Inside this issue

Medico-legal advisers: specialists in ethico-legal medicine

Bullying in the workplace

Anaesthetic anaphylaxis: a question of evidence

Wrong side peripheral nerve blocks

Addiction and anaesthetists
From the Editor

I am delighted to be able to welcome you to the November issue of the *Bulletin* and would like to thank Peter Venn, not only for leaving the *Bulletin* in such fine health, but also for continuing in the background to give me substantial support in my new role as editor until I demit office as Medical Secretary in the New Year. I am looking forward to having the time to dedicate myself completely to this exciting new responsibility. In Peter’s last letter from the editor he quite rightly praised the skills and professionalism of the production team, but the girls would be the first to acknowledge that the structure and forward planning that Peter has introduced to the system has revolutionised their work-stream. I am personally grateful because it makes it considerably easier for me to take over.

Although I may well make some subtle changes to future issues there are some strategies that are too good to change. I really enjoy having a themed issue and I am pleased this has widespread approval. This issue has a medico-legal theme and our guest editorial has been written by Mr Bertie Leigh who has opened the journal with a very thought provoking description of the changing expectations the legal profession towards anaesthetists, since the inception of the NHS, and the value of experience. Other contributions range from how our defense organisations can provide us with support, acting as a medico-legal expert, and salutary lessons about how such evidence may be used in court. After reading these articles the two views on avoiding wrong sided peripheral nerve blocks suddenly seem even more important.

In addition to updates from the faculties, updates about the curriculum and clarification of the role of the responsible officer, this edition includes lessons learnt from the introduction of core training and difficulties providing equitable regional block training across the country. There are also two invaluable articles on bullying and addiction in anaesthetists, raising the profile of these challenging situations, which we often try to ignore.

Our craving for the past is satisfied by the first of a fascinating series on the history of some of our notable anaesthetic departments, and our regular ‘As we were’ series. Looking forward, for those of us who love the science behind our specialty, we also have advanced notice of the very exciting ‘Senseless: Anaesthesia, Consciousness and Pain’ exhibition which is planned for the September 2012 in London’s Science Museum and I would like to draw your attention to the final section of the article on page 49, entitled ‘Get involved’ and encourage you to do just that!
At the risk of seriously stressing the Bulletin production team I submitted my President’s Statement for this issue even later than usual in the hope that I could announce some good news on a number of issues.

**ACCEA**
Unfortunately, the release of the report from the Advisory Committee on Clinical Excellence Awards (ACCEA) on this year’s round of awards brought little to celebrate, especially for our specialty. The 299 awards in this 2011 round were even less than last year (317), after almost being halved compared to previous years (601 in 2009). Of the 299, only 6% went to anaesthetists. To my mind, there is now a serious danger that our specialty will effectively withdraw from the process unless the forthcoming report from the Review Body on Doctors’ and Dentists’ Remuneration makes some worthwhile recommendations to encourage those who are not practising in the main medical or surgical specialties. The report was due to be published in July of this year but remains with ministers; it will be interesting to see how the different views of the devolved administrations fare when it is finally released. The on-going lack of recognition for the contributions anaesthetists make may well be felt over the next few years in education and training.

I am particularly concerned about work for the wider NHS such as that done for deaneries and for national curriculum development and examinations. I will continue to press for time and resources to be made available by employers for this and other essential work relating to professional standards. The Health and Social Care Bill went to the House of Lords in early September and the Academy is pressing to incorporate into the Bill such a duty on local employers.

**Educational Outcomes Framework**
The torrent of publications from the Department of Health shows no sign of abating as Mr Andrew Lansley ploughs on with his reforms; this autumn we will see even more. From the College’s perspective one of the most important will be the Educational Outcomes Framework which has been developed at breakneck speed over the summer. A draft was circulated widely at the end of September but, such is the pace of change within the Department of Health, there was very little time for comments. I would like to say thank you in advance to those who did feedback general comments, and especially if there were suggestions for appropriate metrics by which to judge the performance of local education providers.

Linked directly to this initiative is the ongoing work to get Health Education England (HEE) up and running. HEE will oversee the delivery of all healthcare education in England, not just medical, and will hold a budget of nearly £5 billion; the Senior Responsible Officer will be in place by the time you read this. The EOF should act as a means to influence local employers and show them that having trainees will bring income to their hospitals but that they will lose it if training is not of a satisfactory standard.

