith Hulf as the Society granted her Honorary Membership (see www.ics.ac.uk for the full version).

Clinical Excellence Awards
The build up to the next round of National Awards will be well and truly under way by the time you read this; please refer to the timetable for 2011 below.

Those of you who are involved in the process in England and Wales should already have been contacted by your Regional Assessor asking for submission of your ACCEA forms to them for the sieving meeting that is run regionally prior to the College meeting on 1 October. The process is very tightly compressed over the summer months so please submit your forms now if your local deadline has not already passed. The College is keen to help but can only do so if your forms are well written and reach us in time.

Timetable for ACCEA 2011

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline for CVQs to be submitted to Regional Assessors</td>
<td>Regional Assessors will notify you of the deadline for your Region</td>
</tr>
<tr>
<td>2011 Guide available on the ACCEA website</td>
<td>*July 2010</td>
</tr>
<tr>
<td>2010 round results available</td>
<td>*August 2010</td>
</tr>
<tr>
<td>Deadline for each Region to submit CVQs to the College</td>
<td>1 September 2010</td>
</tr>
<tr>
<td>Online system for 2011 round available on ACCEA website</td>
<td>*1 September 2010</td>
</tr>
<tr>
<td>College ranking meeting</td>
<td>1 October 2010</td>
</tr>
<tr>
<td>Closing date for receipt of all applications, ranked lists and citations</td>
<td>10 December 2010 at 5.00 pm</td>
</tr>
</tbody>
</table>

*approximate dates provided by ACCEA

Dr Judith Hulf receiving her Honorary Membership from Dr Bob Winter
Guest Editorial

Survey of training opportunities for paediatric anaesthesia in the UK

After discussions between the Royal College of Anaesthetists and the Association of Paediatric Anaesthetists (APAGBI) about competencies for paediatric anaesthesia and their acquisition, it was agreed that a national survey of training opportunities would be undertaken.

The Royal College of Anaesthetists states that consultant anaesthetists employed in general hospitals must be capable of dealing with any patient admitted whilst on-call. Consequently, they require a ‘broad and balanced’ programme of higher level training, normally including obstetric, paediatric, cardiothoracic and neuroanaesthesia. Paediatric anaesthesia is one of the five essential units of training at higher level. In the new curriculum for the CCT in anaesthesia, all trainees are expected to complete higher training in paediatric anaesthesia during their final three years in order to consolidate their experience. Although this would be completed ideally as a single block of training, the College has previously stated that these competencies may be acquired ‘piecemeal’ throughout a rotation.1–2

The perceived problem
A number of recent publications have highlighted concerns amongst trainees with regard to their training in paediatric anaesthesia. A national survey of more than 500 trainees found that 34.7% felt that their training in paediatric anaesthesia was not adequate.3 A joint survey conducted by GAT and the APAGBI also found that many trainees lacked confidence when managing children under the age of five years. Many felt that their confidence would be improved by an additional block of training in paediatric anaesthesia as they neared the completion of their CCT.4 These surveys focus particularly upon the training of those individuals who aspire to become consultant generalist anaesthetists, many of whom will need the skills to manage and stabilise sick children admitted to district general hospitals during their future consultant roles.

Those wishing to pursue a career either with a paediatric interest, or as a specialist paediatric anaesthetist, are required to complete a further year of advanced training in paediatric anaesthesia. A recent retrospective analysis of caseload conducted by a specialist centre reveals that the mean number of cases performed by trainees has fallen by 24% since the staged introduction of the EWTD in 2004.5

Current organisation of training in general hospitals in the UK
With permission of the Royal College of Anaesthetists, all College tutors in the UK were sent an electronic questionnaire requesting information about trainees, rotations and training opportunities for paediatric anaesthesia. The questionnaire had two limbs: one for completion by those working in specialist paediatric hospitals, the other directed to all other types of hospital. The fundamental questions addressed by the questionnaire for those working outside specialist centres asked:

➤ Whether there were paediatric patients listed for surgery in the given hospital.
➤ Whether trainees were assigned to these lists and able to attend them.
➤ If there was under utilised training capacity, where was it, and why?

For those working in specialist centres, an analysis of the numbers and grades of trainees was undertaken. The common perception that such centres prefer trainees with a stated interest in paediatric anaesthesia, was challenged.
Guest Editorial

Ninety percent of replies stated that there were paediatric services in their hospital. These hospitals were distributed through all 29 schools of anaesthesia within the UK. They comprised 72 large district general hospitals (DGHs), 38 small DGHs, 31 university teaching hospitals, 11 specialist children’s hospitals, and two remote or rural DGHs. Although there are nominated consultants with responsibility for paediatrics anaesthesia in 84% of centres, 86% had no separate paediatric on-call rota.

Analysis of the data from the non-specialist centres reveals a large range of trainee numbers and grades, and this reflects the range of hospital types. Of particular interest are the number of pre- and post-CCT fellowships, and the proportions of the different training grades (see Figure 1).

The lowest age limits for elective and emergency surgery are shown in Figure 2. Most centres have a cut off of between one and two years of age for all surgery, although some commented that the age for emergency treatment would depend upon which consultant anaesthetist was on-call. Some stated that they would anaesthetise younger children than was given in their answers for minor procedures.

The number of exclusively paediatric lists per week is shown in Figure 3, and the number of paediatric cases per month is shown in Table 1. There are no exclusively paediatric lists in 17.5% of hospitals, and one or two a week in 30%, but 90% have combined paediatric and adult lists which tend to be ENT, trauma and emergencies. Just over half the centres operate on between 40 and 200 paediatric cases per month. The nature of the paediatric workload is shown in Table 2, ENT and dental lists being the most common.
Specialist hospitals
The data from the 11 specialist paediatric hospitals were analysed separately, and show that more than 12 trainees are usually allocated at any given time to 45% of these centres. More than half never accept ST1–2 trainees. This is mainly because of a lack of capacity, with training slots being reserved for the more senior trainees. Of those that did offer attachments to junior trainees, these were usually rotations of four weeks’ duration. Three-month attachments are commonly offered for SpR training, although one centre only offered attachments for higher and advanced training.

All 11 centres accept trainees aspiring to careers as generalist anaesthetists, rather than reserving slots for those with a special interest in paediatric anaesthesia.

Improving opportunity
At present, there is a large amount of training capacity in paediatric anaesthesia which is underutilised, and many College tutors are aware of this. No doubt the implementation of the EWTD has reduced the number of trainees present on any given day and, of course, there needs to be a balance between training and continued service provision within any institution. However, both of these will impact upon all aspects of key training, and the results of previous surveys of trainees’ experience in paediatric anaesthesia illustrate that many lack confidence when it comes to managing young patients.

Most of the College tutors surveyed work in hospitals without separate paediatric rotas. The consultants of the future must be equipped with the necessary skills to perform their duties to the best of their ability, and with confidence. It should be remembered

Table 1
Estimated number of paediatric cases per month in non-specialist hospitals

<table>
<thead>
<tr>
<th>Number of paediatric cases per month</th>
<th>Response %</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>30.1%</td>
<td>31</td>
</tr>
<tr>
<td>&lt;100</td>
<td>42.7%</td>
<td>44</td>
</tr>
<tr>
<td>&lt;200</td>
<td>13.6%</td>
<td>14</td>
</tr>
<tr>
<td>&lt;400</td>
<td>8.7%</td>
<td>9</td>
</tr>
<tr>
<td>&lt;600</td>
<td>3.9%</td>
<td>4</td>
</tr>
<tr>
<td>&lt;800</td>
<td>1.0%</td>
<td>1</td>
</tr>
<tr>
<td>&lt;1000</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>

Table 2
Nature of paediatric lists in non-specialist hospitals

<table>
<thead>
<tr>
<th>Paediatric lists</th>
<th>Response %</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>68.8%</td>
<td>77</td>
</tr>
<tr>
<td>Urology</td>
<td>50.0%</td>
<td>56</td>
</tr>
<tr>
<td>ENT</td>
<td>83.9%</td>
<td>94</td>
</tr>
<tr>
<td>Dental</td>
<td>80.4%</td>
<td>90</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>49.1%</td>
<td>55</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>56.3%</td>
<td>63</td>
</tr>
<tr>
<td>Plastics</td>
<td>23.2%</td>
<td>26</td>
</tr>
<tr>
<td>Imaging</td>
<td>39.3%</td>
<td>44</td>
</tr>
<tr>
<td>Medical</td>
<td>16.1%</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>16</td>
</tr>
</tbody>
</table>

Table 3
Frequency of trainee allocation to paediatric lists in non-specialist hospitals

<table>
<thead>
<tr>
<th>Frequency of trainee allocation to paediatric lists</th>
<th>Response %</th>
<th>Response count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20%</td>
<td>8.2%</td>
<td>9</td>
</tr>
<tr>
<td>20–39%</td>
<td>9.1%</td>
<td>10</td>
</tr>
<tr>
<td>40–59%</td>
<td>21.8%</td>
<td>24</td>
</tr>
<tr>
<td>60–79%</td>
<td>29.1%</td>
<td>32</td>
</tr>
<tr>
<td>80–100%</td>
<td>31.8%</td>
<td>35</td>
</tr>
</tbody>
</table>

The frequency with which trainees are allocated to lists with paediatric patients is shown in Table 3. Only one-third of lists have trainees allocated more than 80% of the time. Even when a trainee is assigned to a list containing paediatric patients, only 40% of trainees are able to attend the list for more than 80% of the time. These figures illustrate considerable missed opportunities for training in paediatric anaesthesia. The reasons given include a reduction in trainee numbers, and service commitment elsewhere (especially for more senior trainees), but individual comments also stated that some lists are covered by staff-grade doctors (presumably without trainer status). Training opportunities also appear to have been reduced following implementation of the EWTD.

Although over half of the centres do not offer paediatric anaesthesia as a formalised training module, over one-third still sign off assessment forms for training in paediatric anaesthesia. This reinforces the notion of competency based rather than time based training, and clearly demonstrates that there are training opportunities within these centres.

Fifty percent of College tutors feel that paediatric anaesthesia is an under-utilised training opportunity within their hospital. Individual comments explaining the reason include the commitment of trainees to other training modules or to service provision, and reduced trainee numbers within DGHs, often at the expense of filling quotas in the teaching hospitals in order to make rotas compliant.
that paediatric anaesthesia is now one of the five essential higher units of training, and capacity already exists to provide this training, although not necessarily as a defined paediatric block. Skills should be acquired and reinforced throughout any training programme, not reserved for practice within a given ‘module’ only. The nature of training in anaesthesia is changing, and we should strive to provide the highest quality within the confines of the EWTD, and the current length of the training programme. One answer in the future may be to develop movement of trainees within or between schools of anaesthesia, to help to address particular training needs, be they paediatric or within any other sub-speciality, using a model where trainees are mapped to vacant training opportunities for short attachments.

For those wishing to develop an interest in paediatric anaesthesia, a period of advanced training is required. Due to the changes in the working patterns highlighted above, the caseload undertaken during these training periods has reduced. It is interesting to note the increasing number of post-CCT fellowships being offered by the specialist centres. In reality, a period of post-CCT training, either in the UK or abroad, is likely to become the norm for those wishing to sub-specialise in any given area.

Acknowledgement
The authors would like to extend their thanks to all the College tutors who gave their time to complete the questionnaire.

References

Guidance on the Provision of Paediatric Anaesthetic Services
In April 2010, the RCoA guidance for the provision of paediatric anaesthetic services was updated. Two significant amendments, together with the reasons are outlined below.

‘All consultant anaesthetists with a CCT or equivalent will have obtained paediatric anaesthetic training as STs, following which they should, as a minimum, have been assessed as competent to provide perioperative anaesthetic care for common surgical conditions, both emergency and elective, for children aged 3 years and older.’

This is a reduction from the previous age limit of five years of age, because the College wishes all trainees recommended for a CCT to be competent in a wide range of skills, especially those applying for posts as consultants in smaller district general hospitals. This is because:

➤ There is a desire to see as much surgery performed as close to the patient’s home as possible. Although this depends upon the availability of competent surgeons, the anaesthetic service must be able to provide cover – obvious examples being minor cuts and injuries requiring a general anaesthetic.

➤ All consultants working in such hospitals with unrestricted 24 hour access emergency departments, should be able to resuscitate and stabilise any child prior to transfer if needed. Consequently, the younger the child such consultants are competent to manage in routine practice, the better will be their ability to manage sick or injured children of any age needing transfer.

‘The on-call consultant has a duty to deploy staff appropriately. Patients being transferred should normally be accompanied by a doctor with relevant training and experience in paediatric life support including advanced airway management skills, who should be accompanied by a suitably trained assistant. It is the responsibility of the hospital management to ensure adequate and appropriate staffing levels.’

Whilst the consultant’s duties are clearly stated, it is notable that the responsibility of management is addressed for the first time.

Reference
www.rcoa.ac.uk/docs/GPAS-Paeds.pdf

Dr A A Tomlinson
Vice-President and Chairman of the Curriculum Editorial Board
Out of programme experience (OOPE) in acute medicine

On my first day as a medical SHO, I walked into the medical seminar room wondering what to expect. Nervously, I met the clinical lead in medicine, and the rest of the general medical team at King’s College Hospital, London. As I scanned the packed seminar room, I noticed a few familiar faces; maybe I had seen them in the corridors of the hospital, or whilst taking a referral to the intensive care unit.

It was my responsibility to work on the acute medical ward, and as I introduced myself to the team as a new medical SHO, the clinical lead added: ‘Ravi is here to gain experience in acute medicine for his intensive care training, and he is a 2nd year anaesthetic registrar.’ Immediately, I sensed a change of attitude in my new colleagues, as if they felt that they would benefit from a symbiotic learning process. And so it turned out, as I embarked upon a six-month journey into the world of general medicine, a stark contrast to the world to which I was accustomed.

Journey down the valley – is it necessary?

My interest in intensive care medicine influenced my choice of anaesthesia as a career. Having no prior general medical experience, I felt that I needed to complement my anaesthetic knowledge with a short period in medicine, a standard requirement for the dual CCT in anaesthesia and intensive care.1 Although I did not know what to expect from my six months of training in acute medicine, I knew what I wanted to gain from it. I wanted further exposure to medical care, and the treatment of common conditions that we do not manage as anaesthetists, as well as understanding the problems faced by medical teams. I was surprised that the competencies that I was expected to achieve were already well within my skill remit as an anaesthetist. I realised that it was ‘medical confidence’ that I needed, enabling my future interaction with medical teams to be more productive after this attachment.

The learning curve, and those ward rounds...

Acute medicine involves that part of general (internal) medicine concerned with the immediate and specialist management of adult patients suffering from a wide range of conditions, who present to the hospital as emergencies. The specialty concentrates on the early phase of care, typically between 24–72 hours, but may also involve the management of the patients until the acute illness has been treated, and the patient is fit to be discharged. Table 1 lists some of my duties as an SHO in acute medicine.

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>Supervise, monitor and assist foundation trainees and other junior members of medical staff in the day-to-day management of inpatients.</td>
</tr>
<tr>
<td>2</td>
<td>Take part in rostered ‘on-call’ duties.</td>
</tr>
<tr>
<td>3</td>
<td>Write up discharge summaries.</td>
</tr>
<tr>
<td>4</td>
<td>Undertake workplace-based assessments as outlined in the acute medicine curriculum.</td>
</tr>
<tr>
<td>5</td>
<td>Attend teaching sessions in general internal medicine with other trainees.</td>
</tr>
</tbody>
</table>

Ward rounds would last for up to four hours, and on a normal day would leave only the same amount of time to finish all of the jobs required. My tasks suddenly turned from practical and skill oriented to administrative, chasing investigations, ordering scans, liaising with GPs, titrating medications – to say nothing of the endless clerking. There
were limited opportunities to attend outpatient clinics and to perform invasive procedures such as pacing wire insertion, bronchoscopy, or assisting in endoscopy. As an anaesthetic trainee with a different complement of skills, I was treated as a cannulation and phlebotomy expert, and years of experience in anaesthesia and intensive care were limited to performing lumbar punctures, ascitic drain insertions, or an occasional chest drain insertion. Managing patients by means of titrating medications and dealing with the limited resources available was an art that I had yet to master. I had imagined a more senior role in the medical team as I realised that I was no longer a ‘registrar’. It was somewhat difficult to become accustomed to this change in responsibility.

On-call duties were divided between covering acute medical emergencies from the emergency department, and covering medical emergencies already on the ward. Patients presented with a wide range of illnesses, and the experience of dealing with such a case mix was invaluable. The medical management of patients was more ‘protocol led’ than that which I had previously experienced in intensive care. Most of the recent medical guidelines are published on the websites of the Royal College of Physicians (RCP) and Scottish Intercollegiate Guidelines Network (SIGN).2–3

Although my working hours resembled those I had worked previously in anaesthesia, I felt as though I was working increased numbers of anti-social hours, and I was exhausted by the end of shifts. The work was never-ending, and prioritising became my major skill. As an anaesthetist I have often felt that I wait for patients to arrive – now the patients were waiting for me!

The assessment of the competencies gained was similar to the process in anaesthesia and intensive care, and included a clinical evaluation exercise (CEX), direct observation of practical skills (DOPS), case-based discussions (CBD), and multi-source feedback (MSF). Assessments and appraisal documents were web based,4 which differed from the paper-based assessment in anaesthetics. Although it was easier to get the assessment forms completed by the medical registrar during on-calls or ward rounds, getting such forms assessed by the consultant needed a bit more work, because I met the consultant, on average, only twice a week.

There were plentiful opportunities for the teaching of the juniors. In fact, I realised that I had a wealth of experience to share, and ensured that juniors gained from my experience during ward rounds and coffee breaks, even if time was limited! My medical knowledge improved with constant patient interaction, as opposed to formal teaching. Teamwork is an imperative in medicine, and I really enjoyed the experience of being part of a team, with varying responsibilities and experience.

**The down side**

As anaesthetists and intensivists, we are spoiled by the ease with which we can access resources. I felt frustrated by the time taken to do the same in a medical environment. There was a lack of fundamental equipment available for immediate use on the wards, ranging from monitoring to lumbar puncture kits. I have always been used to accessing what I need without waiting, and sourcing the right kit myself was time-consuming and frustrating.

Manpower is also definitely stretched in medicine, and I felt sympathy for the nurses when I asked them to complete a list of tasks for a patient, knowing that they were caring for an entire ward. They are stretched to the limit, and would benefit from increased numbers, as would the quality of patient care. This makes me wonder how things can ever improve if the current reports about job cuts in the NHS turn out to be true.

Furthermore, I had never realised that social problems comprise such a large part of medical management. Physiotherapists, occupational health and social workers constitute the mainstay of the continuity of care for patients being discharged safely back to the community. Sometimes patients would wait to be discharged for days whilst social packages were arranged, and I found this quite disheartening, particularly when many of our ward round notes stated ‘clinically stable, awaiting care package’.

With the introduction of the Working Time Directive (WTD), I became aware of how ‘junior’ my trainees were. They work hard during their shifts, and yet do not benefit in the way that I did, as a junior doctor working longer hours. The learning curve is now much more gradual, and this was made obvious by the uncertainty in some of their clinical decision making.

**Back to the basics!**

I am glad that I have experienced the ‘world of general medicine’, and its stark contrast to the anaesthetic world to which I am accustomed. I have gained insight into the practical problems encountered in ward management and how we, as anaesthetists, are perceived by our fellow medical colleagues. Whilst we are regarded as knowledgeable and approachable physicians, we, in turn, don’t always realise the limitations...
Trainees’ Topics in Anaesthesia

faced by others in their day-to-day medical practice. In the future, I will understand and sympathise more with the dilemmas faced by a medical registrar, when making a referral to me as an intensivist. I have also acquired confidence in my management of medical patients, something that I would have questioned had I not undertaken this OOPE. Although most anaesthetists will have gained some exposure to acute medicine during their early days as a trainee, I wonder whether such valuable experience will be lost in future training.

I have emerged from my six months of training in medicine with great respect for the medical team. They are stretched to the limit by the workload and lack of resources, and burdened by social issues that often inhibit progress of care. I would recommend this OOPE to anyone who wants to develop as a physician, and wishes to see a different aspect of hospital life.

Acknowledgement

I would like to record my thanks to Dr C Bryant, Consultant Physician at King’s College Hospital, London.

References

2. www.rcplondon.ac.uk/Clinical-Standards/Pages/Clinical-Standards.aspx.

with The Lancet’s tongue very much in its cheek – maybe ...

Jonah’s residence in the whale’s belly accounted for on physiological principles, by Dr Pearson.

Physiological facts are never more interesting than when they are found to confirm the great truths of our religion, and to afford a satisfactory explanation of phenomena which infidels have treated with derision, without the necessity of resorting to a miraculous agency. Dr Pearson, of George-street, Hanover-square, in lecturing a few days ago upon the stomach, observed, that this organ had no power over substances endued with vitality; and that this circumstance accounted for the fact of the prophet Jonah having remained undigested in the stomach of the whale for the space of three days and three nights. Dr Pearson’s discovery is highly important, both in a medical and theological point of view: it furnishes a complete answer to all the objections which have been urged by sceptics against that part of the Sacred Volume in which this singular adventure is related. How the prophet passed his time in the cavity of the whale’s stomach – how far the confinement affected his organs of respiration – in what manner he derived his sustenance, or whether he required any sustenance at all, are all questions of minor importance. The fact of the stomach having no power over vital substances having been once established by Dr Pearson, the corollary is obvious. The argument may be thus stated: When Jonah entered the whale’s stomach, either he was alive or he was not alive. If he were not alive, the stomach would have had the same power over him as over any other inanimate substance, and the prophet would have been digested in the ordinary way; but he was vomited out alive on the fourth day: consequently he was alive when he entered the stomach. Now, as he was alive when he entered the stomach, and as the stomach has no power over a living substance, it is evident that he must have continued to live. Hence, when the action of vomiting was excited, and he was thrown up on the fourth day, he was deposited on the dry land, probably without any other inconvenience than some trifling derangement of his canonicals. Dr Pearson deserves the thanks of the pious, as well as the philosophical part of the community, for having explained this phenomenon in a manner which renders it as demonstrable as any of the propositions of Euclid.

* * * * * * * * * * *

So now we know – but please don’t tell Richard Dawkins.