**Have curriculum, will travel!**
The College recently approved a request from overseas to adapt some of the RCoA UK training competencies to reflect local needs. The request came from the Chairman of the Board of Examiners of the Philippine Board of Anesthesiology who has the task of standardising knowledge and skills objectives at training centres across their nation. I would ask all those who have contributed to the curriculum development and training assessment work over the
years to feel proud that their efforts have been recognised in this way.

Health Services Research Centre (HSRC) National Audit Programme

At interview in September Dr Jaideep Pandit, consultant anaesthetist and senior clinical lecturer at the John Radcliffe Hospital, Oxford, was selected to be the Clinical Lead for the College’s fifth National Audit Project (NAP5); my congratulations to him. NAP5 will be run in partnership with the AAGBI and look into Accidental Awareness during General Anaesthesia (AAGA). Although likely to be a difficult audit to run, this topic is of great importance to patients; they frequently ask about it during the pre-operative visit. It is also of great importance to anaesthetists as it is seen as a failure of their practice and commonly leads to litigation, some 20% of all claims. I am confident that our specialty can again lead the world in providing definitive data on an important aspect of anaesthesia care.

The Centre has also received encouraging news from the Healthcare Quality Improvement Partnership (HQIP) regarding the proposed National Emergency Laparotomy Audit. As part of the expanded National Clinical Audit and Patient Outcomes Programme (NCAPOP) the National Emergency Laparotomy Network team led by Dr Dave Murray (James Cook University Hospital, Middlesbrough) is to be funded nationally. Hopefully, the HSRC will be successful in its bid to run the audit when the tendering process starts. Again, this is exceptionally good news for our specialty as we bid to become more involved in perioperative care in its widest sense.

Sense about Science

I’m not sure how many Fellows and Members knew previously of Sense about Science (see www.senseaboutscience.org) but I expect many of you will have read or heard about them in the media in mid-September when they launched their Ask for Evidence campaign. I have been extremely impressed by the work of this organisation over the last few years, especially the quality of their publications, and hope that you will help build momentum for their campaign by asking any organisations with which you have affiliations to sign up and publicise it.

Seasonal influenza

Last year many ICUs came under serious pressure because of H1N1 infections. The Chief Medical Officer, Dame Sally Davies, has written personally to College presidents seeking their support, and that of their Fellows and Members, for the vaccination programme this winter. Remarkably, many frontline healthcare workers do not have the ‘flu jab’ even though it has been shown to significantly lower the rate of illness, hospitalisation and mortality in the elderly in healthcare settings as well as protecting themselves. I believe we have a duty to protect our patients and I would ask that you all actively support the national vaccination programme this year. There will be no media campaign so please stress the importance of vaccination to your patients, family and friends.

Changes at the top of the table

Following the elections in June of this year, Council had a slightly different look at its meeting in September when Professor Robert Sneyd took his place as the newly-elected Vice-President. Dr J-P van Besouw was re-elected for a second year, and I entered my third and final year as your President. Rob brings a wealth of experience from numerous local, national and international bodies and has already shown on Council his ability to see and think strategically. I look forward to working closely with him on a number of issues. Demitting office after two exceptional years as Vice-President was Dr Andrew Tomlinson to whom the whole of Council, and all Fellows and members, owe a debt of gratitude. Andy has been the driving force behind a number of initiatives but I would like to thank him publicly for all his time and effort in helping to develop the 2010 curriculum and leading the work on revalidation over the past two years. He has been a source of great support for me personally and thoroughly deserves all the plaudits he has received.
On 5th July 2013, those anaesthetists who share the birthday of the NHS will reach the age of 65 and would, in the ordinary course of events, be expected to retire full of years. It is worth considering the predicament that they pose for society, and examine how we are responding.

Typically, they will have been consultants for between 25 and 30 years, and will have trained for 10 to 15 years before they were appointed to that senior grade. During those years of training they may have worked for up to 50,000 hours, and will be likely to have gained experience of managing cases alone and without direct supervision, and have seen 95% of the range of work that they will have handled later as consultants. It is not necessary to engage in the now futile debate about the wisdom of the changes that have been made to medical training over the last 15 years in order to recognise that our present generation of senior consultants, as a group, are a ‘national treasure’.