Reference


David Zuck

History of Anaesthesia Society
Trainees’ Topics in Anaesthesia

Reforming the induction process requires a complete change in focus

It was with a heavy heart that I agreed to audit the induction process at a London teaching hospital. In my experience, mentioning the words ‘induction process’ to colleagues elicits deep sighs, and significant eyebrow raising.

Dr S Hammond
Specialty Registrar (ST7B), Royal Surrey County Hospital, Guildford

The National Health Service Litigation Authority (NHSLA) states that the purpose of induction is ‘to enable new staff to feel orientated within the organisation and confident and competent to undertake their role’. After completing the induction programme at my trust, one-third of doctors questioned did not feel that the process lived up to this expectation, and some elements were rated as useful by less than 20% of new starters. Despite the Royal College of Anaesthetists, the AAGBI, Department of Health and PMETB all rating the importance of induction highly, it seems that the present process has lost sight of its true purpose.

Why isn’t the current system working?
There is a significant strain on all departments during changeover, as trainees are unavailable for increasing amounts of time, often emerging from induction lectures seemingly no better prepared to perform the day job than if they had not bothered to attend. It seems that we love to hate induction, and it’s not hard to see why most trainees and consultants are disillusioned with the current process. Anaesthetists provide an acute out-of-hours service in high risk areas, and should deserve an induction which reflects this. It is unacceptable to allow a group of professionals to muddle through the first few weeks of their job, trying to manage as best they can because of the system.

Induction consists of two main components: the trust or corporate induction, followed by the departmental or local induction. Aspects of the trust component are governed by bodies stipulating mandatory inclusion, and in part determine a hospital’s risk assessment and, therefore, financial contribution to the NHSLA scheme. For example, requirements from health and safety legislation, Care Quality Commission, and NHS London all determine the content of the day before any consideration of the real needs of the new starters. This ensures that reforming the process is incredibly difficult.

A familiar experience?
Currently, a trainee on a hospital specialty rotation could sit through more than 15 of these compulsory programmes. The veteran trainee knows that priorities include visiting human resources, security, and IT, in order to get paid, obtain an ID badge, and passwords for the computers respectively. This must be expedited to ensure access to relevant clinical areas and patient results, because failure to achieve such in a timely manner results in subsequent weeks of ‘aggro’ and wasted time. Unfortunately, these tasks are often frantic pursuits during coffee time, because they may not be included in the timetabled events. Instead, it is mandatory to listen to a set of lectures with random content, including what to do when the settee catches fire in outpatients, followed by a long wait to be bled (again) by occupational health.

Trusts are aware of the disengagement that they face from trainees, and so the latest vogue is for compulsory online ‘e-modules’ to be completed in personal time. These ‘prove’ coverage of certain topics with varying threats of loss of study leave or certain privileges if not completed within an allocated time frame. Only 17% of the trainees whom I surveyed...
found the ‘e-induction’ a useful exercise, but this may be because much of the material was a duplication of the lectures already attended. Because e-learning is an evolving resource, online modules could be potentially useful clinical training opportunities if they were specialty specific. For anaesthesia, a quick module on the new transfusion guidelines, or a quiz about correct prescribing on the new drug chart, would familiarise trainees with new policies and documents, with obvious patient safety advantages.

Asking the people who matter
There are recommendations about how to improve the process. Most recently, the London Deanery stated that it was ‘important to take into account what doctors want and need to know rather than deluging them with everything and anything’. In 1998, an article in the BMJ entitled ‘Improving quality in hospital induction programmes’ made some exceptionally pertinent comments:

‘Effective doctors must master the hospital infrastructure as well as their specialty’ and ‘currently most program-mes and topics are chosen by senior staff, though there are recommendations which suggest that trainees should be involved in the planning, selection, implementation, and evaluation’. This article also highlighted that ‘there is little evidence that programmes are evaluated for their usefulness or value to the trainees who attend’. Unfortunately, there appears to have been little progress since 1998. I have never been asked to provide feedback on the usefulness of an induction programme, nor given the opportunity to suggest how one could be improved.

Going to the top
Following my questionnaire of trainees’ opinion on induction, I met and discussed my findings with the people involved in organising the trust’s component. Apparently, they see one of the main purposes of corporate induction as a logistical opportunity to get as many new starters through mandatory training as possible. Because all new employees have to sit through a trust induction, it was difficult for them to understand why junior doctors should receive different treatment. I explained that the criticisms of this aspect of the induction process related to a doctor being able to perform their role safely and effectively out-of-hours, from day one, when there are not people around to help. In our survey, over two-thirds (68%) of new starters were on-call within the first 24 hours, and the majority (57%) felt that this had a negative impact on the induction process.

The trust has since developed a blanket policy: no new starter should work the first night on-call in the trust. At the last changeover, arranging out-of-hours cover proved to be a logistical nightmare for the anaesthetic department, as the vast majority of anaesthetic trainees were moving on. Using locums as a stop gap for one night is probably no better, and may be worse, than using new trainees. If more trusts adopt this policy, a solution could be for consultants to provide the out-of-hours service for the changeover night.

I also requested certain fundamental information that should be provided during trust induction, rather than an assumption that it be provided at departmental level. Some agreed action points from this meeting included:

➤ The introduction of ‘working in the hospital at night’ – the infrastructure, people around, services provided, logistics of getting things done.
➤ The appointment of a senior trainee to attend induction planning meetings.
➤ Asking for feedback.
➤ Reforming e-induction to be more clinically useful.

Anaesthetic department induction: friend or foe?
Traditionally, the local departmental induction has been the most clinically useful for familiarising trainees with the job they are about to undertake. The first week of August is now the major changeover period in my region, and so a massive cohort of new starters appears in the anaesthetic department, expecting to be orientated. However, the questionnaire results demonstrated that this proved to be an unpredictable and an underutilised opportunity to impart and instil key information to new members of the department. This is consistent with the findings of an independent PMETB survey. Trainees commented that they were not shown around key clinical areas, neither were they provided with useful departmental information. The RCoA recognises that common reasons for failure include inadequate time provision, and a lack of commitment to the programme. This can result from trainees arriving in the department at unpredictable times, depending upon how efficient the trust part of the programme is, creating difficulties with the planning, and in part because clinical commitments on the changeover day do not permit spare senior staff
to conduct an induction in any sort of reliable fashion. Would it not be appropriate to scale down clinical duties on changeover day, allowing trainees to be induced without the inevitable disruption to operating time?

Following the questionnaire results, the department acknowledged changes needed to be made, and has made the following commitments to reforming induction:

➤ The appointment of a nominated induction consultant to take responsibility for, and co-ordinate, the induction process. The aim of this is to ensure the consistency and quality of information delivered, and to allocate sufficient time for orientation around the hospital, including key areas such as A&E. This is a new role, but could be one suited to the College tutor.

➤ A sub-specialty induction should take place to familiarise trainees with the new working area, because this is a large teaching hospital where most trainees rotate through four different areas in a year.

➤ Trainees should evaluate each induction, helping to improve the process and address the changing needs.

My re-audit of the process, following the introduction of a presentation and tour of relevant areas, highlighted that trainees wanted more time for familiarisation in certain clinical areas where equipment differed from the rest of the hospital.

My involvement in this project has altered my opinion of induction enormously. Asking trainees about their experience has provided me with a clearer understanding of how the process should work. It is imperative that induction changes from a management driven tick box exercise, to one that focuses upon the needs of the junior doctor, especially during the management of services out-of-hours. It is absurd that a process whose purpose is to enable new doctors to perform their role effectively, has no significant contribution from this actual group. Junior doctors must be empowered, and provided with the opportunity to contribute to reform. By ensuring that junior doctors receive the knowledge, skills and equipment necessary to undertake their roles from the outset, hospitals will be inherently safer places in the month of August.
In the May issue of the Bulletin, we reported the establishment of a working group to review aspects of the College’s proposed scheme and matrix for continuing professional development (CPD). One of the main aims is to ensure that the College’s CPD scheme is fit for purpose, and that it meets the core principles for CPD required by the General Medical Council.

**GMC principles for CPD**

Since the publication of the CPD matrix for consultation on the College’s website, the GMC has published its consultation document ‘Revalidation: The Way Ahead’. In it, the GMC states that doctors should:

‘Identify their professional needs and competencies and take into account the needs of patients and the healthcare system when planning their CPD’, ‘plan and participate in a wide range of CPD covering the scope of their practice’, and ensure that learning is ‘relevant to the current and emerging knowledge and skills relevant to their specialty, practice or areas of professional responsibility and development’.

The importance of reflecting on practice and evaluating that which has been learnt from CPD activity is stressed, as is the impact of CPD on improving practice.

**The College CPD scheme**

As the College refines its CPD scheme and new online system, these principles will guide our final advice for anaesthetists. For example, we have received a number of suggestions about how to refine our matrix of core, higher and advanced CPD. One of the first tasks of the CPD working group has been to review the content of the matrix, particularly level 1 (core), where broader topics will assist anaesthetists better in planning CPD. Currently, guidance on appropriate CPD for anaesthetists and appraisers is lacking. The College’s CPD matrix and associated guidance will help anaesthetists to plan their CPD over a five-year cycle, and act as a guide to appraisers with regard to the content that is appropriate.

**Online CPD system**

The College recognises that, as well as providing assurance that doctors are fit to practise, revalidation is a formative learning process. The RCoA’s online CPD system supports this through the CPD matrix, a personal development plan (PDP), and the need for reflective review.

The online CPD system will be available without charge to fellows and members from the autumn of 2010. Included within it will be the following features:

- A CPD diary which allows the user to record activity and add a reflective review.
- The ability to link CPD activity to topics in the matrix and personal learning resources.
- A searchable database of College CPD accredited courses encompassing CPD topics, titles and keywords, and the ability to subscribe to individual courses in CPD diaries.
- A personal development plan linked to the CPD diary.
- CPD certificates providing a summary of annual and five-yearly CPD when completed.
- A breakdown of credits gained from internal, external, clinical and professional CPD.
- Integration with e-Learning Anaesthesia (e-LA). Time spent on e-learning, including assessments such as MCQs, will be able to be passed to the online CPD system via a data import, rather than the user inputting this information manually.

**Strengthened medical appraisal**

A central element of revalidation is ‘strengthened’ (or enhanced) medical appraisal. The NHS Revalidation Support Team has proposed that all appraisers should be selected based on a pre-defined person specification and job description, and that they be adequately trained and equipped. We support some, but not all, of what is being proposed. We are working with the other royal colleges to consider specialty specific considerations relevant to the training of appraisers. This is important, because appraisers for anaesthesia will be required to evaluate appraisees as specialists, whether in the practice of anaesthesia, intensive care or pain medicine.

Related to the training of appraisers is the development of the role of the lead appraiser in each department of anaesthesia, pain medicine and intensive care medicine. In June, we ran a successful all-day workshop involving regional and deputy regional advisers, members of our Revalidation and Appraisal Experts Group, and clinical leads and directors from departments of anaesthesia in hospitals undertaking the national revalidation pathfinder pilots. The aim was to develop specialty guidance for a training-the-trainers programme that can be used locally through the lead appraiser. We will publish a full report on the outcome of this workshop in a future issue of the Bulletin.

In addition to all of the above, we are developing short film clips and guidance materials about appraisal which will help, we hope, to demystify the concept of strengthened medical appraisal and bring to your attention some of the questions, answers and discussion points that will be raised during the process. These will be available on the College website later this year, and we are grateful to Professor Chris Dodds for leading on this project and for developing the scenes and scenarios for the film clips. We would also like to thank Dr Jim Watts and Dr Akbar Vohra in their roles as appraiser actors.

**Constructive feedback**

A number of Fellows and Members have expressed their feelings, thoughts and ideas to the College. We welcome them all, as they help to inform the development of policy, and enhance discussions with regulatory and government bodies about revalidation issues. We believe that the College really can influence the shape of revalidation, for the benefit of patients and doctors alike.

The next update on revalidation in the Bulletin will include a step by step guide to using the online CPD system. In the meantime, please visit our website: [www.rcoa.ac.uk/revalidation](http://www.rcoa.ac.uk/revalidation) for the latest updates on CPD or email revalidation@rcoa.ac.uk.

Ms S Drake, Director of Education
Mr D Liu, Revalidation Project Manager
The Faculty of Pain Medicine

News from the Faculty of Pain Medicine

In The Waste Land TS Eliot wrote, ‘April is the cruellest month’, and so it seemed on Easter Sunday this year when Ed Charlton died. Although already retired from the NHS when the Faculty was formed, Ed was overjoyed at the creation of the organisation and was proud to become a Foundation Fellow. Ed spent over 30 years advancing the cause of pain medicine on the national and international scene. He was present at the now legendary meeting when the formation of the International Association for the Study of Pain was mooted. He went on to become Secretary of IASP and most latterly, in 2005, edited the Third Edition of the IASP Core Curriculum for Professional Education in Pain that now underpins our own curriculum for advanced training in pain medicine. Ed made a massive contribution to pain medicine and was one of the Faculty’s strongest supporters. He will be greatly missed.

Revalidation for pain medicine specialists

The short-life CPD Working Group established by the College met in late April 2010 to review aspects of the College’s proposals for CPD within the context of the whole revalidation package. The Faculty was represented. It is apparent that there have been significant shifts in attitude at many levels as is evidenced by the aforementioned (May Bulletin) General Medical Council consultation document ‘Revalidation: The Way Ahead’. The College’s Working Group has a tight timetable so it is impossible to predict what will have evolved by the time this Bulletin is published in July, but once again pain medicine specialists can be reassured by quotes from the GMC: ‘Revalidation is about what doctors do in their actual practice’ and ‘Continuing Professional Development (CPD) must be tailored to the specific needs and interests of individuals and their practice.’ I am optimistic that a satisfactory solution will be devised.

Publications

Revision is nearing completion of the 2002 joint publication ‘Recommendations on the use of epidural injections for the treatment of back pain and leg pain of spinal origin.’ A draft has been taken to RCoA Council because the new recommendations will have implications for any anaesthetist who does therapeutic epidurals (i.e. epidural steroid injections) and not just for pain specialists. Once we have agreement from the pain medicine and anaesthetic fraternities we will consult more widely. Some of the potential difficulties relate to recommendations about the venue (always an operating theatre?), the need for nil by mouth, and the use of fluoroscopy.

Faculty business

Daniel Waeland and Natalie Lowry have revolutionised the administration of the Faculty so that we now have some highly efficient systems in place. We have identified a range of short-term, tactical improvements as well as long-term, strategic developments that will strengthen the organisation. Daniel was the prime mover in the production of the first edition of Transmitter, the Faculty Newsletter. Very good progress is being made in the development of the examination for the Fellowship of the Faculty. Examiners for the examination are being recruited and there will be opportunities for more and more Fellows to contribute to other enterprises. We look forward to this greater involvement and welcome your input.

Dr D M Justins
Dean
The National Institute of Academic Anaesthesia (NIAA) has been established for two years, and so it is worth recording what has been achieved, and postulating on the future.

The NIAA has demonstrated clearly that anaesthetic organisations can work together successfully on a national level to support our academic profile. The initial funding partners of the Research Council of the NIAA (RCoA, AAGBI, BJA, and Anaesthesia) have worked productively in committee, forming new and genuine relationships. Others have now joined the Research Council, including the Obstetric Anaesthetists’ Association, Society for Education in Anaesthesia UK, Association of Cardiothoracic Anaesthetists, Anaesthetic Research Society, Neuroanaesthesia Society of Great Britain and Ireland, and the Association of Paediatric Anaesthetists of Great Britain and Ireland. The Research Council has completed four research grant calls, so far awarding £904,000 for anaesthesia research. This funding gives essential support to existing academic teams and to new researchers (both university and NHS affiliated). It also sends a clear national message that our profession is serious about the academic arm of our specialty, and is willing to work together in effective partnerships to deliver the resulting benefits.

After a comprehensive inspection of our grant assessment process, the NIAA has been awarded National Institute for Health Research (NIHR) partnership status. Although this was reported in the Bulletin recently, its importance cannot be over emphasised. NIHR partnership status indicates that NIAA funded clinical projects appear on the NIHR national portfolio and, therefore, are recognised as first class studies with real potential benefit for patients. Furthermore, studies are eligible for support from the NIHR research networks.

The research priority assessment exercise has produced substantial and credible results. Two proposals have been submitted to the Health Technology Assessment (HTA) for consideration of national funding. Furthermore, we have been in discussion with the NIHR service delivery and organisation funding stream, who have expressed an interest in our data. Our support of military academia has been particularly successful. Military colleagues are producing a significant and increasing number of academic outputs, enhancing their collaboration with civilian academics, and building a cohort of academic staff within the armed services.

The first NIAA academic trainee day was held in March. Included were lectures, discussions, and presentations of original work with prizes awarded. The feedback from this event was very encouraging, and we intend to hold further meetings on a regular basis. The NIAA Health Services Research Centre has now been established with Mike Grocott as its director. The precise portfolio is being defined, but there will be an initial emphasis on morbidity, mortality and developing outcome measures.

There are three priorities for the coming year. Firstly, we need to maintain the momentum of the first two years. Secondly, we must ensure the rapid success of the Health Services Research Centre, and, thirdly, ensure funding by members of the NIAA of high profile multi-centre clinical trials. The NIAA needs to involve more members of the profession at large, and we are keen to hear from you. We welcome feedback about our progress to date, our future strategy, and the involvement of anaesthetists in general in the affairs of the Institute. Please contact us if you would like to contribute – the light at the end of the tunnel is getting brighter!

One of the ways you can make an immediate contribution is to submit a design for a logo for the NIAA. The best logo, as judged by our Communications team, will feature on all our future material, and the winner will be announced in the next edition of the Bulletin.

Please send your designs to: info@niaa.org.uk
The joint RCoA and AAGBI SAS survey 2009

Dr R Laishley
Deputy Chairman

The SAS committees of the AAGBI and RCoA have undertaken a joint survey of all grades of SAS doctors working in anaesthesia, intensive care and pain medicine. It was completed in the fourth quarter of 2009, after 431 replies had been received. The 2007 RCoA census identified 1,879 SAS doctors, so this represents a response rate of approximately 23%.

Demographics
In comparison to 2007, SAS doctors are getting older, and 38% are now over 50, compared with 24% in 2007. The workforce is also represented by an increased number of females, up from 34% in 2007, to 42% now. Nearly one-third undertook their undergraduate medical education in the UK, and some 40% have the Primary FRCA from the UK or Ireland.

Employment and career support
Staff grades continue as the largest group, with specialty doctors accounting for 15%. Around one-third of associate specialists appear to have moved into the new contract. It was encouraging to see that only 3% are in trust grade posts that are not protected by national terms and conditions (possibly an under representation).

Perhaps surprisingly, for a group of doctors with a large service role, only 60% had an on-call commitment.

Encouragingly, most had sessions for audit and administration, and relatively few admitted to difficulties with obtaining study leave.

For the vast majority, an SAS post remained a career choice, most aiming to develop areas of interest. Some 12% were planning to re-enter training, possibly using the SAS grade as a provisional ‘stopping off’ point in their career.

There remains a big problem with support in the workplace. Disappointingly, very few had time or training for appraisal, only 27% had a mentor, and less than half had an annual job plan review. Only a quarter were aware of the welfare resource pack developed by the AAGBI.

Feedback
The many comments received suggested common themes of concern including:

➤ Article 14 applications
➤ Clinical supervision
➤ Contractual issues
  - Appraisal
  - Optional and discretionary points
  - Study leave
  - Reregistration
  - New contract implementation
  - Revalidation
  - Teaching/education

Of these, the vast majority concerned contractual issues. Our two SAS committees have sought to open dialogue with the SAS Committee of the BMA to seek a collaborative approach, and to identify mechanisms whereby progress can be made.

Summary
Difficulties in getting support, and opportunities for career progression within the SAS grade, remain, and this is a major challenge for our two bodies. However, there have been some encouraging developments. Many deaneries now have deans or associate deans with responsibility for SAS doctors. Employers are being encouraged to appoint SAS clinical tutors and mentors. The RCoA document on career development seeks to address these issues. Opportunities for teaching and training are available, for which we have an excellent resource. It is encouraging to see that some 10% of respondents have completed an educational supervisor’s course, and I urge you to use these skills to encourage and improve the opportunities available to our colleagues.

We foresee that future specialty doctors will have less experience initially and, undoubtedly, educational support will be valued. However, it remains inevitable that opportunities for career progression will be dependent to some extent upon individual enthusiasm and personal drive.

The publications by Professor Sir John Tooke2 and Lord Patel3 have a number of encouraging areas where SAS doctors can capitalise. PMETB (now subsumed within the GMC) has developed a credentialing working party. Whilst there are understandable concerns, especially regarding a possible restriction of practice, there may also be an opportunity to provide a framework that could lead to the acquisition of additional recognised training and experience.

Lastly, I would like to thank all of you for taking the time to get involved and for contributing to the survey.

References
Staff and Associate Specialists Committee

Survey results
Number of replies: 431

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### Qualifications

1. Where did you receive your undergraduate medical education?
   - UK = 138 (32%)
   - Outside UK = 291 (68%)

2. What postgraduate qualification do you have?

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3. What type of contract do you have?

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### Employment

4. How many years have you been in your current post?
   - <5 = 177 (42%)
   - 6–10 = 104 (24%)
   - >10 = 148 (34%)

5. How many notional half days or sessions or PAs are you contracted for per week?
   - 1–4 = 40 (9%)
   - 5–9 = 55 (13%)
   - >10 = 329 (78%)

6. If you are on the old contract, are you intending to change to the new contract (2008)?
   - Yes = 244 (71%)
   - No = 27 (8%)
   - Undecided = 71 (21%)

7. Do you have an on-call commitment?
   - Yes = 255 (60%)
   - No = 171 (40%)

8. Do you get a session/PA for pre- and post-op visits in your job plan?
   - Yes = 329 (78%)
   - No = 95 (22%)

9. Do you get a session for audit and administration?
   - Yes = 266 (62%)
   - No = 161 (38%)

10. Do you encounter problems getting study leave for CPD?
    - Yes = 69 (16%)
    - No = 358 (84%)

11. How do you anticipate developing your career?

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<thead>
<tr>
<th>Career Path</th>
<th>Number</th>
<th>Percentage</th>
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</thead>
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<tr>
<td>Remain in current post</td>
<td>106</td>
<td>22%</td>
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<tr>
<td>Remain in current post but with developed responsibilities/areas of interest</td>
<td>217</td>
<td>46%</td>
</tr>
<tr>
<td>Re-enter recognised training programme</td>
<td>57</td>
<td>12%</td>
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<tr>
<td>Change career but stay within medicine</td>
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<td>2%</td>
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<tr>
<td>Change to a non-medical career</td>
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<td>2%</td>
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<tr>
<td>Emigrate</td>
<td>17</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>12%</td>
</tr>
</tbody>
</table>
Appraisal

12 Do you have:
   a  an annual appraisal?  Yes = 368 (89%)  No = 46 (11%)
   b  an annual job plan review?  Yes = 201 (48%)  No = 217 (52%)

13 Have you received training for appraisal?
   Yes = 118 (28%)  No = 308 (72%)

14 Were you given protected time to prepare for your appraisal?
   Yes = 97 (23%)  No = 318 (77%)

15 Did you have a choice of appraiser?
   Yes = 236 (56%)  No = 184 (44%)

16 Do you have a mentor?
   Yes = 112 (27%)  No = 310 (73%)

17 Are you aware of the AAGBI Welfare Resource Pack and the Doctors for Doctors advisory helpline?
   Yes = 101 (24%)  No = 326 (76%)

Teaching

18 Do you have the RCoA 'Approved to Teach Certificate'?
   Yes = 93 (22%)  No = 337 (78%)

19 Have you completed an educational supervisor course?
   Yes = 43 (10%)  No = 387 (90%)

Your opinion

20 The remit of the RCoA is primarily about education, training, professional standards and patient safety, whilst that of the AAGBI involves education, professional standards and safety but also includes contractual and welfare issues. How well do you think the relevant SASC has supported SAS issues with regard to their areas of responsibility?
   (where 1 = totally unsatisfied, 10 = totally satisfied).

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You may think this a strange choice of topic for the outgoing Chairman of the PLG. I make no apology – where there is a live transmission of an operation being performed there is an anaesthetist involved, and my eight-year membership of the PLG has given me more insight into the issues than most lay people. When undergoing surgery, the patient depends on the knowledge and skills of the treating anaesthetist for their survival and well-being just as much as on those of the surgeon. As there was no anaesthetist in the invited audience at the Live Surgery Seminar at the Royal College of Surgeons of England in April, I would like to offer some lay feedback, before putting three questions to Bulletin readers.

During the introduction and overview of the range of applications for live surgery broadcasting (LSB) it became apparent that this seminar had come about because of disquiet which had increased with the Channel 4 series in May 2009 – should there be a UK policy? The first session debated the place of LSB in teaching, training and research. The member of council who spoke against has wide experience of being filmed for professional training purposes. His views included some strong language: ‘surgical ego is a frightening thing’, ‘there are a lot of exhibitionists around’, ‘suspect motivation’, ‘goes to the heart of medical ethics’. The director of education (an academic surgeon) then gave a history lesson, starting with the STEP distance learning courses in 1994, which seemed to be a precursor of e-learning, and the use of videos of laparoscopic procedures by the three national training centres, where many courses provide a DVD for students to take home. There was agreement that surgical trainees learn more from watching one error by an experienced surgeon, and how this is managed, than seeing 20 successes – I expect that this applies equally to trainee anaesthetists?

The editor of The Annals, a general surgeon, raised some interesting questions. Is on-line video publishing a gimmick, or a ‘must have’ accessory? Will it become almost obligatory, and if so how can patient anonymity be assured? Should online information try to serve both professional and patient interests? (His view is that although generic information may be helpful, it will not tell patients about a particular surgeon’s technique nor give them an understanding of the complication rate involved.) This was not discussed, but I think it will be, as my PLG RCSE counterpart was scribbling furiously on my left.

Session 2 had the air of an impeachment. The cardiothoracic surgeon who had starred in the C4 series opened by saying: ‘Why did I do it? Not for entertainment. I was shocked to see this word used as part of the title of this session.’ (Live Surgery as Entertainment and Education). His motivation was to help patients to realise that the skills at work are reproducible, teachable, and safe; to make people think about their own health; and to appreciate the beauty of the cardiovascular system. He also wanted to demonstrate the professionalism of the team at work (but rather spoiled this by later saying that it is vital for the surgeon to seize and maintain control of the operating environment). He emphasised that at all times the needs of the patient must come first, and described the meticulous planning involved, including the pains that he had taken to obtain fully informed consent, and assuring the patient that it would be possible to abort at a late stage. Even with pre-recorded film in the can as fall back, I am unconvinced that a patient would be psychologically strong enough to do this – might not the excellent doctor/patient relationship described cause the same anxieties as letting down one’s bridegroom by leaving him at the altar? The surgeon was supported by two young women, one from the Wellcome Collection (the venue for the interactive audience) and the other a film maker from the
company who produced the series for C4. They formed a sort of mini Greek chorus: ‘raise understanding’, ‘inspire next generation’, ‘feedback all positive’ and, ingenuously, (to the charge of entertainment) ‘not entertainment, as the film was produced by the factual programmes department’.

I asked a question. Although partly reassured by the description of the careful process of obtaining consent, I referred to the fact that when Japanese colleagues had met to agree guidelines for live surgery, the lawyer among the three lay representatives on the committee had asked the medical professionals who among them would be willing to be a patient in a live surgery session. Volunteers were there none, which caused the patient representative to enquire: ‘In that case, shouldn’t live surgery be prohibited?’ I asked: ‘What did these Japanese surgeons know that patients don’t? (About how live television affects performance).’ The reply was simply a repeat of what had been said, and a comment that the negative response was typical of a committee situation.

A council member proposed that a vote should be taken at the end of the afternoon to determine how many of the audience would volunteer to be a patient in such circumstances. In her view, the conditions for the C4 series were ‘sanitised’ and did not convey the daily reality of surgery. The speaker took exception to this. Another council member contrasted the circumstances with how he preferred to work with no distractions – was there not a risk for the focus of the whole team in knowing that everything is live and cannot be edited? Again, the speaker stressed that the meticulous planning and film crew rehearsals meant that disruption had been kept to a minimum. At what cost, I wondered? Although this was probably a model for good practice (assuming that the concept is acceptable) it may be more difficult to achieve with fewer resources.

Session 3 covered regulation, patient safety and ethics. The director of policy and communications at the Medical Protection Society wondered whether LSB actually delivered patient centred care. Was the intention to train and to inform, or was it just voyeurism and entertainment? She, too, wondered whether live transmission limited withdrawal of consent, and whether there was some financial or emotional coercion, and a ‘silent promise of preferential treatment’. (I suppose the patient is pretty sure they won’t be cancelled!) A well rehearsed top team would be fielded, prepared for the highest risk, but in terms of distraction could there be a lack of insight into the extent that judgement might be compromised while thinking about how performance will appear on live transmission? What price professionalism, as the custodians of the patient’s privacy, dignity, interests, safety and well-being? The deputy director of the Centre for Ethics in Medicine at Bristol University referred generally to legal judgements around proper medical treatment capable of withstanding logical analysis, before quoting from Prince Charles v Associated Newspapers (2006): ‘Does it strike a balance between individual and public interest?’ He observed that most of the debate related to professional teaching and education, and there seemed to be no support for LSB. Apart from educating future surgeons, is there a similar benefit for patients? Is LSB in the public interest, or merely interesting to the public? Should there be an Advisory Ethics Panel? (NB: if this comes to pass, I would like the RCoA to be represented).

In summing up, the president said that while there was no problem (with reservations) with real time filming for professional training purposes, there was no formal support by other organisations for LSB. There are safety issues around normal behaviour and a possible conflict of interest with consent. It is not enough to be a good technical surgeon, and it would be difficult to accredit surgeons for live surgery. He acknowledged that some people work better with an audience, and a ‘little showing off is not necessarily harmful’. (I don’t think that one should confuse leadership with showmanship!) Although he can’t see the RCS following AATS by banning LSB, there is a duty as a standard setting body to consider guidelines.

So – watch this space.

And now the questions:

➤ Do you think that LSB affects performance?
➤ Would you be prepared to be the patient in a live surgery scenario? If not, why not?
➤ If you would be willing to anaesthetise a patient in these circumstances, what would be your rules of engagement, and, ideally, what would you like to see included in any guidelines which might be produced (from the anaesthetist’s perspective?).

Further information

Surgery as spectacle, Duke E Cameron MD

www.ctsnet.org/sections/newsandviews/inmyopinion/articles/article-55.html

Guidelines for live surgery, Shinichi Takamoto MD

www.ctsnet.org/sections/newsandviews/inmyopinion/articles/article-63.html

The Operation – Surgery Live

www.channel4.com/explore/surgerylive/theatre3.html
Avoiding needle nightmares
Improving anaesthesia information for children

The Anaesthesia Information for Children Project, supported by the Royal College of Anaesthetists and the Association of Paediatric Anaesthetists of Great Britain and Ireland, is about to launch a series of age-appropriate information leaflets for younger patients. We’d like to introduce you to Rees and Davy, and share the development of their stories.

Why provide information for children?
There is no doubt that the admission of a child to hospital for an operation is a source of considerable stress. Pre-operative anxiety can be associated with a variety of adverse responses, including distress at anaesthetic induction, behavioural changes, sleep disturbances, and increased post-operative pain. However, adequate information, and preparation of the child and parent before anaesthesia may help to improve both compliance with anaesthetic induction, and the quality of the peri-operative and post-operative experience. Options for preparation include the use of books, films, puppet shows, relaxation training, pre-admission hospital tours, role play or play therapy, and interactive computer packages and cartoons, although few of these are available in all healthcare settings. Although the impact of many of these formats has been researched with promising results, many children still undergo preparation for anaesthesia and surgery only after admission to the ward. Clearly, there is a need for information to be available for children to explore at home prior to admission.

Currently, the only available information resources nationally about anaesthesia for children are two booklets produced originally in 2003 by the patient information project, supported by the Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). These booklets, entitled ‘Your child’s general anaesthetic’ and ‘Your child’s general anaesthetic for dental treatment’, were revised in 2008, and are available on the RCoA website. They provide comprehensive information for parents, designed to address their questions and alleviate anxiety. However, there is no current provision of information appropriately written and presented for the younger patients themselves. Although a number of published children’s books depict the hospital experience, none provides a comprehensive, reassuring and accurate description of the anaesthetic process.

The Anaesthesia Information for Children Project was conceived to redress this gap in information resources. Children have the right to receive information that is meaningful to them. They develop the capacity to be involved in some healthcare decisions from a very early age, but their concepts of health and illness differ markedly from those of adults. At present, most children are reliant upon the information that their parents give or feel that they need. However, parents may underestimate the emotional impact of the situation, or the child’s capacity to understand, and may therefore limit discussion about impending treatment. There is an increasing drive for children’s views to be addressed and for information to be designed specifically to meet their needs. The production of such information for children allows professionals some input into the style of information delivery and the language used to describe unfamiliar procedures and situations. It provides a source of material for parent and child to discuss, informing them both as they explore the new experience together.

What do children want to know?
In all spheres of activity relating to children and young people, consultation with the ‘consumer’ is becoming increasingly important when planning resources. Therefore, in order to
Developing storylines and characters
We realised at an early stage that the traditional fact-based format of adult information would be unsuitable for children, but it was a challenge to find innovative ways of sharing with children the experience of a hospital visit and an anaesthetic. Knowing that a tour of the hospital environment and pre-admission rehearsal of procedures are some of the most powerful methods of reducing preoperative anxiety, we wished to recreate these elements of preparation in a virtual way. We were reassured, after a little research into developmental psychology, that the preference shown by young children for a story-based approach, using anthropomorphic characters, would be entirely appropriate as a method for imparting new information. The information for young children is therefore designed as a story told by a young bear, who has had a recent anaesthetic and wishes to share what happened at the hospital. Parents and children can read the story together, learning from both the text and the detailed pictures.

What styles of presentation appeal to children?
To guide the presentation style of information within the three leaflets, we carried out an additional consultation with 95 children aged between two and 16 years, who provided opinions about their preferences for illustration and text format from a range of examples. This consultation revealed that younger children prefer story-based information involving animal characters, that junior school aged children are flexible in their preferences, but find comic book style information with a mixture of facts and storytelling appealing, and that teenagers like fact-based information. All age groups preferred professionally produced illustrations, indicating that we would need to work with talented illustrators and have professional graphic design input when preparing the leaflets.

How should we deliver information to children?
In choosing a medium for information delivery, we considered that it should be:

- Appealing to young people.
- Accessible to socially, psychologically and/or physically disadvantaged children.
- Amenable to regular updating.
- Transferable from one hospital to another.
- Easy and inexpensive to distribute.

Internet-based resources have many advantages, as do short films or slide shows, but these may not be accessible to all families and can be expensive to produce and difficult to transfer between hospital settings. After much deliberation, we decided to create a series of three age-appropriate, suitably illustrated paper leaflets, available for local printing. These would be cheap to distribute, easy to update and usable without the need for any special equipment.

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The junior school age leaflet is designed to follow the story of a boy who is disconcerted to find that he needs an operation under anaesthesia, and is determined to find out all he can. We have used a comic book format to illustrate the story of his detective investigation with the help of his friends, and have included information in the form of notes made
as he discovers new facts. We have also included a brief discussion of risk and some information on strategies for coping with anxiety.

The text for the three leaflets has been developed by the local project team, with comment and constructive criticism from appropriately aged children, educational experts, and lay advisors. Text for all of the project leaflets has been granted a Crystal Mark from the Campaign for Plain English.

Introducing Rees and Davy
One of the surprises of the project was how difficult it proved to be to choose names for our main characters. We felt it important to choose names that were slightly unusual, to prevent children from immediately identifying the characters with themselves or their friends, and that could be associated with a variety of cultures. After many incarnations, the bear who shares his story with young children is called ‘Rees’, named after Gordon Jackson Rees, a pioneer of paediatric anaesthesia, and our boy detective who finds out about anaesthetics is ‘Davy’, after Humphry Davy, another important personality in the history of anaesthesia. The ‘look’ of the characters has also been an evolving process. We have been lucky to work with two talented and dedicated illustrators who have brought the stories to life.

Information for older children and younger adults
Children in their teenage years were quite clear that they preferred factual information. They were also clear that they did not like to read many pages of text, but liked well-constructed brief points of fact and advice, with the opportunity to seek out more comprehensive information on their own terms. We felt it inappropriate, therefore, just to adapt the existing adult information leaflets to make them more suitable for a slightly younger audience. However, so much excellent work went into the preparation of the adult information series, in terms of the wording and explanations agreed with the expert patient advisors, that we took advantage of existing phrases in constructing a brief guide as a three-fold leaflet on one page of A4 paper. The leaflet is supported by a comprehensive web-based version of ‘You and your anaesthetic’, adapted for young adults with hyperlinked additional pages of further explanation on a variety of topics.

Resource availability
The three project leaflets will be available to order from the RCoA appointed printers and posted on the RCoA patient information web pages for download (www.youranaesthetic.info). Hospitals and anaesthetic departments will be able to purchase the leaflets, or reproduce them locally in colour or black and white, and they will be available to individual patients on demand. The website will also provide the hyperlinked information designed for older children and young people. We hope our leaflets will become familiar to patients, parents and professionals looking after paediatric patients, as a source of honest, accurate, reassuring and useful information about having an anaesthetic.

Acknowledgements
We would like to thank the members of the Anaesthesia Information for Children Project team and steering group for their dedication to the project, the play specialists who helped with the consultation for their assistance and expertise, and the RCoA and APAGBI for the provision of funding.
Chloroform to sevoflurane
A personal reflection on 50 years of paediatric anaesthesia

I gave my first anaesthetic (chloroform on an open mask) in 1959 as a medical student on the flying squad in Nottingham, supervised by the obstetric registrar – ‘pour it on until I tell you to stop’! However, it wasn’t until I had reached the dizzy heights of pre-registration house surgeon two years later, that I was expected to provide anaesthesia for children. In the subsequent half century, there have probably been more changes in paediatric anaesthesia than in any other period in the history of our specialty.

Training
It wasn’t until the end of my first house job at University College Hospital, that I found out that one of the duties of the surgical appointment that I had just obtained at Harrow Hospital was to administer the casualty anaesthetics at night and during weekends. Since, like most of my contemporaries, I had taken virtually no interest in anaesthesia during my four-week undergraduate exposure to the subject, I viewed this prospect with a certain amount of apprehension. Fortunately, I had a four-week break before I took up the post, and so I approached an anaesthetic registrar friend, John Bland, whom I knew from our hockey-playing days, and persuaded him to teach me enough to be safe. In his wisdom, he took me to the dental hospital where I rapidly became pretty competent in administering nitrous oxide, oxygen and trilene (preceded by pethidine 20 mg intravenously in any adult who was bigger than me). On taking up the appointment, I soon found that the casualty officers were asking for me, since my anaesthetics were considered superior to the hypoxic mixtures administered by the other house surgeons. My training had clearly been above average!

I'm not sure when the appalling level of training disappeared, but I suspect it was a gradual process. Some exposure to anaesthesia for children during general professional training was recommended by the 1980’s, and moves by the Faculty – and later the College – towards minimum time-based, and then competency-based training, were undoubted landmarks, together with the requirement for an initial period of totally supervised training for all anaesthetists. However, concerns that all trained anaesthetists were expected to anaesthetise even the smallest children, even if they did so but occasionally, were only expressed by a few far-seeing individuals like Dr Jackson Rees, despite the establishment of the Association of Paediatric Anaesthetists in 1973. In an editorial in Anaesthesia in 1984, I pointed out that there was not enough paediatric surgery for all anaesthetists to be properly trained, and to maintain their skills.1 At this time, 70% of children under three years of age, and almost 50% of neonates, were anaesthetised on general surgical operating lists in district general hospitals (DGHs), and the Court report on child health services in 1976 had expressed concern about the quality of anaesthetic provision for these children. However, it was not until the publication of the 1989 NCEPOD report, challenging the practice of ‘occasional’ paediatric surgery and anaesthesia, that moves towards a degree of centralisation of children’s services began.2 The danger that this policy would lead to a de-skilling of DGH anaesthetists was raised with justification by many, and I believe a sensible compromise has now been reached in the current RCoA guidance on the provision of paediatric anaesthetic services.3

Drugs, techniques and equipment
The first Ramstedt procedure that I saw for pyloric stenosis in 1962 was performed with the baby sedated with chloral and honey on a dummy, and tied to a cruciform frame. However, by this time the Liverpool group were pioneering the nitrous oxide/
curare technique, which many were following. At Great Ormond Street, where I worked as a registrar in 1965, induction was usually undertaken using cyclopropane, after heavy premedication with rectal thiopentone for children up to 15 kg, or with either Omnopon and scopolamine or Vallergan for older ones. Neonates were invariably intubated awake.

In most children, spontaneous breathing was maintained with nitrous oxide (from cylinders), and halothane, although ether, administered by a combination of Schimmelbusch mask and a warmed Boyle’s bottle, was still used for tonsillectomy. Antistatic precautions were essential, and this made the breathing circuits, t-piece, Magill’s attachment or Bain system, cumbersome and heavy. I recall long hours holding a facemask on a child, or devising ways to prevent airway obstruction when the mask was secured with a Hudson harness. Oh for the laryngeal mask airway!

Disposable equipment was unheard of, apart from plastic syringes which were replacing the old glass ones, and the phasing out of re-usable metal needles. Blood came in glass bottles with re-usable rubber and glass giving sets. Most anaesthetic rooms had equipment for boiling red rubber tracheal tubes and airways, which were then stored in drawers like cutlery, with no attempt to maintain sterility. It was not unknown for blockage of a tracheal tube to occur, due to congealed blood from a previous case where the technician had failed to pass a wire brush through it before boiling. Fresh gas flows were relatively high, because rebreathing systems were seldom used, and my attempts to introduce a scavenging system at Great Ormond Street were not universally popular. When curare was used, ventilation was either maintained by hand using the t-piece, or through the use of the Sheffield ventilator.

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Monitoring
Monitoring of patients in the 1960s relied largely upon placing a finger on the pulse, a precordial stethoscope, and observation of colour and peripheral perfusion, but at least these methods kept the anaesthetist in close clinical contact with the patient. The crude ECG oscilloscopes available were reserved for cardiac and other major cases, and blood pressure measurement by sphygmomanometry was deemed to be impractical and of little clinical significance. It wasn’t until the late 1970s that the first automated blood pressure devices appeared, and in the early 1980s pulse oximetry became available. These two devices revolutionised patient monitoring, with the addition of capnometry and, later, inspired gas analysis.

Surgical practice
Some of the operations performed on children 50 years ago are now of historical interest only, whilst many procedures carried out today, particularly the diagnostic and minimally invasive ones, were unheard of at that time. Some operating lists were devoted almost exclusively to procedures for children with meningomyelocele and hydrocephalus, who needed not only the initial closure of the back, but insertion and multiple revisions of various types of ventricular pressure-relieving shunts.

ENT surgeons made a healthy living from the (often unnecessary) removal of tonsils and adenoids.

Much cardiac surgery was palliative, because corrective operations were seldom attempted in young children, so Blalock-Taussig and similar shunts, banding of the pulmonary artery and Blalock-Hanlon procedures were common. These incomplete surgical corrections not infrequently required long periods of post-operative ventilatory support.

Post-operative care
Immediate post-operative care usually took place in the theatre corridor or a similar area, with return to the general ward after a few minutes. Most cardiac cases were ventilated with the huge Engström 150 flow-generating machine, with some children being ventilated for several years. Bird ventilators were used for the less difficult cases, including post-operative neurosurgical ones. These machines were replaced gradually by the new generation of Siemens Servo ventilators, whose autoclavable circuits were a great advance over the previous method of sterilisation with ultrasonically nebulised alcohol. Until the classic Australian papers demonstrated the feasibility of prolonged tracheal intubation, tracheostomy, largely pioneered by the cardiac surgeon E Aberdeen, was used in virtually all ventilated children – even neonates. Over 500 tracheostomies were performed at Great Ormond Street between 1959 and 1967, with only seven fatal complications related to the technique. The day-to-day care of these patients was largely in the hands of a small group of cardiac
anaesthetists, and it was not until the 1970s and 1980s that the value of establishing paediatric intensive care as a multidisciplinary sub-specialty was recognised.