As they retire, they will be replaced by people who have a fraction of the experience that used to be the norm. Furthermore, the younger doctors bring with them a different attitude to work. Reflecting a new respect for the work-life balance, the new appointees characteristically share a different attitude to continuity of care. Whereas the ‘national treasure’ was trained to regard the treatment and protection of their patient from the beginning to the end of the process as their first duty, the new generation regard themselves, at least while they are juniors, as playing a brief part in the patient’s journey through the system. Continuity of care may often matter a little less in anaesthesia than in other specialties, certainly the disasters that I see in my work as a defence lawyer seem to involve the results of ‘handoveritis’ more often in the surgical specialties but, equally, I have the impression that the anaesthetist who pops into the hospital unbidden on a Saturday morning, just to see how Friday’s patients are feeling, is more likely to be a senior.

Furthermore, the work-life balance has been accompanied by a more restricted view of the role of the doctor. There has been a general loss of the sense of ownership of the service as a whole, and this has led to a long term and progressive decline in productivity. Surgical lists seem to be much shorter and more prone to disruption. There is less slack in the system and a greater disinclination to compensate, to patch things up by extra-contractual individual efforts.

One thing that could postpone the loss of the ‘national treasure’ whilst their successors gain more precious experience, is the more flexible attitude to retirement. In future it will be much harder for an employer to tell an employee that they must leave the NHS simply as a result of having attained their 65th birthday. There is now, at least, a process of negotiation and consideration. Unfortunately for the service, this tends to lead to a larger cohort of doctors leaving before they reach the age of 65 than those who intend to carry on a bit longer. I suggest that it would be in the interests of both the service and the prospective new appointees, if more of these doctors could be persuaded to stay. In some respects, changes in the law are helping to support this aspiration. For example, the extension of the provisions of...
the Equality Act 2010, which prohibits discrimination on grounds of age so as to protect people approaching the age of 65, will obviously help to enable some of the ‘national treasure’ to defer retirement, and so their loss to the service. However, far more feel that they are being driven out a year earlier by the provisions relating to the taxation of their pension pots. Any doctor who has not obtained specialist advice in this area, and who may be affected, will be wise to do so without delay.

Those doctors who do retire early will have the opportunity as before of returning to work post retirement. Unfortunately, the short term financial problems facing NHS bodies mean that employers are anxious to make any savings that they can, and will see a senior doctor as a more expensive alternative to a junior.

How has this come about? The answer, in anaesthesia at least, is almost certainly a function of the success that has been achieved by the ‘national treasure’ and their predecessors, over the decades since the NHS was born. In 1948, mortality from anaesthesia was not regularly measured. The only one of the confidential enquiries that was undertaken at that time was the original enquiry into maternal mortality. The first estimate of mortality from anaesthesia is probably the Beecher & Todd’s study of cases from highly respected American university hospitals between 1948 and 1952. This included 108,000 cases from 1948 where the death rate from anaesthesia was 1 in 1,440, although it could not be said that it was the sole cause of death in all cases.

Today, the same figures would be very difficult to calculate for a number of reasons. Firstly, because the denominator to give any sort of realistic indication of risk when dealing with such a rare event, has to be enormous and, secondly, because the proportion of patients requiring surgery in ASA grades 3, 4 and 5 has gone up greatly. I suspect that the figure for an equivalent population would be in excess of 1 in 250,000. The consequence of this for the individual anaesthetist is not wholly comfortable. It was because surgery was perceived as being such a hazardous activity that the Law Courts treated anaesthetists comparatively kindly in cases such as Bolam, and Rowe v The Ministry of Health, in the 1950’s. The General Medical Council would then be highly unlikely to consider that the death of a patient on the operating table called into question a doctor’s fitness to be on the medical register, nor would such a death often cause an employer to have second thoughts about the wisdom of employing such a doctor. I can remember hearing medically qualified coroners in the 1970’s telling bereaved families that, despite all the skills of the modern medical profession, anaesthesia remained intrinsically dangerous and that it did sometimes happen that, after an anaesthetic death, neither the pathologist nor the anaesthetist could provide any explanation as to why it had happened. Furthermore, that this chain of events did not necessarily reflect adversely on the doctors involved. Because the song was regarded as difficult to perform, the singer’s value was high. Today, the song is regarded as comparatively straightforward provided the rules are observed and, therefore, any false note is unacceptable. The doctor is seen as providing a commodity: if he is confident that the disastrous is going to happen whichever doctor is chosen, the employer feels forced to choose the cheapest option.