**Psychological considerations**

This article would not be complete without reference to the change in attitudes towards the psychological well-being of children and their families in hospital. Fifty years ago, visiting times were severely restricted in most hospitals, and overnight parental stay was unheard of, not to mention the idea that parents might accompany their child to the operating theatre.

Despite the recommendations of the Platt report in 1959, and the Court report in 1976, for greater attention to be paid to the emotional and mental needs of the child in hospital, and the development of a service which is child-centred, little change occurred for many years. One of the prime movers for change in our own specialty was the late Dr W R Hain from Nottingham, a leading advocate for unrestricted visiting, and the provision of overnight accommodation for parents. He also introduced a pre-operative tour of the unit for children awaiting surgery, together with parents and siblings, a tape-slide lecture of ‘life in hospital’ and, subject to the agreement of the anaesthetist, arranged for a parent to accompany his or her child to the anaesthetic room. Even by today’s standards he was arguably ahead of his time, and perhaps it is appropriate that this article ends where it began, in Nottingham.

**References**


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**Advertising in the Bulletin**

The Royal College of Anaesthetists’ *Bulletin* is published bi-monthly and distributed to over 14,000 anaesthetists worldwide, the vast majority being in the UK. Being so widely distributed, it is obviously seen by many other professionals who work alongside anaesthetists. Advertisements for courses and meetings from anaesthetic societies, or those organisations that are of interest to anaesthetists, are accepted with prior approval of the Editor or Editorial Board. Each advert is generally placed to the rear of the *Bulletin* amongst the other notices.

Images, logos or crests should be submitted with the advert text. Please ensure that these are at least 300 dpi in resolution and are sent in either .tif, .jpg, .pdf or .eps format. We are unable to accept images that are embedded within a Word document.

The size of the advert is to some extent dictated by content and the layout of all adverts will be in keeping with the *Bulletin* style and design. It is not possible to include loose inserts in any issue.

Advertisements must fit with the aims and aspirations of The Royal College of Anaesthetists, be related to anaesthesia, critical care and pain medicine and will be accepted at the discretion of the Editor or Editorial Board.

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www.rcoa.ac.uk/bulletin
The evolution of paediatric anaesthesia

When I started my training in anaesthesia (back in the Dark Ages) there was a folk myth that young babies didn’t feel pain; or they didn’t feel it very much; or they didn’t interpret it as such; or, at any rate, that they didn’t remember it. Although every parent knew this to be untrue, the medical profession, in its wisdom, inflicted much suffering on little children. Thus, in The Lancet in 1881, Dr W Puginthornton wrote: ‘In the operation for the removal of tonsils, where an anaesthetic certainly is not required, I have never found a gag desirable. A child does not generally give trouble in the removal of one tonsil if there be no previous display of instruments, and should it close its mouth during the very short time occupied in putting the guillotine in order for the second tonsil, it is only necessary to compress its nostrils, and immediately the mouth is opened to push the instrument in sideways.’

This was not, fortunately, the universal view. More humanely, ’MRCS’, quoting Professor James Miller of Edinburgh University, wrote in The Times in 1858, during the controversy about the use of chloroform following a number of deaths (the first of which was in a child, Hannah Greener, aged 15 years): ‘In the case of children, its effect is both rapid and easy, it annihilates an agony which otherwise would have proved a sad penance to both surgeon and patient.’

There was research being carried out in anaesthesia for children. For example, H Tyrrell Gray, Resident Medical Superintendent at the Hospital for Sick Children, Great Ormond Street, reported on an astonishing series of spinal anaesthetics in 1909. In his first series of 100 patients aged three months to 13 years, he reported a total of four failures. His series included 12 laparotomies. The reported side effects were: 21 patients vomited during the operation, six retched, one was nauseated, and two vomited post-operatively. Given that his chosen method of sedation was the presence of a familiar nurse and sponge cake or a milk feed during the procedure, his patients seem to have got off lightly. Intra-operative hypotension was treated with brandy.

He reported no long-term or serious sequelae, although two patients developed headaches. However, he did say that serious sequelae had been reported from the Continent, which he thought was due to a family history of nervous disease.

The first textbook

The first British textbook of paediatric anaesthesia was 'Anaesthesia in Children', written by Dr Christopher Langton Hewer of St Bartholomew’s Hospital, published in 1923, just five years after he qualified in medicine. It was aimed primarily at GP anaesthetists, but included discussions of psychological preparation of the child, pre-operative fasting, parental presence during induction, monitoring and equipment. While not all of his views are in line with current thinking, they differ less than I, for one, would have anticipated, nearly 90 years later.

The National Health Service

The introduction of the NHS in 1948 produced a national framework and brought a degree of uniformity to the provision of services. The plight of children in hospital became a matter of interest.

In 1953, James Robertson, a psychotherapist and campaigner for children’s rights, produced two films: ‘A Two-year-Old Goes to Hospital’ and ‘Going to Hospital with Mother’.

Dr A-M Rollin
Consultant Anaesthetist,
Epsom and St Helier
University Hospitals NHS
Trust

Dr Christopher Langton Hewer
In 1959, the Platt report ‘The Welfare of Children in Hospital’ appeared. This concerned itself with the emotional (rather than the clinical) welfare of children, and recommended the introduction of children’s wards, and unrestricted visiting. The report was accepted by government, and a spate of official circulars, about facilities and visiting, followed. However, progress was very slow, and in 1961 a pressure group ‘Mother Care for Children in Hospital’ was set up. This has since evolved into ‘Action for Sick Children’.

In 1976, the Court report ‘Fit for the Future’ reaffirmed the Platt report and encouraged centralisation of services both within and between hospitals. The road to hell is paved, as we all know, with good intentions and worthy official reports. A Consumers’ Association survey in 1980 showed very limited progress towards these objectives (which are still largely objectives today).

Paediatric anaesthesia
Where were the anaesthetists in all this? In 1976, Dr Gordon Jackson Rees assembled a steering committee to set up the body which became the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI). The aims were: ‘To promote the study of the science and practice of paediatric anaesthesia and the proper teaching thereof.’

Initially, membership was limited to paediatric anaesthetists who spent more than 50% of their professional time anaesthetising children. They had a substantial influence on the standards of paediatric anaesthesia, but most children were still being anaesthetised by non-specialist anaesthetists in district general hospitals (DGHs). The very first NCEPOD report in 1989 examined deaths in children aged ten years or under within 30 days of surgery. It is important to bear in mind that the first conclusion of the report was: ‘The overall surgical and anaesthetic care of children is excellent’. Nevertheless, the report radically changed the patterns of provision of anaesthesia for children. Its core recommendations were that surgeons and anaesthetists should not undertake occasional paediatric practice, consultants must stay up to date and competent, and that trainees should be supervised. Those recommendations now seem obvious; at the time they were revolutionary.

The report was followed, as always, by a welter of publications and reports from assorted august bodies about the standards to be achieved by competent surgical services for children. This was all to the good, and standards of equipment, monitoring and staffing were indeed subjected to productive scrutiny. However, the Law of Unintended Consequences ensured that the downside of the recommendations gradually became apparent. Anaesthetists in DGHs became anxious about anaesthetising children. What had previously been a routine and, indeed, an enjoyable part of the day’s work came to be seen as a minefield. As recommended, anaesthesia for children was concentrated in the hands of a limited number of anaesthetists. This, of course, resulted in the deskilling of those anaesthetists who did not do routine children’s surgery. In most DGHs, however, there were not sufficient anaesthetists to run a separate paediatric rota, and emergencies were, perforce, seen by clinicians who were out of practice in the management of sick children. This resulted in more referrals for relatively minor procedures to the specialist centres, which rapidly complained that they were being overwhelmed with routine work for which they lacked resources.

The current situation
When it became apparent that the pendulum, while needing to swing, had swung too far, the profession began its usual self-righting exercise. The current emphasis is on individuals and departments working within the limits of their competence, and on networks which provide comprehensive and co-ordinated services in a given geographical area. It is acknowledged that it is neither possible nor sensible for all children to be anaesthetised in specialist centres and that sick children will continue to appear in DGH emergency medicine departments, regardless of whether or not the hospital provides paediatric surgery.

In recognition of this, a number of developments are afoot. The APAGBI has long welcomed as a member any anaesthetist who anaesthetises children, and many specialist hospitals act as resource centres for their surrounding DGHs. The Royal College of Anaesthetists’ Guidance on the Provision...
of Paediatric Anaesthetic Services stipulates that all consultants should be competent to provide peri-operative anaesthetic care for common surgical conditions, both elective and emergency, for children aged three years and older. In addition, all hospitals should be able to resuscitate and stabilise children of all ages, prior to transfer.

Changes in the provision of services are inevitable and largely unpredictable, especially in the current unstable economic climate. No doubt, we haven’t got it quite right, and will have to be flexible and modify what we do, as always. Nevertheless, it is reassuring that we have moved some distance from the time when anaesthesia was not thought to be necessary for children undergoing tonsillectomy.

Acknowledgements
I am grateful to Dr David Zuck for pointing me in the direction of many of the historical references. His encyclopaedic knowledge and his enthusiasm for sharing it far outdo Google.

References
2 MRCS. The Times, 1 September 1858.
General anaesthesia for dental extractions in children

The safety of general anaesthesia for dental extractions in children has been a subject of concern for many years, prompting the publication of reports and recommendations from expert groups and professional bodies. In 1990, the Standing Dental Advisory Committee published a report entitled ‘General Anaesthesia, Sedation and Resuscitation in Dentistry’, also known as ‘The Poswillo Report’.¹

This report listed 22 principal recommendations related to staff training, standards of equipment, recovery from anaesthesia, consent and record-keeping.

In 1999, the Royal College of Anaesthetists published ‘Standards and Guidelines for General Anaesthesia for Dentistry’.² This recommended that general anaesthesia should be limited to those patients and clinical situations in which local anaesthesia (with or without sedation) was not an option. A year later in 2000, the Department of Health published ‘A Conscious Decision’ which recommended that general anaesthesia should be used less frequently for the provision of dental treatment.³ This report also required that, from 31 December 2001, general anaesthesia for dental treatment should only take place within a hospital setting.

Despite these recommendations, unconfirmed reports suggest that, within the last ten years, at least two children have died whilst undergoing general anaesthesia for dental treatment, and others have suffered significant harm. Moreover, questions continue about issues such as the requirement for intravenous access during general anaesthesia for dental extractions in children, as well as minimum standards of monitoring for this procedure.

What is happening now?
A survey has been undertaken to estimate the number of general anaesthetics performed for children requiring dental extractions in centres across the UK. We also sought details about the anaesthetic technique that might be employed for a typical healthy five-year-old male Caucasian, requiring general anaesthesia for the extraction of all four of his second deciduous molar teeth (Es). In all, 270 questionnaires were sent to anaesthetists with a response rate of just under 80% from 180 centres.

Table 1 shows the number of general anaesthetics performed for paediatric dental extractions, and extrapolation of the data suggests that, in the UK each year, well over 60,000 children undergo general anaesthesia for dental extractions.

What about the anaesthetic technique for the five-year-old?
Premedication for our ‘model patient’ varies from none to topical local anaesthetic cream either alone, or in combination with oral analgesia and/or midazolam. No-one in the group surveyed would routinely use midazolam alone.

Sevoflurane or propofol are almost universally used for induction of anaesthesia, although three anaesthetists would still use thiopentone and one would use halothane; 17% of anaesthetists would rarely, or never, establish intravenous access in this patient.

Maintenance of anaesthesia using sevoflurane, either in oxygen alone or in combination

Table 1
Number of general anaesthetics performed for paediatric dental extractions in UK centres

<table>
<thead>
<tr>
<th>Number of cases per annum</th>
<th>Number of centres</th>
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</tr>
<tr>
<td>500–999</td>
<td>47</td>
</tr>
<tr>
<td>1,000–1,499</td>
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</tr>
<tr>
<td>1,500–1,999</td>
<td>5</td>
</tr>
<tr>
<td>&gt;2,000</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
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with nitrous oxide, is most widely used, but other choices include isoflurane, desflurane and propofol. One anaesthetist would use halothane for maintenance, but, interestingly, this was not the same respondent who would use halothane for induction. Another anaesthetist would not use any maintenance agent at all, so that the extractions would be performed during emergence from anaesthesia.

The use of pulse oximetry is almost universal (bar one respondent), and electrocardiography, non-invasive blood pressure, capnography and end-tidal volatile agent concentration are usually monitored. The laryngeal mask airway, nasal mask and standard facemask are all in current use for airway maintenance.

**Patient position, analgesia and discharge**

Whilst almost three-quarters of anaesthetists would have this patient lying supine on either a trolley or an operating table, 17% would use a reclining or sitting posture on a trolley, and 10% reported that the patient would be in a dental chair.

The majority would prescribe oral paracetamol, with or without ibuprofen, although four anaesthetists would not give any analgesia at all. Choices for intra-operative analgesia ranged from intravenous paracetamol and fentanyl to rectal paracetamol and diclofenac, and nearly half reported that their surgeon would regularly infiltrate local anaesthesia.

Table 2 shows the expected length of time between emergence from anaesthesia and discharge home for this patient. Three respondents would discharge the patient less than 15 minutes after emergence from anaesthesia, and over half would discharge the patient within one hour. Five respondents commented that the patient would be discharged home once they satisfied unspecified discharge criteria, irrespective of time.

**Variations in care**

Thus, it appears that there is considerable variation in the management of a healthy five-year-old male Caucasian presenting for the extraction of all four Es under general anaesthesia. Premedication varies from none at all, to local anaesthetic cream in combination with oral analgesia and midazolam. Sevoflurane and propofol are the agents most commonly used for induction, although one anaesthetist would use halothane. Whilst the majority of anaesthetists would use sevoflurane for maintenance of anaesthesia, one anaesthetist would choose halothane despite concerns about the increased incidence of arrhythmia. Simple oral analgesia is popular with additional local anaesthesia reported by approximately half of respondents.

**IV access**

The requirement for intravenous access for such a short procedure remains a subject of controversy. Macmillan and Wildsmith comment that, in most clinical situations in anaesthesia, intravenous access is now considered as necessary as standard monitoring. Nevertheless, nearly one in five respondents to this survey reported that they would not routinely obtain intravenous access in the patient described. From the free comments written on the questionnaires, the most common factor that would influence this decision was reported to be the skill of the operating dental surgeon. This is because, in some centres, the task of inserting an intravenous cannula is left to the dental surgeon whilst the anaesthetist manages the patient’s airway. Thus, if difficulties are encountered with cannula insertion, the decision is often made to proceed with the dental extractions in the absence of intravenous access. Also, if it is considered that the dental extractions can be performed in less time than it takes to insert a cannula, then no attempt is made to insert one. Other considerations mentioned by respondents included the visibility of the child’s veins, the general health of the child, and the requirement for blood tests or intravenous medication.

**Monitoring**

The use of intra-operative monitoring also varies considerably, with many anaesthetists reporting levels of monitoring which do not comply with the standards recommended by the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The pulse oximeter is the monitor most frequently employed. However, despite the reported 12% incidence of hypoxaemia during paediatric dental anaesthesia, oxygen saturation is still not universally measured, and nearly one in three anaesthetists would rarely,
or never, measure the blood pressure. The percentage of respondents who do not employ carbon dioxide or agent monitoring routinely, is just under 10%.

Why does this matter?
It appears that each year in the UK, over 60,000 children follow widely differing care pathways through the course of general anaesthesia for their dental extractions. This suggests the need for national guidelines to clarify and optimise the care pathways, thus allowing children to receive consistent standards of anaesthetic management. The results of this survey have led to collaboration between the Association of Paediatric Anaesthetists, the Association of Dental Anaesthetists, the British Society of Paediatric Dentistry, the RCoA, the AAGBI, and the Royal College of Nursing, in order to address this issue. The aim is to produce evidence-based and consensus guidelines for referral, assessment, preparation, intra-operative management, post-operative care and discharge planning, for outpatient paediatric dental general anaesthesia. A draft document is scheduled for peer-review this year.

References
7 Patel D, Hamlin GW. Hypoxaemia during Paediatric Dental Anaesthesia in the Community. BDJ 1994;176:467–470.

FRCA Examinerships 2011–2012
The College invites applications for vacancies to the Board of Examiners in the Fellowship of the Royal College of Anaesthetists, from the academic year 2011–2012. 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:
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 2011 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.

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.

Application forms and information for applicants can be downloaded from the examinations section of the College website (www.rcoa.ac.uk/examinations).

Or can be obtained from Miss Chloe Scrivener, Training and Examinations Directorate by tel: 020 7092 1525 or email: cscrivener@rcoa.ac.uk.

The closing date for receipt of completed application forms is Friday, 15 October 2010.
Paediatric anaesthesia is a key unit of intermediate training. Trainees complete between one and three months of training in this unit in ST 3 or 4. Trainees acquire knowledge about medical law and ethics throughout their training. However, within paediatric anaesthesia, consent, and the withholding of consent, are ethical topics that trainees need to understand.

Compliance
The term compliance means practising within the laws, regulations and conventions that apply to consent for children. This involves understanding the legal basis of consent and the refusal of treatment of those under 18-years-old. Gillick competence is a term used to decide if a child under the age of 16 is able to consent to treatment. This is based on a decision from the House of Lord’s with respect to the Gillick case. Lord Scarman’s judgement was that a child could consent if they fully understood the treatment proposed. He stated: ‘As a matter of law, the parental right to determine whether or not the minor child below the age of 16 will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed’ (Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402HL).

Conversion
Conversion is the ability to negotiate and accept a course of action, whilst respecting the patient’s point of view. Refusal of treatment by adolescents can represent difficulty. Consideration of what is in the child’s best interest is necessary, and often
involves a multidisciplinary team approach. Legal intervention may be necessary if disputes cannot be resolved. There are examples where courts have overturned the wishes of adolescent patients – for example, the compulsory feeding of a 16-year-old with anorexia nervosa, or giving antipsychotic drugs to a 15-year-old who had been previously assessed competent to make decisions.

**Teaching compliance, concurrence, conversation and conversion**

The teaching of compliance and concurrence can be achieved through lectures and small group work. Lectures should describe the legal background of current practice in consent and ethics, and include:

- The Gillick principle.
- ‘0–18 years: guidance for all doctors’ – The General Medical Council.

Small group work can enable trainees to discuss case studies related to paediatric anaesthesia, using lectures as the basis for decision making. Case studies suitable for discussion might include the following examples:

- A four-year-old girl arrives in the anaesthetic room, she refuses a gas induction or the placement of an intravenous cannula. What are appropriate next steps?
- A 13-year-old boy refuses anaesthesia for surgical treatment of curly toes. What would you do?
- A 14-year-old girl with a ruptured ectopic pregnancy refuses surgery because she does not want her parents to know about the pregnancy. However, she is losing blood, and becoming cardiovascularly unstable. What are the appropriate next steps?

A discussion of the issues posed might include:

- The legal position.
- The ability of children to consent to and refuse treatment.
- The role of premedication.
- The consequences of cancelling the case.
- The role of allied professionals – such as a child psychologist, play therapist or ward nurse.

Ethics can also be taught through hospital grand rounds, and through departmental meetings. These may include clinical seminars to discuss consent within paediatric anaesthesia, or a journal club citing publications about ethical issues.

The analysis of data relating to patient or staff complaints, and critical incidents, may reveal topics about consent in paediatric anaesthesia practice. For example, the complaint from a ward nurse that a six-year-old was inappropriately restrained against his will for induction of anaesthesia, would justify a discussion during a multidisciplinary team session.

Conversation and conversion can be taught through practical sessions. Videos can be used to demonstrate situations of ethical dilemma. These may include conversing with children and their parents who have particular religious beliefs. There should be an opportunity to discuss the interaction between the medical professional and the family. This would highlight good practice demonstrated in the video, and identify areas for improvement.

Trainees can also learn in role-play environments, with actors assuming the parts of parents and adolescent children, in situations where ethical issues play a major role in decision-making. These situations would enable trainees to improve their listening, communication and negotiating skills, when discussing the views and concerns of patients and parents. The provision of effective feed back to the trainee participating in the role-play would highlight good practice and suggest areas for improvement.

There are benefits in adopting a multidisciplinary approach to ethics teaching in paediatric anaesthesia. Paediatric ward nurses, operating department assistants, theatre staff, anaesthetists, surgeons, play therapists and child psychologists can all be taught simultaneously, because all of these have a role to play in ensuring children are managed in a way that respects their autonomy, and in ensuring that all medical personnel act with professional, ethical and legal principles.

**Competencies in knowledge, skills and attitudes**

Trainees need to understand the basic concepts of ethics and the law. They also need to be able to use this information in situations regarding consent in paediatric surgery and anaesthesia. Trainees should be taught the principles of patient autonomy, patient and parental rights and paternalism.

These knowledge-based competencies can be assessed in multiple choice question papers and short answer questions. The trainees’ knowledge base can also be explored in objective structured clinical examinations (OSCEs), and structured oral examinations (SOEs).
Furthermore, trainees would need to demonstrate ethical awareness and demonstrate moral reasoning – weighing up options, and giving reasoned choices based upon ethical principles.

These competencies can be assessed through workplace-based assessments (WbAs), clinical evaluation exercises (CEXs), and case-based discussion (CBD), highlighting and discussing the ethical issues that trainees manage during their day-to-day practice. Such assessments allow the assessor to evaluate the way in which the trainee manages consent in their practice. OSCEs and SOEs can also be used to assess the skill that trainees apply in ethical practice. The OSCE can assess communication skills, where, for example, the trainee needs to discuss with a Jehovah’s Witness how the anaesthetic team will manage their child for a tonsillectomy, and the possible outcome of a primary bleed in the first few hours after surgery. Within the SOE, a scenario might be posed of a child who refuses anaesthesia. The trainee would be assessed on their knowledge of the legal and ethical position of this situation, and would be assessed on their problem solving and management of this potentially difficult situation.

Trainees also need to demonstrate professionalism in their practice. This includes being aware of legislation, and respect for the views of others where they differ from their own.