Where medicine is a commodity, it is easy to fall into the trap of thinking that doctors are interchangeable, and that the cheapest will offer the best value. Because it is hard for managers to measure productivity, and almost impossible to assess the value of relative knowledge and skills amongst doctors, the ‘national treasure’ is being allowed to slip away unnoticed.

Reference

Regional anaesthesia is an integral part of anaesthetic practice, and has recently seen a dynamic development following the advent of ultrasound guided regional anaesthesia, and increasing use of continuous peripheral nerve blocks. The growing role for regional anaesthesia is reflected in the training curriculum for the Certificate of Completion of Training (CCT) in Anaesthesia.

Straight to the point – background
In essence, both the 2007 and 2010 curricula envisage that trainees at their intermediate level of training should be able to perform central nerve blocks, as well as a minimum of one major upper and one major lower limb block. However, both editions of the curriculum admit that availability of training opportunities will be subject to local variation, and that not every trainee will become competent in every regional technique. It suggests that, if training in particular blocks is not available at the intermediate level, it should be deferred to years 5−7, or even until after the award of the CCT. Ultimately, the 2010 curriculum classifies spinal, epidural (including thoracic), femoral and axillary blocks as essential, the remaining being optional. Compared to the older edition, the 2010 curriculum introduces the use of ultrasound guidance for regional anaesthesia and peripheral nerve catheters.

Whilst the Royal College documents are quite specific about the competencies trainees need to achieve, little is known about the practical skills that they actually acquire, their self-confidence in using regional anaesthetic techniques, or their satisfaction with training in this sub-specialty.

Therefore, we conducted a nationwide online survey to provide a detailed insight into the current situation regarding training in regional anaesthesia within the UK. We hoped that the results would help to identify areas of improvement in the training schemes, as well as giving junior doctors the opportunity to compare their own skills with those of a relatively large sample of UK trainees.

We received 379 replies (representing 13% of approximately 2,900 UK anaesthetic trainees) which consisted of 221 replies from junior (CT1–2/ST 3–4) and 158 replies from senior (ST5–7) trainees.

The following figures indicate self-perceived competence of both junior (Figure 1) and senior (Figure 2) trainees at a variety of regional anaesthetic techniques.

It appears that senior anaesthetic trainees are generally competent at neuroaxial blocks using the landmark technique, and a vast majority are comfortable with simple lower limb blocks, hence meeting the training targets set out in the curriculum. However, self-confidence at upper limb blocks is significantly lower: only about 65% of senior trainees felt comfortable when performing an axillary block (regarded as ‘essential’ in the 2011 curriculum) unsupervised.

This most likely reflects:

- Fewer training opportunities, because in most trusts the bread-and-butter hip, knee and foot operations outnumber the relatively
Consultants to deploy the ultrasound-based technique (46%), limited access to an ultrasound machine (28%) and, finally, personal preference for the landmark-based technique (24%). Whilst 73.4% of respondents recognised that it could be useful potentially for difficult neuraxial procedures, competence at using ultrasound in this context is a rarity. Only 0.4% of junior and 2.6% of senior trainees are confident to use ultrasound for neuraxial blocks, and nearly 65% of junior and 49% of senior trainees have not even witnessed an ultrasound-guided neuraxial blockade.

In practical terms, lack of training opportunities for trainees is probably the main impediment to wider use of ultrasound.

No satisfaction

Only 23% of junior and 35% of senior trainees are satisfied with their training in regional anaesthesia, specifically training in upper limb blocks, and the use of ultrasound does not appear to meet the trainees’ expectations.

These numbers indicate that there is a significant mismatch between supply and demand for training opportunities in regional anaesthesia. The mismatch could be, in theory, rectified by either:

1. Increasing training opportunities
2. Rationalizing the demand for training in regional anaesthesia.

Increasing the training opportunities

There is quite a lot one can do to increase the success of blocks before actually meeting a real patient. Thorough knowledge of anatomy is absolutely essential. Whilst there is no way around the good old textbook, novel sources of information abound.

Have you got the nerve? – ultrasound guided regional anaesthesia

The National Institute for Health and Clinical Excellence (NICE) has recently published guidance documents supporting the use of ultrasound for placing both peripheral nerve blocks, as well as difficult epidural catheters. At the same time, 62% of our respondents believe that the use of ultrasound guidance for peripheral nerve blocks will become mandatory in future.