Whilst attitudes can be assessed by some of the methods mentioned above, the approach of trainees to ethical issues may also be assessed through multi-source feedback. In this process, a number of staff from different disciplines are asked to comment upon the trainee’s working practice and competence, attitudes and behaviour.

Summary
There are benefits in teaching consent for children through lectures, small group work and case studies. Videos and role-play help to demonstrate techniques, and multidisciplinary groups should participate in teaching sessions to ensure breadth of understanding and approach in discussion. Knowledge, skills and attitudes in consent can be assessed through OSCEs, SOEs, WbAs and multisource feedback. The SLICE model is a useful framework for developing a teaching plan to enhance the necessary learning.

SAFE ANAESTHESIA LIAISON GROUP
Patient Safety in Anaesthesia

Did you know that the anaesthetic eForm is now available for the specialty specific reporting of patient safety incidents? 
https://www.eforms.npsa.nhs.uk/asbreport/.

The number of critical incidents reported via the anaesthetic eForm is increasing. By reporting through the anaesthetic eForm you will positively contribute to ongoing learning and improvement in patient safety. If you would like information on the eForm and how to use it please contact salg@rcoa.ac.uk or call 020 7092 1574.

Do you have positive learning that you would like to share with the specialty? SALG is a mechanism to share learning from critical incident reporting nationwide and would like to hear from you.

The Patient Safety area of the website has been improved. Please visit www.rcoa.ac.uk/safety for updates and projects on making the specialty safer.

salg@rcoa.ac.uk 020 7092 1574
www.rcoa.ac.uk/safety
Safeguarding – where are we now?

In all parts of the UK, there have been high profile cases of child neglect and maltreatment. These have aroused public shame and political disquiet, and provoked a sustained and ongoing review of services. Wide ranging plans are now emerging, intended to help teachers, social workers, nurses and doctors to spot problems sooner.

Health professionals are a key group to engage with, and ‘safeguarding’ is now seen as a core skill, forming part of the mandatory training of all hospital staff. Competencies are generally related to those described in the 2006 Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document, which describes six levels of training for safeguarding in detail, with elaboration of the accompanying knowledge, skills and attitudes required.1

A poor state of affairs

Against this background, it was unsurprising that, in 2007 and 2009, safeguarding training was a key indicator in reviews of secondary care acute services for children in England by the Health Care Commission (HCC).2–3 Basic (‘level 1’) training was used as a benchmark of quality and, in both reviews, it seemed that compliance was low, with large numbers of the anaesthetists and surgeons who work with children having had no documented formal training. Following swiftly on the heels of this review, in July 2009 the Care Quality Commission (CQC) (which replaced the HCC) published the results of a broader survey of the training on safeguarding children, this time looking at ‘level 2’ and beyond.4 This also appeared to show a picture of ‘could do better’. Furthermore, these poor results were almost universal across professional groups, with GPs, dentists and paediatricians (as well as surgeons and anaesthetists) not having undertaken appropriate or regular training.

This CQC review followed on from the ‘Laming 2’ work, which was commissioned after the so called case of ‘Baby Peter’.5 It pointed to the numerous inadequacies in a system that had already been reviewed in detail in 2001, which also surrounded a specific tragic case.6 The government’s response to Lord Laming’s report in England,7 included the following measures:

➤ The formation of the National Safeguarding Children Unit.
➤ A new Chief Advisor on Safeguarding Children (Sir Roger Singleton).
➤ Charging the National Director of Children’s Services in England (Dr Sheila Shribman) to review training provision.

The RCoA and Association of Paediatric Anaesthetists (APA) were concerned about some of the conclusions made by the HCC, and in particular the competencies expected within the IC document (which we believed were not written with the majority of secondary care clinicians in mind). The APA subsequently surveyed the views of the linkman group. Their opinion was unanimous: ‘Give us realistic, accessible training appropriate for our level of expertise, exposure to the family, and responsibility (which is often relatively small)’. These results were fed into the Department of Health (DH) England training review process.

What next?

As a follow on from the review, the Royal College of Nursing (RCN) is leading the revision of the 2006 competencies document. The time scale for this is tight, and is in association with the recently revised key reference for safeguarding in England and Wales entitled ‘Working Together to Safeguard Children’. There is enthusiasm from all of the professional groups represented, to make ‘core’ competencies much more succinct, with the development of additional modules for those with different levels of responsibility. For instance, the competency required for a consultant radiologist may vary greatly from that required for a general practitioner. Within anaesthesia, those with greater
paediatric responsibilities will also require extended knowledge.

The intention is that this work can be translated into training which is appropriate for all parts of the UK. The challenge is also to make it deliverable, relevant, and more useful to all professional groups.

**What should anaesthetists do now?**

At a trust level, you will have been urged to undergo level 2 training as a minimum. This advice is reiterated within the GMC 0–18 guidance.6

There are several ways of undertaking this training, including online DH modules which can be found easily within e-Learning Anaesthesia. These modules were developed by DH England, refer to procedures in England, and differ somewhat from other parts of the UK. Face to face sessions with designated doctors or nurses are also available in most trusts. These are ‘generic’, and are often run by a lead nurse for safeguarding. As such, they may not be prescriptive about individual circumstances for instance, involvement with the admission of a serious non-accidental head injury in a small child. Even so, they should give an insight into local systems and the legal framework, and may promote a dialogue between professionals locally. It is clear from personal experience, and indeed from the national review, that these are variable in quality and duration.

Another approach may be to arrange for a professional in child protection to attend a session(s) within your regular clinical governance programme, ensuring that attendance is recorded centrally. They can be briefed about your expectations, and the needs of the department. It is worth backing this up by studying the DH modules, and other material more specific to your particular part of the UK. More generic resources are recommended below.

In fact, the principles are actually very simple and should not be controversial:

- Think first of the child.
- Improve your knowledge of signs that might indicate abuse.
- Ask for help if you are unsure, and know from whom to get it.
- Maintain confidentiality and share information on a ‘need to know’ basis.
- Keep clear notes, and stick to the facts.

**Further resources can be accessed at**

- Welsh Child Protection Systematic Review Group [www.core-info.cf.ac.uk](http://www.core-info.cf.ac.uk)

**References**

Paediatric resuscitation training

Paediatric resuscitation has improved in the last 20 years, with survival rates for inpatients rising from below 10% to current rates close to 30%.¹⁻² This improvement has been due to an increase in the refinement and simplification of guidelines and in team training, rather than to new techniques and drugs. Most anaesthetists will have undergone some training in paediatric resuscitation by attending one of the national courses such as European Paediatric Life Support (EPLS) or Advanced Paediatric Life Support (APLS). However, this initial training is often not sustained.

Clearly, such skills require regular updating, because guidelines evolve, and because resuscitation of a child is, fortunately, a rare event, but is extremely stressful when it does occur. The Care Quality Commission (CQC) looks for evidence of ongoing provider status through the national courses, but many anaesthetists believe that this is less relevant, much of the time being spent learning practical skills in which anaesthetists are already expert, such as mask ventilation and vascular access.

A new approach

In response to these concerns, the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) has been in discussion with the CQC, the RCoA, AAGBI and Resuscitation Council (RC[UK]) about alternative methods of maintaining expertise. We have suggested that annual knowledge updates, through a lecture or e-learning, together with scenario-based team training, would be preferable and possibly even be more effective. Team training would involve local protocols and procedures (for instance, actually having to get the Intralipid from its local storage area for a lipid rescue LA toxicity scenario). However, there is a danger of this approach becoming a ‘box-ticking’ exercise of low quality, without any external verification. One big advantage of the national courses is that they are very carefully quality controlled, and are run by trained and accredited instructors. National officers oversee the courses, ensure the qualifications of instructors, and guarantee that the educational material is ‘fit for purpose’. One compromise might be to use national course instructors, together with local resuscitation officers, to deliver training using nationally developed materials, possibly derived from those already in use for simulators and other courses. The responsibility for ensuring quality control could be devolved to the local resuscitation committee, in turn assessed by the CQC.

There is already good support for this approach from RCoA, AAGBI and RC(UK), and a consultation document is on the APAGBI website,³ and feedback is welcome. In addition, the Education and Training Committee of APAGBI is engaged in the development of training materials.

This is not intended to replace national training, which is of high quality and relevance. Indeed, it is vital that anaesthetists in training undertake at least one national course, partly because the training is multidisciplinary, and partly because anaesthetists should continue to be involved as instructors. Rather, the intention is simply to provide an alternative way of updating knowledge and skills in resuscitation for those who don’t feel that the national recertification process meets their local needs.

References

Checklists and team briefing at Great Ormond Street Hospital

It should have been a relaxing list of minor cases, but the normal consultant surgeon was away, and a young registrar from another theatre was despatched to cover at short notice. The order of the list had changed due to a late arrival. The surgeon walked into theatre: ‘So, this is the child for the orchidopexy...’; ‘No, this is the child with haemophilia for a circumcision.’ The third child was not marked – the notes said left side, the consent form said right – half an hour delay to find the parents. More lost time resulted in cancellation of the last patient – a huge inconvenience for the family.

The morning had dissolved into a shambles, due to poor communication and planning. When the WHO Surgical Safety Checklist was introduced in the UK, I wondered if it might provide a focus at GOSH to improve our systems for communication and team working in theatre.

Adverse events in surgery

Major adverse incidents in paediatric practice are uncommon, but when they do occur they are rarely due to the isolated action of a single individual, rather due to a whole series of factors that result in a preventable catastrophe for the child, family and the team looking after them. Minor errors and glitches are more common, and result in complications, delays and poor staff morale. It is essential to capture these minor problems to prevent escalation into more serious events.

Complications in healthcare often result from human error, due to slips and lapses, mistakes or procedural violations, by those at the front line (‘active failures’). ‘Latent errors’ in the system allow the accident to occur, examples including poor teamwork, communication, assessment, scheduling, planning and co-ordination, equipment design, or systems for drug administration. Both active failures and latent errors need to be considered to improve patient safety.

Both types of error can be addressed through developing the ‘non-technical skills’ of the team, in particular, leadership, teamwork, decision making, situational awareness and communication. Communication errors have been reported as the root cause of over 60% of sentinel events reported to the USA Joint Commission on Accreditation of Healthcare Organizations. The patterns of communication failure will be familiar to us all: the information is passed on too late to be effective, the content is not consistent or is inaccurate, key individuals are excluded, or issues are left unresolved until they become critical. Hierarchies in theatre further inhibit effective teamwork and communication, and nurses’ views on how well the team is functioning may differ significantly from those of the physicians with whom they work.

Checklists in high-risk industries

Checklists are routinely used in high-risk industries to address human factors principles such as team working, communication and standardisation of performance, to reduce the reliance on memory, and to improve information transfer and feedback. Checklists have been trialled in surgery for some years. In our practice, we found that a standardised ‘aide memoire’ enabled us to hand over complex patients to the ICU in a more efficient manner, and with fewer mistakes. It also had the knock-on effect of improving relationships between the theatre and the ICU teams and we started communicating effectively with each other. We were less reliant on our expertise in dealing with crises because we made fewer mistakes in the first place.

The WHO Patient Safety Initiative: ‘Safe Surgery Saves Lives’

The WHO Patient Safety Initiative was established in 2004, and was led by Sir Liam Donaldson, the Chief Medical Officer for
England. The second WHO Global Patient Safety Challenge 'Safe Surgery Saves Lives' (SSSL) acknowledged that the global volume of surgery was significant, and that adverse events from surgery constituted a public health concern (234 million operations per year resulting in one million deaths and a further seven million harmed). Evidence-based interventions to improve surgical safety were considered by the SSSL team, led by surgeon, public health physician and writer Atul Gawande. An international consortium, including representatives from surgery, anaesthesia, nursing, infection control and quality improvement, convened to write evidence-based guidelines and identify a core set of safety standards that could be applied in all countries, and in all settings. Many common complications were considered preventable by good communication and team working. The SSSL team designed the WHO Surgical Safety Checklist as a key intervention for the surgical team to use at critical points during the patient’s peri-operative care; and now that the checklist is in routine use, it is difficult to understand why we did not do this before, because it formalises many aspects of good practice of which we were already aware.

The SSSL team investigated the impact of the WHO checklist in eight hospitals worldwide, four in high-income settings, and four in middle to low income settings. Data were collected prospectively from patients enrolled consecutively, 3,733 before, and 3,955 after, the introduction of the checklist. The overall death rate was reduced from 1.5% to 0.8% (p<0.001), and inpatient complications fell from 11.0% to 7% (p<0.001). We are familiar with the Patient Safety Alert issued by the National Patient Safety Agency in the UK in January 2009, requiring all NHS organisations to implement the Surgical Safety Checklist by February 2010, and a number of campaign organisations have been working with the NPSA to facilitate the implementation of the checklist (Patient Safety First, the 1,000 Lives Campaign). Commonly reported benefits of the checklist are improved teamwork, smoother and quicker procedures, and improved staff morale. Timely administration of antibiotics and thrombo-embolic precautions have also been reported. However, there have been a number of challenges to implementation of the checklist, particularly the tendency to see the checklist as a ‘tick box’ exercise, and lack of engagement of some clinicians with the process. Many trusts are using the checklist with a pre-list briefing, and use of briefing and debriefing is now recommended by the NPSA (www.patientsafetyfirst.nhs.uk).

There are now 3,791 hospitals in 120 countries that have registered with the SSSL programme, with 25 countries implementing the WHO Surgical Safety Checklist at a national level. The SSSL team recommends modification to suit the local situation, but not to make the checklist too complicated. Buy-in by the theatre team is best achieved by working with champions and enthusiasts, with support from the clinical and hospital leadership. Measurement is also important; for instance, outcomes and complications (surgical site infection rate, unplanned return to theatre, surgical mortality), theatre efficiency (the list overruns, the number of times the theatre nurse leaves the operating theatre for supplies), and processes (the number of times when blood is not available, antibiotic prophylaxis is not given, key concerns are discussed). Tension is created if the checks interfere with critical tasks, particularly for the anaesthetist, and it is often a challenge to gather team members together to do the checks. The process can be used to promote leadership amongst the nursing staff, but is not useful if led by an individual who does not have full knowledge of the patient.

Implementation of the WHO checklist at Great Ormond Street Hospital

We have learnt many lessons during introduction of the checklist. With the support of the executive team, we established a small working group of anaesthetists, surgeons and nurses to trial the checklist in one theatre, before rolling it out over a period of six months. We learnt that it was important for individuals to understand the background of the checklist, that the checklist needed to fit in with the workflow of the theatre, that support from senior clinicians was enormously influential, and that simply ticking boxes was not going to change the way that we communicated with each other.

We undertook numerous educational sessions for the nurses, surgeons anaesthetists, ODPs and HCAs. We made a training video that is on the GOSH website (www.youtube.com/watch?v=SMfYv84j_ME). We laminated the checklist so that it could be used as the basis of a formalised conversation between members of the theatre team. We added an extra field to our electronic record to monitor compliance and generate monthly reports for the Clinical Governance Group.
We learnt that many problems occurred ‘upstream’ from the operating theatre; for instance, surgical site marking was not always being completed before the patient left the ward, and we worked with the wards to achieve this. We changed the wording on the checklist: ‘is the blood in the fridge?’ and ‘are there any new team members?’ work well for us. Introductions that initially felt awkward are now routine. We only added one item, ‘check the ward checklist’, as this is a long established part of the nursing paperwork.

We realised early on that the checklist would not work in our setting without a ‘team brief’ at the start of the session. We structured the team brief on the Cornwall Theatre Team Resource Management project ‘How to have a good day in theatre’, which we have attached to the wall above the scrub sink to remind our surgical colleagues: ‘who is on the team, what are we doing today, do we have the kit, are there any staffing issues, any outside issues, any time issues?’ One of the main challenges has been identifying a time for the team brief. For most theatres we have decided ‘by 8.30 am’. Most of the teams comment that the team brief is one of the most helpful elements, and it has been easy to establish the routine. We have measured the benefits of the checklist on the culture in the operating theatre – the feedback has been positive, particularly from the nursing staff. As one member of staff commented, it is not about senior members of the team learning anything new, it is about sharing information with the rest of the team.

We have had a major incident since the introduction of the checklist – five members of the cardiac team completed the Time Out, but the bypass strategy was not discussed. This is a conversation that is usually held between the consultant surgeon and the perfusionist, but the consultant was at a different meeting, and assumptions were made that resulted in serious harm to the patient. The consultant surgeons now all attend the morning team brief, a decision reached by the theatre team, and not the hospital management.

We have reached our second anniversary of using the WHO checklist. It is now embedded in practice and no longer needs prompting. We are not perfect, and we still need to work on the theatre debrief at the end of the day – how did it go, how could we make it better next time? The scenario illustrated in the opening paragraph is a thing of the past. The most obvious effect of the checklist has been a change in the culture of the operating theatre, so that the language of safety is now in everyday use. The nursing staff realise the importance of speaking up; as a theatre team we think proactively about how we can stop errors occurring, and how to improve the safe care of our patients. The checklist will not prevent all incidents in theatre, but introduction of this simple piece of paper has helped us to communicate and work effectively as a team. It has changed the culture of safety in our theatre and I believe it will change the culture of safety in operating theatres around the world. In the NHS, the checklist offers a consistent approach to the surgical pathway that will benefit patients, trainees and experienced clinicians.

Finally, I would like to acknowledge the help of our theatre team in implementing the checklist, especially Julie Plumridge and Tracey Anthony, and our checklist champions who eased the way, together with Martin Elliott, Ian James, Imran Mushtaq, and Sister Goh and her colleagues.

References
Paediatric neuroanaesthesia
The current position

Approximately 4,300 paediatric neurosurgical procedures take place in England each year, within the confines of 15 neurosurgical services. Of these, seven units undertake more than 300 cases per year, four between 200 and 300 cases, whilst the remainder operate on fewer than 200 cases per year.

In 2009, Professor Sir Bruce Keogh, Medical Director of the NHS, asked the National Specialised Commissioning Group (NSCG) to conduct a review of neurosurgical services for children in England: the ‘Safe and Sustainable’ review. The aim of this review is to develop a safe, sustainable, and world class service for children requiring neurosurgery.

There are two interlinked phases. Phase one relates to the development of clinical and commissioning standards, involving the collection of relevant data. During phase two, the outcome of phase one work will be used to develop a strategy for future commissioned service configuration across the country. The NSCG has established a steering group to lead this programme, supported by a working group responsible for developing service specification standards.

Establishing the facts
The review has important implications for anaesthetists delivering peri-operative care for children requiring neurosurgical intervention. Anaesthesia is represented on both the steering and standards groups, through the Royal College of Anaesthetists (RCoA), the Association of Paediatric Anaesthetists (APA), and the Neuroanaesthesia Society of Great Britain and Ireland (NASGBI). In defining standards for anaesthesia, it is important to understand the models by which elective and emergency neurosurgical anaesthesia is being delivered currently to children across the country and to obtain a clear picture of the parent sub-specialty of the anaesthetists involved, whether that is paediatric anaesthesia, neuroanaesthesia, or training in both of these sub-specialties.

To establish current practice, a telephone survey of the 21 neurosurgical services providing emergency or elective paediatric neurosurgery in England was undertaken during October 2009, using association linkmen as an initial point of contact. The survey also provided an opportunity to assess the range and availability of options for paediatric neurosurgical post-operative care.

Elective paediatric neurosurgery
Fifteen centres admit children for elective neurosurgical procedures and, of these, six are dedicated children’s hospitals. There are three common models for service provision. Firstly, care may be provided exclusively by trained paediatric anaesthetists with a regular commitment to neurosurgery, a small number of whom also have responsibility for adult neurosurgical patients.

Secondly, care may be delivered by adult neuroanaesthetists with a regular commitment to paediatric neurosurgery, some also maintaining their paediatric skills through regular non-neurosurgical paediatric lists.

Four centres use a third model of care, which combines the two models above.

In centres other than the children’s hospitals, neurosurgical operating lists are scheduled with both adults and children listed for surgery in the same theatre.

Emergency paediatric neurosurgery
Currently, 18 centres in the UK will accept emergency paediatric neurosurgical patients. Another three units do not accept children unless they require immediate life-saving surgery, and cannot therefore be transferred safely for surgery. Arrangements for on-call cover for emergency surgery are more varied than are those for elective care. The models vary not only between hospitals, but from one night to the next within the same unit, depending upon the available skill mix.
Only one centre provides 24-hour cover with paediatric anaesthetists who have day-time commitments to neuroanaesthesia. One-third have 24-hour cover from trained paediatric anaesthetists who may have no regular neurosurgical day-time sessions. Seven units involve a mix of personnel from the paediatric or neuroanaesthetic on-call rotas, depending upon the age of the child. Children below a specified age are ‘usually’ managed by consultants from the paediatric anaesthesia rota, with older children being cared for by adult neuro-anaesthetists. The changeover point varies between institutions, and ranges from two to five years of age.

In one institution, 24-hour emergency paediatric neurological anaesthesia is provided by adult neuro-anaesthetists with ongoing skills in paediatric anaesthesia. In another unit it is delivered by a second on-call sub-rota of six anaesthetists who have regular paediatric lists. There is only one centre where emergency cases are looked after by the general adult on-call rota, of whom a small cohort maintain paediatric skills through regular non-neurosurgical paediatric lists.

Finally, one unit falls into the ‘mixed model’: paediatric anaesthetic input for young children, and adult neuroanaesthetic input for older children. However, in this model the paediatric input is dependent upon the composition of the on-call teams for anaesthesia and paediatric intensive care (PICU), on any particular night.

**Post-operative care**

Good quality specialist post-operative care is particularly important for neurological children. A variety of models of care exist currently in England.

With the exception of one unit, all emergency patients have access to the PICU beds and, generally, these are on the same site as that providing the emergency neurological provision. Two units have off-site PICU provision, but both plan to provide on-site services within the next two years. One unit has access to an adult general ITU which incorporates two staffed PICU beds, and only one centre has to use adult general ITU beds, if critical care is required and the child cannot be transferred.

About one-third of centres have access to a general paediatric high-dependency unit (PHDU). A further three centres have a specific paediatric neurosurgical ward with PHDU beds employing specialist neurosurgical nurses, with appropriate nurse to patient ratios, whilst almost two-thirds have a dedicated paediatric neuroscience ward. In the remaining services, paediatric neurosurgical patients are nursed on general paediatric wards.