In spite of this, ultrasound guidance for peripheral nerve blocks still appears to be a growing skill. Forty percent of junior, and 29% of senior trainees had some sort of informal training on accompanied teaching lists, and 13% of trainees attended a relevant formal course. However, only 7% of junior and 23% of senior trainees felt comfortable when using ultrasound for peripheral nerve blocks without direct supervision.

Examining the reasons for this, lack of appropriate training is the most commonly quoted obstacle (53%), followed by reluctance of supervising consultants to deploy the ultrasound-based technique (46%), limited access to an ultrasound machines (28%) and, finally, personal preference for the landmark-based technique (24%).

Surgeons are generally open to femoral/fascia iliaca blocks for fractured necks of femur, and yet they tend to oppose regional anaesthesia in upper limb fractures for fear of missing compartment syndrome.

Perceived higher risks involved in inserting a needle into the close proximity of large vessels and the pleura.

Panel

Figure 1
Percentage of junior trainees (n=221) who feel confident in their ability to perform a block without direct supervision.

Figure 2
Percentage of senior trainees (n=158) who feel confident in their ability to perform a block without direct supervision.

The next step involves making a meaningful correlation between the beautiful coloured drawings in Grey’s Anatomy, and the black-and-white patterns on the ultrasound screen.

A good way to start is by attending one of the many regional anaesthesia courses available. These days, practically all of them focus on the use of ultrasound rather than landmark based techniques. (Those planning to obtain the European Society of Regional Anaesthesia (ESRA) Diploma in Regional Anaesthesia need to be aware that, to qualify to sit the examination, you must have attended two ESRA approved courses. However, not all are recognized by ESRA, and you are advised to check the ESRA website before booking.)

No matter how good, a course can only be an introduction to the art of scanning. You will have to spend some time with an ultrasound machine, lots of ultrasound gel and few willing volunteers (ODP’s, fellow trainees) in a convenient dark room. ‘Scanning parties’ (you-scan-me-I-scan-you) will not only enhance your ultrasound competence, but also prove a fairly positive team building experience.

The next (often frustrating) hurdle is learning to get the needle where it needs to be. Even fancy enhanced echo-needles can be difficult to keep within the view of the ultrasound probe. You may choose to practice your eye-hand-coordination proves, either on commercially available needling models (expensive), or homemade budget alternatives (turkey breast, olives-and-spaghetti-in-tofu).

After exploring a few necks and arms (more readily accessible than the subgluteal and inguinal territories) and becoming an expert in impaling olives buried under and inch of solid tofu, you are ready to proceed to part two of your training: practice on real patients.

This can be far more difficult, and maximizing exposure may depend on input from both the departments and the schools of anaesthesia concerned. Training opportunities can be increased by promoting the use of regional anaesthesia/analgesia where appropriate (for instance by the setting up of block rooms, dedicated regional anaesthetic services for hand surgery, regional pre-operative analgesia services for trauma patients). Equally, making the most of the opportunities available is crucial, including establishing formal modules with well-defined training outcome modules. (These are not universal yet: 87% junior and 69% senior trainees in our survey have not done a dedicated module in regional anaesthesia.) Promoting pre- or post-CCT fellowships of six, or ideally 12 months duration would be desirable for trainees with a special interest in regional anaesthesia.

**Rationalising the demand**

The results of our survey seem to indicate that regional anaesthesia is a fairly popular special interest. Overall, 88% of our respondents were interested in investing substantial effort, time and money into acquiring ultrasound guided regional anaesthesia skills, and 66% of the trainees were keen to obtain a formal qualification in regional anaesthesia (for instance, the ESRA Diploma). Arguably, our results are probably skewed by the fact that it may have been mainly the ‘regionalist enthusiasts’ who responded to our survey. Still, we may assume that a large number of trainees is keen to augment their experience in regional anaesthesia (be that out of genuine enthusiasm or the compelling need to enrich one’s CV in today’s competitive climate).

This large demand for training in regional anaesthesia raises a couple of important questions: What are the realistic training outcomes in regional anaesthesia, and can everyone interested get the exposure they desire? The answer will probably vary from region to region.

In areas with sufficient case loads, reasonably universal acquisition of even less common blocks by a majority (if not all) trainees within that region might be feasible. However, limited numbers of appropriate cases in other regions will preclude competency at a wider range of skills. In this scenario one might advocate teaching the common techniques (neuroaxial, femoral, ankle +/- axillary blocks) to all the trainees, whilst reserving the less common techniques (within that region) for trainees with special interest in regional anaesthesia.

We will probably see a classification of regional procedures into various categories, depending on the prevalence of their use, risks involved, and overall value:

- Basic techniques (neuroaxial, transversus abdominis plane (TAP), inguinal, femoral, ankle).
- Intermediate (axillary, popliteal, sciatic, penile).
- Advanced (supraclavicular, infraclavicular, interscalene, obturator).

Clearly, whilst basic techniques will remain a generic skill, most
practitioners may neither attain nor retain an adequate level of competency in the advanced or even intermediate blocks. The onus would be on every anaesthetist to prove acquisition and maintenance of skills by keeping a logbook detailing numbers of procedures, success and complication rates. Such a development would only parallel what has been seen in other sub-specialty areas of anaesthetic practice, and would most likely improve patient safety and satisfaction.

Our survey had a low response rate, which probably reflects a certain ‘survey fatigue’ that renders trainees more likely to respond selectively to surveys from within their areas of special interest. Indeed, the high percentage of respondents keen to invest effort, time and money into further training in regional anaesthesia suggests that it was mainly the keen ‘regionalist’ who responded to our survey. However, this may not necessarily diminish the significance of our findings. Rather, it makes them even more worrying because they imply that even trainees who are highly motivated and dedicated, achieve less than ideal outcomes. A low degree of self-perceived competency in this context probably equates to a lack of training opportunity rather than lack of initiative on the part of the respondents.

Whilst we are all too aware of the limitations of our survey, which suggests that a number of trainees may not be achieving the training objectives set by the College. Unfortunately, the low response rate prevented us from comparing outcomes between different schools of anaesthesia (as we had originally planned), which would have allowed us to offer constructive feed-back to regions performing less well, and identify training opportunities worth exporting to other parts of the country.

We suggest that similar surveys in the future might be a useful tool for monitoring training success within particular schools, as well as comparing outcomes between them.

References
Since the beginning of 2011, NHS trusts, health boards and other so-called ‘designated bodies’ have been required to appoint Responsible Officers (ROs) and provide appropriate support to assist them in establishing the necessary systems required for revalidation. In this article we highlight the statutory duties of ROs as laid out in the Medical Profession (Responsible Officers) Regulations 2010 and summarise their crucial role. Arguably the most visible and important of these is making recommendations to the GMC concerning suitability of individual doctors to continue to practise and, hence, whether he or she should be revalidated.

For most doctors, revalidation will be conducted through a workplace process. They will therefore be reliant on local clinical governance and information management systems to provide evidence that demonstrates their effectiveness as individuals and/or team members in the delivery of high quality patient care; and which should feed into quality improvement processes and their professional development. Such material will be brought to appraisal and, when presented as part of a portfolio of supporting information, will facilitate discussion concerning performance, permit the identification of objectives for a personal development plan, and thereby enable the appraiser to inform the doctor of their progression towards revalidation over a five-year cycle.

Role and responsibilities
In an NHS acute trust, the RO is likely to be an executive board level appointment and in many organisations will be the existing medical director. Having only been established recently, the RO role is evolving, but essential items on their task-list include:

➤ Ensuring clinical governance and information management systems are properly resourced and functioning: Department of Health guidance accompanying the 2010 Regulations stipulates that organisations have a duty to fully support and resource an RO in carrying out their duties. Thus, establishing and maintaining governance systems to monitor clinical activity and patient outcomes and act as an underlying resource to improve quality of care will undoubtedly require significant resources from designated bodies.

➤ Establishing a system of strengthened appraisal: doctors are already required to participate in a robust annual appraisal. Enhanced appraisal will deliver the necessary formative and summative elements of revalidation. A number of Trusts are setting up a hierarchical structure by appointing an associate medical director (AMD) to oversee the appraisal and revalidation process, as well as appointing senior or lead appraisers. In addition, many trusts are providing specific training to appraisers enabling them to deliver, manage and quality assure appraisal so that it is a robust, consistent and fair process. Colleague and patient feedback is a requirement of revalidation (once in a five-year cycle) and systems, developed locally or commercially available, and compliant with GMC guidance, are needed to capture such feedback as appropriate.