**Piecemeal provision**

The variety of models of care for emergency paediatric neuroanaesthesia and post-operative care is surprising, and strikingly different from most other anaesthetic sub-specialties. Each service appears to have evolved a unique structure of care, resulting from the challenges presented by the existing hospital layout and location, supporting services and personnel. It is almost certainly the case that all services are providing a safe standard of care, although specific outcomes in terms of neuroanaesthesia and peri-operative care are not actually being monitored. Anaesthetists, whatever their parent sub-specialty, have utilised and adapted the skills available, in order to ensure that the safest and most workable solution for the local network can be provided.

Whilst many children can be safely cared for on a children’s neurosurgical ward post-operatively, others require a higher intensity of specialist nursing and medical input following more major neurosurgery. In the absence of PHDU facilities, many hospitals routinely send post-operative (level 1) neurosurgical children to PICU, even when ventilation is not required. This practice, although safe, places a stress on PICU beds with the potential for cancellation of elective cases during periods of high emergency activity. Specifically, several centres send non-ventilated patients, following posterior fossa craniotomy, to a PICU, despite having a PHDU on site. It is difficult to know if the reason is to secure the PICU bed should post-operative complications arise, or whether it is because of the possible absence of neurosurgical nursing care in a general PHDU. Paediatric neurological admissions to PICU thus vary throughout England, depending upon the local organisation, the existence of a PHDU, staffing ratios on the wards, and the presence of specialised neurological nursing staff. Whatever the reason, the effect on clinical outcome remains unclear.

The argument for providing a PHDU to give specialist care to children following neurosurgery is strong; it should decrease PICU admissions, provide care in a more appropriate environment for non-ventilated children, allow vulnerable patients to be monitored in level 1 beds for longer than the 24 hours of level 2 that is usually allocated by the PICU, and should concentrate specialist neurological nursing expertise in one area.

A recurring comment noted, when talking to the clinicians during the telephone survey, was the need for experienced paediatric neurological nursing staff to care for post-operative neurological children.

**Ringing the changes**

This brief survey provides an overview of the complexity and variety of the current models for the delivery of anaesthesia and post-operative care to children requiring neurosurgery in England. The specific standards pertaining to anaesthesia have now been agreed by the RCoA, APA and NASGBI (Box 1). There has been much debate concerning the balance between aspirational excellence and achievable reality for the provision of paediatric neurosurgery and support services. There is no doubt that many
departments feel threatened by the prospect of change, with an uncertain future. However, it is clear that the very existence of defined and agreed standards for the care of paediatric neurosurgical patients will help to drive all units in the direction of sustainable, high quality care.

Early in the process of reviewing current neurosurgical provision, concern was expressed regarding the care of the child who requires life-saving neurosurgery, but who presents at a hospital with ‘adult’ neurosurgery only, or with no neurosurgical service at all. It is vital that professionals who may be called upon to provide life-saving resuscitation, direct transfer, or surgery to these children, have the support of the hospital trust board, and the professional bodies to which they belong. The fact that a forum is already discussing these issues has allowed the Society of British Neurological Surgeons (SBNS), RCoA, AAGBI, APA, NASGBI, Intensive Care Society (ICS) and Paediatric Intensive Care Society (PICS) to agree the wording of a joint statement soon to be published.

In the era of revalidation, and in addition to the GMC competencies and RCoA specialty competencies, there is a clear need to specify those required for the optimal delivery of paediatric neurosurgical anaesthesia. However, developments must recognise the complicated delivery of emergency care, and the variety of parent sub-specialties from which participating anaesthetists originate. Proposals must include all practitioners, and provide a structure around which they can acquire and maintain relevant skills. This is complicated, because it needs to encompass adult neuroanaesthetists with paediatric expertise, paediatric anaesthetists with neurosurgical expertise, and anaesthetists working in non-neurosurgical centres who may be called upon to provide emergency neurosurgical anaesthetic management in the emergency department, or during a transfer to another centre. Work in this area is on-going.

Currently in England, children are not all receiving the same model of emergency anaesthetic input or post-operative care for neurosurgery. The impact of this on outcomes is unclear, and needs to be studied further. Work is in progress to determine the model of care that will achieve peri-operative care of the highest quality, and in the most sustainable manner, for children requiring neurosurgical intervention across the UK.

Change is always difficult, but if it leads to greater safety and better outcomes, we should embrace it.

References

Box 1

All neonates, infants and children requiring elective or emergency neurosurgery should receive the highest standard of anaesthetic and peri-operative care, delivered by consultant anaesthetists demonstrating training, continuing clinical experience and professional development in this specialised area of practice. Every child should have care delivered by an anaesthetist or anaesthetists who possess the relevant competencies as demanded by the patient’s age, disease and co-morbidities.

In paediatric neurosurgical centres, the necessary competencies will be held by a consultant anaesthetist with a regular commitment to elective paediatric neuroanaesthesia and who have trained to the equivalent level identified in the CCT in Anaesthesia. Consultant anaesthetists who provide emergency neuroanaesthesia in these centres should possess the necessary competencies required to provide high quality and safe anaesthesia for such surgery. New appointees to consultant posts with a significant or whole-time interest in paediatric neuroanaesthesia should have successfully completed ‘Advanced Level’ training in paediatric anaesthesia as defined in the CCT in Anaesthesia (August 2010), or equivalent, and an additional six months’ training in adult and paediatric neuroanaesthesia in a recognised neurosurgical centre. It is recognised that this training will need to be individually tailored after discussion with the RCoA Training Department and local school of anaesthesia. For highly specialised or complex procedures, joint working of two consultant anaesthetists bringing together their individual expertise may be in the best interests of the patient.

In adult neurosurgical services admitting less complex elective and emergency paediatric cases, relevant anaesthetic competencies may be provided by neuroanaesthetists who can demonstrate that they undertake regular paediatric anaesthetic practice and CPD in paediatric anaesthesia, resuscitation and peri-operative care. Emergency cases may require the combined efforts of an adult neuroanaesthetist working with a paediatric anaesthetist to ensure that the required competencies are assembled for any particular patient.

The RCoA will define the competencies required for revalidation in conjunction with the relevant specialist societies.

It is not the intention of the Working Group to interfere with the established convention that in a life-saving emergency situation all qualified anaesthetists are competent to undertake life-saving care for children.
Paediatric cardiac anaesthesia in Sri Lanka

Sri Lanka (which means ‘venerable island’ in Sanskrit) lies in the Indian Ocean, 20 miles off the southern coast of India. It is about half the size of England, and has a population of 20 million. Known as Ceylon until 1972, it gained independence from Great Britain in 1948; its national sport is volleyball, although the most popular sport is cricket, the men’s national team winning the ICC World Cup in 1996. Sri Lanka is most famous for its tea and the Tamil Tigers (Liberation Tigers of Tamil Eelam), who waged a civil war in the north east of the island until their defeat on 19 May 2009.

Charitable work

The aim of the mission is to perform operations on children with fully investigated, and accurately diagnosed, correctable cardiac conditions. Palliative procedures are not undertaken because there would be too many patients requiring follow up, either cardiological or surgical. The team consists of a cardiac surgeon, paediatric cardiologist, anaesthetist, two paediatric intensivists, two scrub nurses, a perfusionist, and four paediatric intensive care nurses. All twelve members of the team are regular contributors, working during periods of annual leave as unpaid volunteers.

The flight to the capital, Colombo, is followed by an 88 mile journey south to Galle along a beautiful coastline, unfortunately devastated by the Tsunami of Boxing Day 2004, before finally reaching Karapitiya Teaching Hospital. This is the largest tertiary care centre in Southern Province, and was established in 1982. It has 54 wards and 1,560 beds, including a stand-alone cardiac unit, with a resident surgeon and anaesthetist (plus the occasional trainee), who perform adult cardiac surgery and simple paediatric procedures throughout the year. Some complex paediatric patients are transferred to Colombo or abroad for treatment; however, this is not only dangerous, but expensive with few families able to afford it, the average income being less than £1,000 per year. Indeed, 14% of the population lives on less than £1 a day. By comparison, the cost of each mission is £15,000, which represents about £1,000 per life saved – not a bad return on the investment.

The anaesthetic

I anaesthetise patients with the help of a paediatric intensivist trained in anaesthetics as there is no operating department practitioner. Most patients receive an inhalational induction using halothane, because there is no topical anaesthesia to aid venepuncture whilst awake. I take a box of venous cannulae to Sri Lanka, because the cannulae in the hospital, if not out of date, are completely blunt. I also take a selection of disposable paediatric laryngoscope blades and T-piece circuits; these are popular and they often disappear overnight, never to be seen again.

Monitoring is fairly basic, and there are no end tidal carbon dioxide, oxygen or inhalational agent monitors. Although there are arterial and central venous transducers, they are unreliable and need frequent recalibration. Strong opioids are left out on the shelf for anyone to pick up and nearly all the equipment is recycled in some form or another. I realise that my conduct would be frowned upon in the UK and yet this makes the anaesthesia challenging, and one needs to think ‘outside the box’! On my first visit five years ago there was no ventilator available for children weighing less than 5 kg.

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The Guy’s (Paediatric Cardiac) Surgery Mercy Mission is a registered charity formed in 2001. It is funded solely by donations and sponsorship, and has gained status as the leading British-based Sri Lankan charity. It started in December 2000 when cardiac surgeon Conal Austin performed coronary artery bypass surgery on Jai Lameer, a London-based Sri Lankan. Conal expressed an interest in going to Sri Lanka to operate on children with complex congenital heart disease, having visited the island on his honeymoon. Following his recovery, Jai and his wife organised the first trip in 2002.
so I had to hand ventilate patients throughout the surgical procedure. The next year I took a portable Penlon ventilator with a Newton valve and formally handed it over to the resident anaesthetist in a touching ceremony; it has been in constant use ever since. I also take a small activated clotting time (ACT) machine and cartridges in order to assess heparin activity, because the heparin batches provided can only be described as ‘dodgy’ and, obviously, clotting of the cardiopulmonary bypass circuit would be disastrous. We do manage to obtain banked blood, but there is no means of properly checking its compatibility with our patients, it has no expiry date, and it has the consistency of treacle!

Obviously, there is a plus side. The single operating theatre is huge, extremely clean (no MRSA or C. diff here!), and air conditioned for surgical comfort. All the ancillary staff are helpful, but delegation of tasks is difficult – if I ask for a piece of equipment, everyone runs off in different directions, some disappear for days, and no-one ever comes back with the right bit of kit!

Following completion of surgery, the patient is transferred to the five bedded paediatric intensive care unit (PICU) down the corridor from the operating theatre where there is a thorough handover to our excellent PICU nurses and intensivist. We try to get patients extubated as soon as possible post-operatively, but there are no forced air warmers so the patients can still be quite cold on arrival in the PICU. Most inotropic drugs are available locally, but we do take a small supply of milrinone (an inodilator), and sildenafil (Viagra), which we crush up and can administer down a nasogastric tube in patients with pulmonary hypertension. Although there is no formal training of junior staff, I give lectures and provide in-theatre teaching whilst I am visiting, and the staff appear enthusiastic, even if some cannot understand a word that I am saying!

### The surgery

Over the last five years we have operated on 78 children (see Figure 2), the most common procedure being correction of tetralogy of Fallot (26 patients), usually involving closure of a ventricular septal defect and trans-annular patch repair of the pulmonary valve. The median age of the patients is two years, with a weight of 10 kg, most of the procedures being performed utilising cardiopulmonary bypass lasting an average of 93 minutes, and ranging from 32 minutes in a nine-year-old boy with cor triatriatum, to 279 minutes in a nine-year-old girl requiring an extensive aortic arch reconstruction. The six patients operated upon without cardiopulmonary bypass were for patent ductus arteriosus ligations, end-to-end aortic coartation repairs or shunts, including a 2.7kg neonate, the smallest child I have anaesthetised in Sri Lanka. Patients are generally undernourished and about half of the weight of equivalent aged children in the UK. Our cardiologist decides which patients we should operate on, and chooses the sickest babies for surgery early in the week in order to closely follow their post-operative progress, with the less sick patients being operated on towards the end, because their post-operative care will be in the hands of the local team later. Memorable cases include an arterial switch (Jatene) procedure in a three-month-old 4 kg boy involving three hours of bypass. The patient had transposition of the great arteries (TGA) with a patent ductus arteriosus keeping him alive and thankfully survived, as did a 14-month-old girl weighing 9 kg with anomalous origin of the left coronary artery from the pulmonary artery (ALCAPA). In 1933, Bland, White and Garland first described this rare but serious congenital abnormality where, after birth, the relatively desaturated blood from the pulmonary trunk under low pressure supplies the left ventricular myocardium. Initially myocardial ischaemia is transient, occurring during feeding or crying, but further increases in myocardial oxygen consumption later can cause infarction, with mitral valve papillary muscle dysfunction. Left untreated, mortality is 90% in the first year but

![A patient post-operatively](image1)  
![Pre-operative echocardiography assessment](image2)
our patient had managed to survive to 14 months of age, presented in congestive cardiac failure, and did well following corrective surgery.

**Downtime**
The working day is long. We arrive on Friday lunchtime following an overnight flight and, after breakfast of curry and hoppers (a bowl-shaped pancake made from batter and filled with fried eggs), the first patient is anaesthetised at 8.00 am on the Saturday. We operate on three patients a day, but each case is complicated and takes about four hours, so we finish at approximately 8.00 pm, after which we are taken back to our hotel for dinner and bed (provided there are no patient complications). After six days of operating we have a day of leisure before flying home. There are plenty of things to do in Galle, including visits to tea factories, textile and jewellery workshops, as well as lounging by the swimming pool or shopping for cheap ski wear (top brand clothing is manufactured locally!).

**Why go on these missions?**
It may seem crass to say that I enjoy ‘giving something back’, but that is definitely part of the reason. I admit that a lot more lives could be saved if we provided basic sanitation, clean water and vaccinations, but that is not what the team was trained to do, and there are other charities which provide such services in Sri Lanka. The smiles of gratitude from patients, relatives and local staff at the end of each mission are proof enough to me that the trips are worthwhile. They have attracted fantastic publicity which has further generated donations. In 2006, we were sponsored by an English national newspaper that provided a reporter and photographer to monitor our progress. In 2007, our surgeon received a children’s champion award, and was honoured at a reception attended by the ubiquitous Simon Cowell (and Tony Blair!). We have been sponsored by the Beckham Charity and, in 2008, were voted the ‘most outstanding Sri Lankan charity’ in the UK. On our last trip in October 2009, the Prime Minister of Sri Lanka, Ratnasiri Wickramanayaka, visited the hospital whilst we were there and attended a reception organised for all our survivors over the years, in recognition of the 100th operation.

**We need your help**
I would like to encourage an anaesthetic trainee to come out with me in September 2010 – it is a fantastic experience for anyone considering a career in paediatric cardiac anaesthesia, and there are bursaries available to help with the financial commitment. Permission to come is easy to obtain, basic vaccinations are all that is required, and there is very little in the way of red tape to prevent the trip. If you are interested please contact me, and anyone who wishes to donate or learn more about the charity can visit our website: www.mercymission.co.uk.

I cannot finish without thanking my team colleagues who have to put up with me for ten days each year: Jai Lameer who organises us, my Guy’s and St Thomas’ NHS Foundation Trust employers who allow me to go, and my colleagues back home who cover for my absence (but are probably glad to see the back of me for a couple of weeks!)
Consultant job prospects: an update

Three years ago, we published data which showed a precipitous fall of 47% in the number of advertised consultant anaesthetic posts in the UK, over a five-year period from 2002–2007. Regional and sub-specialty variations were also described.

This update reviews the data from 2007–2010 and supplements the previous publication. It shows a reversal of the former decline in numbers of advertised consultant anaesthetic posts. In 2008 there was a 43% increase in the number of advertised NHS consultant posts in the United Kingdom. This increase in demand was also maintained during 2009. Sub-specialty and geographical variations are also presented.

Fact finding
There is no foolproof method of collecting data in order to analyse trends in the consultant job market within the UK. Correspondence received as a result of our last publication highlighted some potential difficulties with national data collection, such as irregular local advertising methods for foundation trusts, and the fact that posts left unfilled might at some point be re-advertised.

Advertised consultant anaesthetic posts within the British Medical Journal careers section, were analysed for an additional three-year period as a continuation of our previous study. Similar methods were used to give consistency to our data which analysed:
- The number of advertised UK consultant anaesthetic posts per year.
- Their geographical spread.
- The sub-specialty area of interest included within the job description.

Once again, only NHS advertised posts were considered, and duplicated job adverts were ignored. A further 1,316 posts were advertised from 7 January 2007 to 6 January 2010.

Data from 2002–2007 showed a 47% overall reduction in all advertised posts in the UK with a reduction in the number of advertised posts in every region of England, but an increased number of posts in Scotland and Wales.

There was not much change in the number of advertised posts for the period representing 2007–2008 (3% reduction in all posts, which numerically was only a reduction in 10 posts nationally) giving a lower plateau of 342 advertised jobs (Figure 1). Subsequently there has been a 43% increase in all advertised consultant anaesthetic posts between 2008–2009 (Table 1). This has remained stable during 2009–2010. There has been no significant change in the number of advertised posts in Scotland and Northern Ireland over the last three years; however, Wales has shown a year on year reduction (Figure 2). Advertised job numbers for the first time outstrip the estimated number of new English CCT holders for the 2008–2009 year by approximately 140.

All sub-specialties showed an increase in numbers during this latest three-year period (Figure 3).

<table>
<thead>
<tr>
<th>Year</th>
<th>General</th>
<th>Paediatric</th>
<th>Cardiac</th>
<th>Pain</th>
<th>ITU</th>
<th>Neuro</th>
<th>Obstetrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002 v 2003</td>
<td>1%</td>
<td>3%</td>
<td>48%</td>
<td>36%</td>
<td>-7%</td>
<td>-20%</td>
<td>15%</td>
</tr>
<tr>
<td>2003 v 2004</td>
<td>-12%</td>
<td>-21%</td>
<td>-32%</td>
<td>-57%</td>
<td>-14%</td>
<td>0%</td>
<td>-30%</td>
</tr>
<tr>
<td>2004 v 2005</td>
<td>-8%</td>
<td>-7%</td>
<td>-28%</td>
<td>52%</td>
<td>-18%</td>
<td>-10%</td>
<td>0%</td>
</tr>
<tr>
<td>2005 v 2006</td>
<td>-41%</td>
<td>-4%</td>
<td>-6%</td>
<td>-11%</td>
<td>-14%</td>
<td>-61%</td>
<td>-48%</td>
</tr>
<tr>
<td>2006 v 2007</td>
<td>-11%</td>
<td>11%</td>
<td>-53%</td>
<td>3%</td>
<td>9%</td>
<td>-43%</td>
<td>82%</td>
</tr>
<tr>
<td>2007 v 2008</td>
<td>48%</td>
<td>53%</td>
<td>238%</td>
<td>34%</td>
<td>0%</td>
<td>375%</td>
<td>23%</td>
</tr>
<tr>
<td>2008 v 2009</td>
<td>-16%</td>
<td>-35%</td>
<td>-37%</td>
<td>33%</td>
<td>25%</td>
<td>-5%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Table 1
Annual trend broken down into sub-specialty areas and annual comparisons reflected as a % change
What are the reasons for this new upward trend?
The demand in the United Kingdom for consultant anaesthetists within the NHS has once again increased after the fall that we previously described. There are several key questions that need to be addressed as a result of these new data.

Frequent previous predictions have attempted to estimate the number of consultants that may be needed in the future. If the reasons underlying the large fluctuations were better understood, the process of workforce planning would be made easier. Without speaking to the management teams who made the decisions for each and every business plan or advertised post, the following reasons also remain speculative, and are certainly not exhaustive.

The Working Time Directive (WTD) and foundation status
Trainees are responsible for a significant proportion of service delivery within most departments. With the gradual stepwise reduction in trainee working hours as a result of the WTD, trusts have had to look at alternative methods to plug this potential service gap. Common solutions to this increased requirement for service delivery have been to use either additional middle grade anaesthetists or consultants. Therefore, it is possible that many trusts have turned to a consultant-based solution which may explain the changes that our data have shown.

There has been a gradual increase in the numbers of foundation trusts with each wave of the application process. These trusts typically compete with other trusts in the provision of the more profitable services. With service expansion, comes the necessity for additional staffing and service requirements. With services that require anaesthetic input, this service expansion would result in an increased number of consultant anaesthetic posts. Furthermore, some trusts have decided to use consultants to provide evening and weekend resident work. This results in an increased demand for consultant service provision with the possibility for more posts.

In 2008, there were approximately 140 more consultant posts advertised in the UK than the number of CCTs awarded by the RCoA.

Increased numbers of consultant retirements
A total of 800 consultants will have retired between November 2007 and December 2012, and there are increasing numbers due to retire each year as a result of the age demographics nationwide. In the last few years there has also been a predicted increase in retirements that have occurred as some switched from the old to the new consultant contract, with the additional pension related benefit.

Recruitment problems
In 2008, there were approximately 140 more consultant posts advertised in the UK than the number of CCTs awarded by the Royal College of Anaesthetists. There was also evidence that new consultant appointments with alternative working patterns, including resident night shifts, were difficult to recruit to, as demonstrated by the experience at Warwick Hospital. The recent College census report states that there were 230 reported unfilled consultant anaesthetic posts in the United Kingdom in November 2007.

There is a global market in the provision of medical services. Many of our younger trainees have been recruited to work in alternative climates (Australia, New Zealand and Canada). Naturally, this process could be reversed, but for senior positions if they remain vacant. Any doctor who has the equivalent to a CCT, is on the specialist register, and has full GMC registration, is eligible to apply for a consultant post. European and international medical graduates who meet these criteria are also eligible to be appointed.

At present there are more consultant jobs being advertised than there are UK CCT holders. This suggests that foundation trusts would have difficulty in recruiting to alternative contracts, or ones where working hours were
interpreted as sub-standard with reference to the October 2003 consultants contract. These current favourable market conditions for newly trained anaesthetists make any attempt to initiate a sub-consultant grade unsustainable.