➤ Bring doctors back on track: it is the responsibility of the RO to identify the need for, and implementation of, local measures aimed at correcting performance concerns identified through the appraisal process. Most are likely to be minor and amenable to correction via an effective personal development plan, the completion of which should form the end of the annual appraisal process. For more serious concerns, remediation and re-skilling options may be needed as outlined in the NCAS Back to Track guidance document. However, doctors thought to pose a risk to patients may have (as now) their clinical practice restricted, and be subjected to investigation. Referral by the RO to NCAS and/or GMC may be needed. All doctors have a duty to refer colleagues who present a risk to patients directly to the GMC; this applies equally to ROs.

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The Responsible Officer in Revalidation

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Ensuring pre-employment checks for doctors new to the organisation are robust and that their records concerning appraisal undertaken previously are accurate: this may represent a significant challenge when employees are attracted from non-UK jurisdictions.

The role of the RO is therefore demanding and the appointment of an AMD will support the RO, as will a committee with appropriate representation from governance, IT and HR departments. Finally, the RO is statutorily responsible for their decisions and recommendations made to the GMC; the role is therefore not one to be undertaken lightly.

Conflicts of interest
The responsibility has provoked concerns expressed by representative bodies such as the BMA regarding perceived conflicts of interest faced by ROs. In many organisations the medical director has taken on the role of RO and it is these joint roles – as the senior medical manager within the trust and ‘agent’ of the professional regulator – which underpin many of these concerns. An example, presented to the parliamentary committee examining the draft RO regulations, projected a scenario whereby an RO would be under pressure from the trust board to use revalidation to ‘manage out’ competent doctors in conflict with management over, for example, the use of expensive treatment procedures. Possible bias when ROs make decisions – for or against – may also be present where close personal relationships exist or in cases that have been influenced by difficult or confrontational situations in the past.

ROs must accept that such concerns are real and manage them accordingly. Many, in their role as medical director, already managed real conflicts of interest in an appropriate and professional way. Possible solutions include seeking advice from an RO from another trust or asking him or her to undertake the RO duty for a particular doctor. Moreover, the use of objective, non-RO dependent systems for revalidation (including revalidation and trust data) should provide checks and balances against the emergence of prejudice. ROs are themselves subject to annual appraisal and will need to demonstrate that they are fit to fulfil their roles in revalidation and management generally. Finally, within the next five years the GMC proposes to audit all ROs, who are responsible both to the Council and to their trust board.

Linking to a Responsible Officer
The vast majority of doctors will have a clear and obvious connection to a ‘designated’ body – usually the NHS trust or health board for which they undertake the majority of their professional practice, even if extended practice is undertaken with another designated body (e.g. in the independent health sector). However, the RO must take into consideration supporting information derived from a doctor’s practice as a whole (NHS and extended practice) when making a revalidation recommendation. Those practising substantially as locums will, in Scotland, use the health board in the area of their registered address as an RO provider; in England and Wales, NHS Professionals or a locum agency (as long as they are part of the government’s procurement framework) may be used. As all doctors will be dependent for their registration on establishing a relationship with an RO, such linkage is essential and should already be in place.

Guidance and advice from royal colleges and faculties
The specialist standards for clinical practice and therefore revalidation have been set by the royal colleges and faculties. Revalidation recommendations made by an RO must be based on supporting information which will require evaluation against these specialist standards. This College and the Faculties of Intensive Care Medicine and Pain Medicine are developing revalidation guidance, with the relevant specialist standards embedded, for the benefit both of their fellows and members and their appraisers and ROs. We are also considering how the existing network of regional advisers can be utilised to provide specialty advice to ROs when needed. Such requests may emerge when trusts are formulating an educational programme for remediation, re-skilling or return to work of individual doctors. The Academy of Medical Royal Colleges is also developing a college/faculty-RO liaison framework so that there is some consistency in the level and quality of advice provided, and is also providing advice concerning the most effective way of revalidating specialist groups, such as clinical academics.

To keep up to date with developments in revalidation, please visit the website

References
The Health Quality Improvement Partnership (HQIP) announced in September that the National Emergency Laparotomy Network (NELN, formerly Emergency Laparotomy Network) is one of eleven new national audits to be commissioned. The NELN and three other audits have been selected for immediate funding from the 2011–12 budget. The remaining seven audits will be supported as funds become available.