**Pressure to reduce supporting professional activities (SPA)**

Recently, the President of the RCoA has highlighted a growing concern about pressures to reduce consultant SPA activity from employing trusts, and thereby to increase the direct clinical care component from 7.5 to 9 sessions for a ten PA contract.\(^a\) For the reasons mentioned above, when the supply and demand ratio tilts towards a buyer’s market, advertised consultant posts containing such a poor provision of supporting professional activity time may be overlooked by applicants in favour of more conventional nationally negotiated terms. We envisage that this current pressure will remain, although not increase, in the current market. However, the supply and demand ratio can change rapidly as our data show (Figure 1).

Most departments work and (just about) manage to cover the service delivery that is required, even when sometimes starved chronically of a full complement of consultant anaesthetists. Extra slack has been taken up traditionally by the current consultant workforce, with an 11th or 12th programmed activity, or by undertaking additional paid lists. Trainee and middle grade doctors are also under pressure to supply this service need.

By our calculations, there was an undersupply of potential consultant anaesthetists (excluding non-UK trained anaesthetists) of 140 in 2008–2009. However, with 6,233 consultants in the UK as of November 2007, this still represents only a 2.2% shortfall. Spread across the 285 departments in the UK, this represents 0.5 whole time equivalent in each department.

**References**

5. Estimated data from The Royal College of Anaesthetists Training Department (www.rcoa.ac.uk/training).

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**In memoriam**

Sadly, Dr Asif passed away on 10 May 2010; this article is printed with the permission of his family. Our thoughts are with his wife and two young boys, as we remember a bright, thoughtful, considerate, much respected friend and colleague who has been taken from us all too soon.
The Academic Medicine Project
Research and audit

➤ Do you know how to design a robust scientific study or audit?
➤ Are you currently doing all your literature searches on Google?
➤ Can you critically appraise a journal article?
➤ Unsure about your confidence limits?

Through a unique collaboration between e-Learning Anaesthesia, the Anaesthetic Research Society and the Academy of Medical Royal Colleges, 12 e-learning sessions have been produced covering the important principles underpinning research in today’s NHS and are now available online at www.e-LA.org.uk under ‘External Content’.

This curriculum was formulated by the Academy of Medical Royal Colleges under the editorial leadership of Professor David Rowbotham. The authors are all internationally-known experts in their field. The 12 core subjects were chosen because they are relevant to all medical sub-specialties and we are proud that anaesthesia has been able to take the lead role in bringing this project to fruition. Although academic, the subject material has been prepared in a very interactive style allowing the reader to approach the subject of designing their own study, using practical examples that clearly demonstrate the dilemmas and decisions faced by medical researchers. Whilst relevant to all doctors, the module will be particularly useful to anaesthetists wishing to understand the processes involved in formulating a research proposal, obtaining ethical approval, and the necessary steps required to apply for grant funding. As an adjunct to these 12 core sessions, a further ten statistics-based sessions have been added from the existing e-Learning Anaesthesia curriculum covering the principles of data analysis that are also relevant to an understanding of research methodology.

To gain access to these resources, you will need to be registered with e-Learning Anaesthesia (www.e-LA.org.uk). The Academic Medicine module is available as ‘External Content’ and this can be found in the list of e-LA modules on the left-hand side of the ‘Home’ page within the Learning Management System (LMS).

Table 1 The 12 Academic Module e-sessions

<table>
<thead>
<tr>
<th>Topic</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology</td>
<td>Paul Silcocks</td>
</tr>
<tr>
<td>Meta-analysis and evidence-based medicine</td>
<td>Jason Walker</td>
</tr>
<tr>
<td>Audit</td>
<td>Andrew Smith</td>
</tr>
<tr>
<td>Searching the journal literature and locating papers</td>
<td>Linda Ward</td>
</tr>
<tr>
<td>How to review a paper</td>
<td>Charles Reilly</td>
</tr>
<tr>
<td>Formulating and writing a research proposal</td>
<td>Jonathan Thompson</td>
</tr>
<tr>
<td>Research governance and ethics</td>
<td>Elizabeth Kettle</td>
</tr>
<tr>
<td>Designing a randomised controlled trial</td>
<td>Matt Wiles</td>
</tr>
<tr>
<td>Cohort studies and measures of association</td>
<td>Jason Walker</td>
</tr>
<tr>
<td>Study design</td>
<td>Jason Walker</td>
</tr>
<tr>
<td>Systematic reviews</td>
<td>Iain Moppett</td>
</tr>
<tr>
<td>Qualitative research</td>
<td>Rachel Evley</td>
</tr>
</tbody>
</table>

Table 2 The ten Statistics Module e-sessions

<table>
<thead>
<tr>
<th>Topic</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimation and decision making</td>
<td>Sue Hill</td>
</tr>
<tr>
<td>Hypothesis testing</td>
<td>Sue Hill</td>
</tr>
<tr>
<td>Confidence</td>
<td>Sue Hill</td>
</tr>
<tr>
<td>Samples of unknown mean and variance</td>
<td>Sue Hill</td>
</tr>
<tr>
<td>Related variables</td>
<td>Anthony McCluskey</td>
</tr>
<tr>
<td>Categorical variables</td>
<td>Anthony McCluskey</td>
</tr>
<tr>
<td>Non-parametric data</td>
<td>Anthony McCluskey</td>
</tr>
<tr>
<td>Diagnostic testing</td>
<td>Ian Kestin</td>
</tr>
<tr>
<td>The display of statistical data</td>
<td>Jason Walker</td>
</tr>
<tr>
<td>Choice of test</td>
<td>Ian Kestin</td>
</tr>
</tbody>
</table>

Pathway: www.e-LA.org.uk > Log-in to your e-learning > Go to: e-Learning Anaesthesia > ‘Start an e-Learning session now’ > External Content > Academic Medicine
Report of the Senior Fellows Club
12 May 2010

The spring meeting of the club was held in London at the College. Following the usual format, the chairman first welcomed the President who gave an update on College matters. In his opening remarks the President paid tribute to those who had guided and influenced his career, some of whom, now retired, were in the audience. Reporting on revalidation, he said that a ‘lighter touch’ approach may be adopted. Dr Mike Grocott had been appointed as first director of the College’s Health Services Research Centre (HSRC). The new curriculum for anaesthesia had been officially approved but that for intensive care medicine had not. The previous Competent Authority for postgraduate medical education, PMETB, wished to classify ICM as a single specialty, and not as a joint or dual specialty. The traditional recognition of the Irish College’s examinations as part of a UK training programme was under discussion as it does not comply with EU regulations. He explained why there would be no elections to College Council this year.

The chairman then welcomed and introduced the guest speaker, Dr Kevin Fong. Dr Fong was recently appointed as consultant anaesthetist to University College Hospital, London. In addition to his medical qualifications, he has degrees in astrophysics and aerospace engineering.

He began by talking about the space shuttle programme. As the technology of this remarkable programme is nearing the end of its natural life, there may only be a further two or three voyages. He related how the two shuttle disasters, Challenger and Columbia, were caused by the failure of minor, but essential, components, the infamous O-rings and a faulty heat shield.

To the inevitable question ‘Is it worth it?’ he reminded the audience that science implies exploration and exploration implies risk. Magellan’s expedition, the first successfully to circumnavigate the globe, had lost 80% of its ships and 95% of its crew. Pure and applied science cannot be separated.

Dr Fong then discussed the likelihood of intelligent extraterrestrial life. During the last 20 years it has become clear that extrasolar planetary systems are ubiquitous. Spectroscopic analysis has shown that polycyclic aromatic hydrocarbons, potential building blocks of life, are widely distributed throughout space. Given the age of the universe, some 13 billion years, the probability of life elsewhere is high though it may be more akin to bacteria than Homo sapiens.

Among the fascinating facts he revealed were: scientists believe they are able to explain the formation of the universe from a time point $10^{-43}$ seconds after Big Bang, the moon may preserve geological samples of rocks, from earth, dating back to the time when life first appeared here and the visible universe contains around $2000 \times 10^{18}$ stars.

Dr Fong possesses a great gift for explaining complex scientific concepts and his talk was delivered with wit and style.

In conclusion, the chairman joined with all those present in wishing Dr Fong every success in his future career. He thanked Miss Karen Slater and all in the Membership Department for making the administrative arrangements for the meeting.

Dr H Seeley, Chairman

The next meeting of the Senior Fellows Club will be held at the Liverpool Medical Institution on Wednesday, 13 October 2010 when the guest speaker will be Dr R E Atkinson.
Report of Council

At a meeting of Council on Wednesday, 21 April 2010, the following appointments/re-appointments were made (re-appointments are marked with an asterisk):

**Regional Advisers**

**Northern**
*Dr K Beacham, Freeman Hospital, Newcastle upon Tyne*

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

**College Tutors**

**Oxford**
Dr B M Slavin, Milton Keynes General Hospital (in succession to Dr J A Cooney)
Dr D M A Choi, Churchill Hospital

**West Yorkshire**
Dr O Akerele, Bradford Royal Infirmary (in succession to Dr A B Swanepoel)

**Northern Ireland**
Dr K A Abraham, Antrim Hospital (in succession to Dr K C Scott)
*From June 2010*

**North Thames West**
Dr M Carrington, Queen Elizabeth II Hospital
*Term extended until July 2010*

**North Thames East**
Dr C Sheppey, Royal London Hospital (in succession to Dr S P Hallworth)

**Mersey**
Dr D Raw, University Hospitals, Aintree (in succession to Dr D T Moloney)

**North West**
Dr D P Fines, Royal Manchester Children’s Hospital (in succession to Dr R Vashisht)

**Sheffield**
Dr T N Wenham, Barnsley District General Hospital (in succession to Dr T J H Moll)

**Wales**
Dr G J Milne, West Wales General Hospital (in succession to Dr R Prasad)
Dr A G Rees, Withybush General Hospital (in succession to Dr M A M Hashem)

**Heads of School**
There were no appointments.

At a meeting of Council on Wednesday, 19 May 2010, Dr John Andrzejowski (Sheffield), Dr Simon Baker (Cleveland), Dr Peter Davies (Plymouth), Dr Andrew Farmery (Oxford), Dr Patrick Hopton (Cambourne) and Dr Andrew Kitching (Reading) were all admitted to the Board of Examiners.

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

**Regional Advisers**
There were no appointments

**Deputy Regional Advisers**
There were no appointments

**College Tutors**

**Northern Ireland**
Dr M E Molloy, Royal Group of Hospitals, Belfast

**Heads of School**
There were no appointments.

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 Monica Trivedi *

**South East**
Dr Gavin Harry Parness

**South Coast**
Dr Andrew Paul Melville Moran

**North Central**
Dr Hui Yun Vivian Ip
Dr Sanjana Singh
Dr Matthew Dylan Bould
Dr Uganthren Reddy

*Left to right: Dr A Kitching, Dr S Baker, Dr P Hopton, Dr A Farmery and Dr J Andrzejowski*
Deaths

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

Dr Parakath Asif
Birmingham

Dr Ed Charlton
Northumberland

Dr Geoffrey Clark
Cardiff

Dr Leslie Hall
Cambridge

Dr Michael C Holderness
Staffordshire

Dr Ravi Ramdas
London

Dr Indraranjan Selvadurai
Burnie, Australia

Dr Ajeet Singh
Coventry

Dr Michael Slazenger
Dublin

The College is able to receive brief obituaries (of no more than 500 words), with a photo if desired, of Fellows, Members or Trainees. These will be published on the College website (www.rcoa.ac.uk/obituaries) for a period of one year, after which they will be moved to a permanent archive. Please email your text and any photo to: website@rcoa.ac.uk.

IMPORTANT NOTICE

Please refer to the College website for details of the election to Council.

www.rcoa.ac.uk/election

Election to RCoA Advisory Board for Scotland

Details of the vacancies on the RCoA Advisory Board for Scotland will be available on the College website from 7 July 2010.

www.rcoa.ac.uk/scotland

Congratulations to the College’s Projects Officer, Edwina Jones, who has given birth to a beautiful baby girl.

Flora was born on 1 April weighing in at 6lb 10 oz.

Mother, baby and husband, Jackson, are all doing well!
Recent presentations and awards

The College would like to congratulate the following on the presentation of their awards at the Diplomates Ceremony on 5 May 2010:

- Dr Claire Noons and Dr Anna Fergusson (Nuffield Prize)
- Dr Victoria Hill (Magill Prize) and Dr Robert Chambers (Macintosh Prize)
- Dr Anne Sutcliffe (Humphry Davy Award)
- Dr Edward Hammond and Dr Andrew McIndoe (The College Medal)
- Professor Ian Gilmore, Professor Jeremy Lambert and Professor Sir Neil Douglas (Fellow by Election).

**Humphry Davy Award**

**Dr Anne Sutcliffe**

The Humphry Davy Medal presented to Dr Ann Sutcliffe is a suitable award for a degree ceremony as it bears similarities to passing fellowship. It represents a belated recognition of very hard work.

Dr Sutcliffe is a worker and achiever and the results of her labours are not glitzy papers in *The Lancet*, names on international conferences nor even has she paced the corridors of Whitehall telling the Chief Medical Officer what a good job he is doing. Instead, the successes are to be seen in the Midlands, Birmingham, and they are home grown, quiet and hardly ever noticed; in short, hard work, attention to detail, teaching and mentoring.

She was appointed Consultant very early in Birmingham. Her fast promotion, meant that her talents were recognised early 30 years ago. During her senior registrar training she wrote and published unaided a book on Trauma and Anaesthesia which is still a good read today. Writing and teaching remain an important part of her academic life.

Her contribution has been to teach generations of people passing fellowship. She has been leading, by example, quietly and effectively so the results to be seen by her successors in the departments she has worked in. Hard work and hard grind.

This picture I have painted is a course of action over years which is open to us all but perhaps not taken by us all. The results, nonetheless, are remarkable and fully deserving of a Humphry Davy Award.

**The College Medal**

**Dr Edward Hammond and Dr Andrew McIndoe**

This award is unusual in that it names two individuals: Dr Ed Hammond and Dr Andy McIndoe. In April 2006 the College was approached by NHS e-Learning for Healthcare that was developing an e-learning course for postgraduate education in partnership with the Royal College of Radiologists, to see whether we would like to participate in a similar project. During the next six months, the RCoA and the Department of Health established the framework for what became e-Learning Anaesthesia. In my capacity as chair of the College steering group it fell to me to make one particularly significant decision. Who would be the lead for anaesthesia in this project? It was clear that the individual needed to be an experienced and authoritative member of the anaesthetic consultant community, with superb team leadership skills, a deep and clear grasp of education theory, advanced understanding of electronic media, good humoured, patient, diplomatic, enthusiastic, optimistic and possessing extraordinary drive and energy. Quite a challenge!

Fortunately, there were two such individuals whose attributes fitted the bill in all regards. As a bonus they also had a track record of extremely successful co-operation working together in previous ventures. Knowing Ed and Andy I hoped for great things of them, but their achievements have surpassed all expectation.

The work that Ed and Andy have done has not only taken forward the anaesthetic project in directions we could scarcely imagine, but it has become the standard against which any medical e-learning programme must be judged. In the field of medical e-learning it is immense. The project won the gold award for the best online or distance learning projects at the e-learning age awards in 2009. The entire e-learning team and the e-LA project have been awarded a number of national and international honours including the Humphry Davy Award of this College. As the responsible member of Council I anticipated that I would often have to step in to help, chivvy and negotiate on behalf of the team. No way! Drs Hammond and McIndoe have led the project themselves, and negotiated their way round all obstacles. There are now over 1,000 20-minute sessions relating to the first two years of anaesthesia training linked to a library of thousands of related anaesthesia articles and a database of related assessments.

The College makes its awards to say thank you to individuals who have made exceptional contributions to its work. I am hard pressed to bring to mind any contribution that is as important as that we now honour. e-Learning Anaesthesia is a quite extraordinary project. It has brought both respect and envy to the College. Awards are often made when the related work is complete. Permit me to say in the immortal words of Bachman-Turner Overdrive ‘You ain't seen nothing yet!’ President, diplomates, guests: I am privileged to introduce to you Dr Ed Hammond and Dr Andy McIndoe for the award of the College Medal.

**Dr D Greaves**
The Events Programme 2010
www.rcoa.ac.uk/events

Advanced airway workshop
8 September 2010 (code: D43)
Royal College of Anaesthetists, London
Registration fee: £245

Becoming a Consultant
A joint meeting with the AAGBI
10 September 2010 (code: B14)
Royal College of Anaesthetists, London
Registration fee: £200 (£150 for registered trainees)

UK perioperative research forum
NIAA and HSRC
13 September 2010
Royal College of Anaesthetists, London

Anaesthetists as educators:
delivering in the workplace
15–16 September 2010 (code: A37)
Royal College of Anaesthetists, London
Registration fee: £395 (£295 for registered trainees)

Core topic day:
fluid management
22 September 2010 (code: C63)
Royal College of Anaesthetists, London
Registration fee: £200 (£150 for registered trainees)

Training in emergency airway management (TEAM) course
27–28 September 2010 (code: D29)
Royal College of Anaesthetists, London
Registration fee: £395

Airway workshop – Glasgow
6 October 2010 (code: C40)
Teacher Building, Glasgow
Registration fee: £245 (£185 for registered trainees)

Core topics day – Dublin
6 October 2010 (code: C97)
College of Anaesthetists, Ireland
Please contact the College of Anaesthetists in Ireland for further information

Training in emergency airway management (TEAM) course
13–14 October 2010 (code: B75)
Edinburgh Royal Infirmary
Registration fee: £395

Core topics day
14 October 2010 (code: C79)
Royal College of Anaesthetists, London
Registration fee: £200 (£150 for registered trainees)

Current concepts symposium
4–5 November 2010 (code: B05)
Royal College of Anaesthetists, London
Registration fee: £415 (£315 for registered trainees)

Continuing Medical Education day
A joint meeting with the AAGBI
6 November 2010 (code: A76)
Royal College of Anaesthetists, London
Registration fee: £225

Anaesthetists as educators:
an introduction
9 November 2010 (code: A12)
Royal College of Anaesthetists, London
Registration fee: £205 (£155 for registered trainees)

Research methodology workshop
10 November 2010 (code: C43)
Royal College of Anaesthetists, London
Registration fee: £135

Faculty of Pain Medicine:
study day
18 November 2010 (A78)
Royal College of Anaesthetists, London
Registration fee: £105

Scottish winter meeting – Edinburgh
Joint meeting with Scottish Society of Anaesthetists
18–19 November 2010 (code: c22)
Royal College of Physicians, Edinburgh
Registration fee: £265 (£200 for registered trainees)

British Ophthalmic Anaesthesia Society
11th Scientific meeting
23 November 2010 (code: C29)
Royal College of Anaesthetists, London
Registration fees:
Trainees: BOAS Members: £150
Non-BOAS Members: £175 (includes one year membership of BOAS)
Consultant and non-Trainee grades:
BOAS Members: £200
Non-BOAS Members: £225 (includes one year membership of BOAS)

Faculty of Pain Medicine:
annual general meeting
24 November 2010 (code: B08)
Royal College of Anaesthetists, London
Registration fee: £155 (£115 for registered trainees)

Anaesthetists as educators:
delivering in the workplace
29–30 November 2010 (code: C80)
Royal College of Anaesthetists, London
Registration fee: £395 (£295 for registered trainees)
Making part-time work

30 November 2010
Royal College of Anaesthetists, London
Registration fee: £30

Airway workshop

1 December 2010 (code: C65)
Royal College of Anaesthetists, London
Registration fee: £245 (£185 for registered trainees)

Recent advances in anaesthesia, critical care and pain management

8–10 December 2010 (code: c11)
Hilton Hotel, Bath
Registration fee: £460

2–4 February 2011 (code: C68)
Royal College of Anaesthetists, London
Registration fee: £460

Sedation event

13 December 2010
Royal College of Anaesthetists, London
Registration fee: £130 (£105 for registered trainees)

Children in the district hospital: essential care

10–11 February 2011 (code: C67)
Royal College of Anaesthetists, London
Registration fee: £415 (£315 for registered trainees)

Final FRCA course

14–25 February 2011 (code: A82)
Royal College of Anaesthetists, London
Registration fee: £650

Anniversary meeting

16–17 March 2011 (code: A03)
Royal Institution of Great Britain, London
Registration fee: £415 (£315 for registered trainees)

Diplomates congress

5–6 May 2011
Royal Geographical Society, London (registration fee to be advised)

A two-day educational programme for diplomates, trainees and career grades. There will be individual sessions in obstetrics, regional anaesthesia, intensive care medicine, advances in airway management and new frontiers in anaesthesia, critical care and pain medicine. The programme includes a dedicated session for trainees and a free paper session, abstract presentations and poster displays. A trade exhibition will accompany the meeting.

Advanced airway workshop

8 September 2010 (code: D43)
The Royal College of Anaesthetists, London

Registration fee: £245
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

Event organiser: Dr R Bhagrath

Becoming a consultant

10 September 2010 (code: B14)
The Royal College of Anaesthetists, London

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

A joint meeting of The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland

This is a new one-day seminar being jointly hosted by the AAGBI and RCoA. The target audience includes trainees approaching CCT, new consultants and anyone preparing for a consultant interview. The day will include lectures by senior anaesthetists on a variety of challenges and issues facing new consultants, including revalidation, becoming a trainer, understanding the political and financial issues associated with working in the modern NHS and dealing with difficult personal and professional situations. There will be plenty of opportunity to ask questions and a drinks reception at the end of the day to allow informal discussion with your colleagues and the speakers.

Event organiser: Dr R Moonesinghe
Anaesthetists as educators: delivering in the workplace

15–16 September 2010 (code: A37)
29–30 November 2010 (code: C80)
The Royal College of Anaesthetists, London

Registration fee: £395 (£295 for registered trainees)
Approved for 10 CPD points

This course builds on the knowledge and skills of ‘Anaesthetists as educators – an introduction’.
It is intended for career grade and senior trainees in anaesthesia, who already have experience of teaching and supervising trainees in the clinical environment. The course looks at the education and assessment of trainee anaesthetists and raises awareness of some of the key concepts associated with education. This highly interactive workshop relies on you bringing your real-life experiences of teaching in the workplace in order to gain the most benefit.

Day 1
Session 1: Basic principles of education
Teaching, learning, training and education
Teaching and learning styles

Session 2: Teaching practical skills
Challenges of workplace teaching
Identifying learning opportunities
Identifying learning needs
Effective supervision
Video-box introduction

Session 3: Non-technical skills
What are they?
Why are they important?
Teaching non-technical skills

Session 4: Small group teaching
What is a small group?
Sociograms
Types of Small Groups, demonstrating:
– Convergent Approach (ATLS example) MC
– Divergent Approach (Faculty to use a current topic, e.g. consent for anaesthesia, selection into anaesthesia) MP
Group processes/difficult personalities

Day 2
Session 5: Assessment of professionals
Principles of assessment
Workplace based assessment tools
Effective workplace based assessments
Performing accurate assessments

Session 6: Giving feedback
Structures for delivering feedback
Effective communication and language
Giving feedback exercise
Feedback from video-box

Session 7: Managing poor performance
Reasons for poor performance
Setting learning outcomes
Delivering effective education
Putting it all together

Event organisers: Dr D Murray and Dr H Walmsley
### Day 1
**Session 1: Peri-operative care**
- Pre-operative cardiac risk stratification  
  Dr P Hersch, Bath
- Cardiology update for anaesthetists  
  Dr R Mansfield, Bath
- Fluids: what's in and what's out?  
  Professor M Mythen, London

**Session 2: Trauma**
- Military trauma  
  Dr D Lockey, Bristol
- Civilian pre-hospital trauma care  
  Dr G Davies, London
- Management of major haemorrhage in trauma  
  Dr K Brohi, London

**Session 3: New developments**
- How NCEPOD has shaped anaesthetic practice  
  Dr A Goodwin, Bath
- Depth of anaesthesia monitoring  
  Dr M Tooley, Bath
- iPhones in anaesthesia and critical care  
  Dr D Low, Bath

**Session 4: Everyday challenges**
- Obesity  
  Dr M Thomas, Bristol
- Enhanced recovery for colonic surgery  
  Dr M Swart, Torbay
- Fractured neck of femur  
  Dr R Griffiths, Peterborough

### Day 2
**Session 5: Innovation**
- Non-compatible neuraxial connectors  
  Dr A Hartle, London
- I-gel  
  Dr M Nasir, Cairo
- Innovation in anaesthesia  
  Dr J Clarke, London

**Session 6: Paediatrics**
- Advances in paediatric anaesthesia  
  Dr A Wolf, Bristol
- Stabilising the critically ill child  
  Professor P Weir, Bristol
- Advances in paediatric airway management  
  Professor M White, Bristol

**Session 7: Resuscitation**
- Resuscitation guidelines 2010  
  Dr J Soar, Bristol
- Post-resuscitation care  
  Dr J Nolan, Bath
- Resuscitation in obstetrics  
  Dr D Gabbott, Gloucester

**Session 8: Drugs**
- Beta blockers and statins in peri-operative care: what to do in 2011  
  Professor P Foëx, Oxford
- Sugammadex: from lab to clinical practice  
  Dr T Bom, Motherwell
- Hunting for new hypnotics  
  Professor R Sneyd, Plymouth

### Day 3
**Session 9: The airway**
- Supraglottic airways  
  Dr C Seller, Bath
- Management of the obstructed airway  
  Dr A Patel, London
- Complications and litigation in airway management  
  Dr T Cook, Bath

**Session 10: Intensive care**
- Liver failure for the general intensivist  
  Dr K Gupta, Bath
- Pandemic flu  
  Dr J Farrar, Vietnam
- Strategies for treating acute lung injury  
  Dr A Padkin, Bath

**Session 11: Regional anaesthesia**
- Nerve blocks without ultrasound  
  Dr W Harrop-Griffiths, London
- Ultrasound directed nerve blocks  
  Dr J Anns, Bristol
- Complications of neuraxial block  
  Dr T Cook, Bath

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**Registration fee:** £460  
**Approved for 15 CPD points**

**Event organiser:** Dr J Nolan

**Recent advances in anaesthesia, critical care and pain management**

8–10 December 2010 (code: C11)  
Hilton Hotel, Walcot Street, Bath
# Current Concepts Symposium

3–5 November 2010 (code: B05)
The Royal College of Anaesthetists, London

**Registration fee:** £415 (£315 for registered trainees)  
Approved for 10 CPD points

## Day 1

**Session 1: Quality improvements in anaesthesia**
- Quality improvement markers in anaesthesia  
  Speaker to be advised
- Best anaesthetic techniques for shoulder surgery  
  Dr J Piccard, London
- Managing pain after major orthopaedic surgery  
  Dr B Fischer, Redditch

**Session 2: Paediatric anaesthesia**
- New airway devices and laryngoscopy  
  Dr C Gildersleve, Cardiff
- Practical use of ultrasound guided regional anaesthesia in children  
  Dr R Blanco, London
- Post-operative delirium in children  
  Dr S Verghese, Washington, USA

**Session 3: Resuscitation and airway**
- Pre-hospital care improves outcome  
  Speaker to be advised
- Protecting the brain after major head injury  
  Dr M Smith, London
- Laryngoscopy – where are we heading?  
  Dr A van Zundert, The Netherlands

**Session 4: Intensive care medicine**
- What is new in ARDS?  
  Speaker to be advised
- Epidemiology of severe pandemic flu  
  Dr C Rowan, London
- New development in infection control  
  Dr V Gant, London

**Drinks reception**

## Day 2

**Session 5: Revalidation and education in anaesthesia**
- Revalidation and the RCoA  
  Dr A Tomlinson, RCoA Vice-President
- Managing CPD in the work environment  
  Dr M Mowbray, Nottingham
- The College, e-Learning and CPD  
  Dr E Hammond, Exeter

**Session 6: Obstetric anaesthesia**
- Modern new frontiers in managing labour pain  
  Dr S Malhotra, London
- Management of the anterior placenta praevia  
  Dr S Catling, Swansea

**Session 7: Regional anaesthesia**
- Risks and benefits of epidural after major surgery  
  Dr T Cook, Bath
- Local anaesthetic toxicity and lipid resuscitation  
  Dr W Harrop-Griffiths, London
- Newer nerve location modalities in modern regional anaesthesia  
  Dr G Slobadan, Belgium

**Session 8: Pain management**
- New frontiers in managing acute pain  
  Dr E Viscusi, Philadelphia, USA
- Pain management in children  
  Dr S Verghese, Washington, USA
- Management of acute on chronic pain  
  Speaker to be advised

**Close**

**Event organiser:** Professor C M Kumar
The Events Programme 2010
www.rcoa.ac.uk/events

Winter scientific meeting 2010
18–19 November 2010
(code: C22)
The Royal College of Physicians, Edinburgh

Registration fee: £265 (£200 for registered trainees)
Approved for 5 CPD points per day

A joint meeting of the Scottish Society of Anaesthetists and The Royal College of Anaesthetists

Day 1
- Modern management of stroke
  Dr M Macleod, Edinburgh
- Battlefield anaesthesia and critical care in the 21st century
  Dr G McCallum, Glasgow
- Recent developments and ethical dilemmas in organ donation
  Dr S Cole, Dundee
- Anaesthesia 2010
  Dr I Wilson, Devon
- ‘It is much better to be able to see round the corner!’
  A pro/con debate on the benefits of the new videolaryngoscopes and other clever bits of kit versus conventional direct laryngoscopy
  Pro: Dr B Shippey, Fife
  Con: Dr B Brampton, Aberdeen
- The Scottish Enlightenment
  Dr J Harris, Fife
- The Gillies Lecture - Nobody’s Perfect
  Professor B Toft, Coventry

Day 2
- Temperature post cardiac arrest – the TOPCAT Study
  Dr R Lyon, Edinburgh
- Putting human factors into anaesthetic practice
  Dr N Maran, Edinburgh
- The high-risk surgical patient: can we provide critical care without an ICU bed?
  Dr R Pearse, London
- Infection control in critical care
  Dr D Swann, Edinburgh
- Critical illness… the long road to recovery
  Professor T Walsh, Edinburgh
- Pain medicine in the next decade
  Professor I Power, Edinburgh
- Anaesthesia at the limits?
  Dr A Severn, Lancaster
- Anaesthesia of the young
  Dr A Baxter, Edinburgh

Event organisers: Dr J Wilson and Dr P Nicholas

Sedation: educating for safety
13 December 2010
Royal College of Anaesthetists, London

Registration fee: £130 (£105 for registered trainees)

From August 2010 sedation will be an official part of the training curriculum for all anaesthetists in the UK.
Sedation is currently practised by many medical specialties but an increasing role for anaesthetists is inevitable as procedures become more complex and patients more medically challenging. This one day meeting will look at sedation as a whole; what it is, is it safe, what problems have there been and how can they be prevented? Taking a very clinically orientated approach, it will show how sedation is currently practised in the UK as well as looking at the role anaesthetists may be asked to play in the future in both service planning and provision, and in education.

Event organisers: Dr S M Blayney and Dr A Wrath

Continuing Medical Education day
6 November 2010 (code: A76)
Royal College of Anaesthetists, London

Registration fee: £225

The format of this year’s meeting has changed.
Delegates will now have the opportunity to attend all lectures presented on the day.

- Safe extubation
  Dr A Higgs, Chester
- Obstetric anaesthesia
  Dr F Plaat, London
- Management of severe sepsis
  Dr M Jonas, Fareham
- Acute trauma management in the elderly
  Dr J Holloway, Poole
- The management of burns
  Dr M Fried, Livingston
- Paediatric anaesthesia
  Dr R Nandi, London
- Regional anaesthesia: can nerve blocks influence mitotic disease recurrence?
  Dr A Sharma, Peterborough
- Training: what is new in the curriculum
  Dr L Brennan, Cambridge

Event organiser: Dr R Griffiths
UK training in emergency airway management (TEAM) course

27–28 September 2010 (code: D29)
The Royal College of Anaesthetists, London
13–14 October 2010 (code: B75)
Royal Infirmary of Edinburgh

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.

Event organisers: Professor J Benger and Dr D McKeown

Making part time work

30 November 2010 (code: D08)
The Royal College of Anaesthetists, London

Registration fee: £30
Approved for 5 CPD points

Supported by the London Deanery

The Less Than Full Time (LTFT) forum is aimed at present and future LTFT trainees, together with TPD’s and representatives from the deaneries. We will give an overview of everything you need to know about part time training, including application, pay, hours, leave implications and returning to work issues. Presentation of a national survey of all LTFT trainees to identify current areas of improvement and discussions as to the future of LTFT training considering the EWTD implications will be included.

Session 1: How to train LTFT
- How to understand LTFT pay, leave and pension implications
  Dr L Dinner, London
- Returning to work
  Dr S Coomber, Ipswich

Session 2: LTFT training current status and future direction
- Is LTFT working?/national LTFT trainee survey results
  LTFT London Training Group
- The future of Medical Training and Implications for LTFT Trainees
  Sir John Temple

Session 3: Making LTFT training work, outcomes to date
- There is no limit with LTFT training
  Speaker to be advised
- Why you should be involved in Education and Training in Medicine
  Speaker to be advised
- Approaching your consultant job as a LTFT trainee
  Dr A Holdcroft, London

Event organisers:
Dr C Pritchard, Dr C Evans and Dr A Chataway

Core topics day

14 October 2010 (code: C79)
The Royal College of Anaesthetists, London

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

The Core Topics day series of lectures are designed to cover the essentials you will need to keep up to date with as part of your revalidation in anaesthesia. The knowledge contained within the core topics programme would allow an anaesthetist to manage a typical range of clinical situations that could be encountered whilst undertaking emergency cover for a hospital.

A feature of the day is ample opportunity for questions from the floor when the experts will be happy to answer queries at all levels. The day covers a variety of topics and our aim is that no delegate should leave for home wishing they had found out more about any of the subjects and not had the opportunity to do so.

Event organiser: Dr C Frerk
REGISTRATION FORM

Please complete this form in BLOCK CAPITALS and return to the:

Finance Department
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London WC1R 4SG
fax 020 7092 1733 email events@rcoa.ac.uk

Your details

Full name:
College Reference Number (CRN):
GMC Number:
Address:
Postcode:
Telephone:
Email:
Hospital:

Please ensure you complete your full postal address.

Event details

Date: D D M M Y Y  Code: 
Event Title:
Registration fee: £

Payment details

☐ A cheque is enclosed and made payable to The Royal College of Anaesthetists.

☐ I wish to pay by the following debit/credit card: ☐ ☐ ☐ ☐

Cardholder’s name: Signature:

Please use BLOCK CAPITALS.

Card number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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Expiry date: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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TERMS & CONDITIONS

☒ Additional copies of this form can be downloaded from www.rcoa.ac.uk/meetings.pdf
☒ Members of the Senior Fellows Club can attend meetings at half price.
☒ Bookings will be accepted on a first come, first served basis.
☒ Please be aware that programmes are subject to change and you should check the College website for regular updates.
☒ Our events are open to all grades of anaesthetists, unless specifically stated otherwise.
☒ When an event is full, this will be publicised on the website. To be placed on a waiting list, please contact the Events Department on 020 7092 1670. We will then contact you as soon as a place becomes available.
☒ All of our events have CPD approval of five points for a full day and three points for a half day, with the exception of FRCA revision courses, which carry a maximum of 15 points, for non-trainees only.
☒ Lunch is included in the registration fee unless otherwise indicated.

Booking and payment

☒ Bookings will be accepted on a first come, first served basis.
☒ Bookings will not be accepted unless the appropriate fee and application are received together.
☒ Please note that places are not reserved until payment is received.
☒ Confirmation of a place will be sent to you within 14 days of payment being received. If you do not receive this, please contact the Events Department.

Cancellation policy

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

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

**March 2010**
- Members
  - Dr Venkata K R Bandaru
  - Dr Praveen K Kondapalli
  - Dr Sunil Jeevan Dasari
  - Dr Madhusudhana R Adala
  - Dr Edward William Curtis
- Associate Members
  - Dr Marouf Mudasir Dhar
- Affiliate Physicians’ Assistants
  - Ms Alison Helen Fiddes
  - Mrs Claire Gillian Hastings

**April 2010**
- Associate Fellows
  - Dr David Trevor Lee
  - Dr Aoibhin B Hutchinson
  - Dr Caroline Elizabeth Kelly
  - Dr Mary Elizabeth Molloy

Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

- Dr E Combeer, Frimley Park Hospital, Surrey
- Dr S E Conolly, James Cook University Hospital Middlesbrough
- Dr P M Foley, The Ulster Hospital and The Lagan Valley Hospital, Northern Ireland
- Dr A K Gopalil Silvadas, University Hospitals of Basildon and Thurrock, Essex
- Dr T A Murphy, Southern General Hospital, Glasgow
- Dr S Y Pangam, West Suffolk Hospital, Bury St Edmunds
- Dr S A Parmar, Darrent Valley Hospital, Kent
- Dr M Trivedi, Addenbrooke’s Hospital, Cambridge
- Dr B C Ulyatt, Ninewells Hospital, Dundee

**Anaesthesia & Critical Care in the 21st Century: The First Decade**

Professor Jennie Hunter’s Festschrift
Thursday 12th & Friday 13th May, 2011
BT Convention Centre, Albert Dock, Liverpool

Organised jointly by the British Journal of Anaesthesia (BJA) & the Liverpool Society of Anaesthetists (LSA)

**All Lectures by members of the BJA Board**

**Opium Receptor Subtypes: Fact or Fiction?**
- An update on analgesics—what’s new?
- Chronic Pain After Surgery, where are we now?
- New hypnotics—survival of the fittest or a quest for quality?
- Are inhaled anaesthetics toxic to the brain?
- Optimising IV drug administration by applying PK/PD concepts
- Medication errors during anaesthesia: can they be reduced?
- Pharmacology of malignant hyperthermia
- Oxidative stress and mitochondrial dysfunction in sepsis
- Management of diabetic surgical patients
- Changing modes of ventilation in the ICU
- The development of the Faculty of Intensive Care Medicine
- Preoperative cardiac management of the patient for non-cardiac surgery:
  - an individualised and evidence-based approach
- Microvascular responses in the perioperative period

**The First T Cecil Gray BJA Lecture by S Shaffer (EIC, A&A)**
From d-lactobacillate to sugammadex, the contributions of T Cecil Gray to modern anaesthesia practice

**Delegate Rates**
- Consultant & NCG Two Days £320
- Consultant & NCG Single Day £188
- LSA Members £300
- Trainers Two Days £275
- Trainers Single Day £150

This meeting has been awarded 10 CPD Points by The Royal College of Anaesthetists
Association of Paediatric Anaesthetists of Great Britain and Ireland

5th National Linkman Meeting
Royal Institute of British Architects (RIBA), London
Friday, 26 November 2010

After a trip to the country (Cardiff 2009), the APAGBI Linkman meeting returns to London for 2010. All APAGBI Linkmen are eligible to attend, but we welcome the participation of any grade of anaesthetist with an interest in paediatric anaesthesia.

Topics to include:
- Tanner Report – Implications, implementation and innovation
- Teaching and training
- Professional standards
- Clinical conundrum – an opportunity to discuss the management of an anaesthetic problem and the issues it raises in your practice

Registration fee: £150

Application forms will be available from August 2010 to download via the APAGBI website: www.apagbi.org.uk or, for further information, please contact: apa.linkman2010@aagbi.org/020 7631 8804.

NATIONAL INSTITUTE OF ACADEMIC ANAESTHESIA

Grants and Awards

The National Institute of 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 £1,000.**

**Stanley Rowbotham Fund**
For education in anaesthesia.
**Value up to £2,500.**

**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 £2,500.**

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

To apply

The closing date for all applications is noon, Wednesday, 1 September 2010.
THE STATE OF THE ART MEETING 2010

MONDAY 13 – TUESDAY 14 DECEMBER 2010
HILTON METROPOLE, EDGWARE ROAD, LONDON

Book now for the most important UK ICM conference of the year; hear renowned academics, international experts and keynote speakers deliver a diverse scientific programme. Learn from a two day lecture course dedicated to cutting edge topics in intensive care, Foundation updates, clinical practice and research forums. It’s a must for all critical care professionals enabling you to keep ahead of all the latest developments and familiarize yourself with all the hottest concepts.

Now open! Free paper abstract submission for presentation in the research and clinical practice research forum as well as applications for the prestigious Research Gold Medal. The deadline for all submissions is 30 August 2010.

CPD accreditation: 10 points pending

Further details including the full meeting programme, registration and guidelines for free paper submissions are available at www.ics.ac.uk or by emailing events@ics.ac.uk
The Mersey Menu

Final MCQ Week 8 – 13 August 2010
Aintree Hospitals, Liverpool

Private SAQ and E&SAQ Weekend 13 – 15 August 2010
Aintree Hospitals, Liverpool

Final Revision (Booker)Course Week 15 – 20 August 2010
Liverpool Medical Institution

Private SAQ and E&SAQ Writers Club Weekend 20 – 22 August 2010
Aintree Hospitals, Liverpool

Primary MCQ Week 22 – 27 August 2010
Aintree Hospitals, Liverpool

Final E&SAQ Weekend 27 – 29 August 2010
Aintree Hospitals, Liverpool

Primary OSCE Weekend 3 – 5 September 2010
Aintree Hospitals, Liverpool

Primary FRCA Viva Weekend 17 – 19 September 2010
Aintree Hospitals, Liverpool

Primary FRCA OSCE/Orals Week 24 September – 1 October 2010
Aintree Hospitals, Liverpool

For further details, assessments and application forms, please see: www.msoa.org.uk
The Final FRCA Examination and The Final FCARCSI Examination 2011

The October Mersey Writers Club

Practise SAQ or E&SAQ Papers
Learn from marking, analysis and advice
Refine your timing
Benefit from revision
Acquire a collection of structured answers

One-off Membership fee of £400

Retain Membership until successful in the Examination without further charge
Attend any Mersey SAQ or E&SAQ Weekend Courses without further charge
Attend the Private Members-only Weekend Courses without further charge

Writers Club – opening Monday, 1 October 2010

Surname ___________________________________________ Initials ______________________
Home address ____________________________________________
________________________________________________________ Postcode ______________________
Home tel ___________________________________________
Mobile ___________________________________________
email ___________________________________________

I intend to sit the Final FRCA Examination (please tick as appropriate) ☐
I intend to sit the Final FCARCSI Examination (please tick as appropriate) ☐

If interested, please extract or photocopy this page, complete the proforma and post together with a cheque for £400, dated 1 September 2010 to The Writers Club, MSA Office, Aintree Hospitals, Liverpool L9 7AL.

On receipt, the MSA Office will email you full details of The Writers Club, the procedures and the protocols, which will allow you to decide whether you wish to join or not and to inform the MSA Office accordingly.

If you decide against joining, your cheque will be destroyed.

Enquiries to: WritersClub@aintree.nhs.uk
Contact information

Chief Executive
Kevin Storey 020 7092 1612
Deputy Chief Executive and
Director of Professional Standards
Charlie McLaughlan 020 7092 1613
Director of Education
Sharon Drake 020 7092 1613
Director of Training and Examinations
Richard Bryant 020 7092 1613

Chief Executive’s Office
Facilities Manager, Martin Bennetts facilities@rcoa.ac.uk 020 7092 1510
Finance Manager, Roger Smith finance@rcoa.ac.uk 020 7092 1585
IT Manager, Richard Cooke support@rcoa.ac.uk 020 7092 1712
Membership and subscriptions subs@rcoa.ac.uk 020 7092 1701/1702/1703

Education Directorate
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e-Learning Anaesthesia e-LA@rcoa.ac.uk 020 7092 1542
Faculty of Pain Medicine fpm@rcoa.ac.uk 020 7092 1727/1729
Human Resources Manager, Isma Zahoor hr@rcoa.ac.uk 020 7092 1542
Meetings and Events events@rcoa.ac.uk 020 7092 1670
National Institute of Academic Anaesthesia info@niaa.org.uk 020 7092 1680

Professional Standards Directorate
Professional Standards Manager, Bob Williams standards@rcoa.ac.uk 020 7092 1694
Advisory Appointments Committees aac@rcoa.ac.uk 020 7092 1571/1572
Bulletin bulletin@rcoa.ac.uk 020 7092 1693
Patient Safety salg@rcoa.ac.uk 020 7092 1574
Presidential Secretariat president@rcoa.ac.uk 020 7092 1600
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