Commissioned audits were judged against a number of criteria including evidence of sub-optimal care, and the potential for significant improvements in that care, evidence of variation in care quality and evidence that the audit might reduce this inequality, presence of relevant standards and measures, and alignment with current health policy direction. The HQIP chief executive, Robin Burgess, commented that the submitted proposal was ‘felt to be clear in concept and design, and to meet the requirements of the criteria published by the National Clinical Audit Advisory Group, as well as covering a clinical area which the Department of Health feels would benefit from the introduction of a new national audit.’

HQIP and National Audits

Responsibility for the national clinical audit programme was transferred from the then Healthcare Commission to HQIP in 2008. HQIP is a collaborative partnership between the clinical professions and patient organizations, and is a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices (formerly the Long-term Conditions Alliance). Following a competitive tendering process, HQIP was awarded the contract to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NCAPOP comprises 30 clinical audits encompassing the care of patients with medical, surgical and mental health conditions.

HQIP plans to expand national audit coverage by inviting applications for new clinical audits as new funding becomes available, and some audits transpose to a subscription based funding model. The aim is to achieve comprehensive coverage across all areas of clinical practice where need can be demonstrated, whilst avoiding unnecessary duplication of activity. Collaboration between audits is encouraged.

HQIP and the Confidential Enquiries

HQIP has also recently taken over responsibility for the Confidential Enquiries (more formally known as the Clinical Outcome Review Programmes) from the National Patient Safety Agency. HQIP has therefore awarded contracts to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) for the Medical and Surgical programme, the National Confidential Enquiry into Suicide and Homicide for Mental Health (NCISH) for the Mental Health programme, and the Royal College of Paediatric and Child Health for the Child Health programme. A new provider is being sought for the Maternal, Infant and Perinatal programme (MIP).

Looking forward

The next step is for HQIP to turn the submitted NELN application into a formal specification, with input from a broader spectrum of stakeholders and experts. Tenders will then be invited from interested and eligible parties. The RCoA intends to bid to run this audit through the HSRC. Our ambition is that the infrastructure and expertise that results will form the core of an expanding audit of perioperative care, focusing on areas of need within anaesthetic and perioperative care. Most excitingly, the NELN and anaesthetists throughout the UK will have access to data which can inform change, drive up standards and lead to improvements in patient care.

Links

➤ The Health Quality Improvement Partnership: www.hqip.org.uk
The Faculty of Pain Medicine (FPM) Annual Meeting will be held at the Royal College of Anaesthetists (RCoA) on 30 November 2011 and we hope that many of you will be able to attend. The programme is available on the website and promises to be very informative and entertaining. Common difficult problems that we face almost every day will be covered in some detail, including what next when pain does not respond to high dose opioids, managing patients who are left with pain after war injuries and a session dealing with medically unexplained symptoms and consequent pain and depression. The Patrick Wall lecture will be given by Prof Maria Fitzgerald from the Pain Research Centre at Great Ormond Street.

The Faculty is in its 5th year and the Board considers itself old enough now to be awarding at the annual meeting Fellowships by Election and the FPM Gold Medal. The regulations for these mirror those of the RCoA. Fellowship by Election is awarded to ‘healthcare practitioners, scientists or other persons’ who have made ‘an outstanding contribution to pain medicine, or any other related field of medicine or science of relevance to the Faculty, whether in the area of practice, education or research’. Such a contribution should also be regarded as nationally or internationally significant.

It is a pleasure to announce that the first Fellowships by Election will be given to Lieutenant Colonel John Etherington and Prof Dame Carol Black. John Etherington is a rheumatologist by trade and Clinical Director, Defence Medical Rehabilitation Centre, Headley Court. The role of this centre in rehabilitating our severely injured service men and women is recognised throughout the world and much of its success is the result of John’s commitment and leadership skills. Prof Dame Carol Black was a very influential President of the Royal College of Physicians (London) and Chair of the Academy of Royal Medical Colleges; she was very supportive of the initial development of the FPM. More recently, Dame Carol has specialised in socioeconomic factors that influence health and, as National Director of Health and Work, has promoted socioeconomic measures of clinical intervention in chronic disorders, particularly return to work.

The first FPM Gold Medal will be awarded to Douglas Justins who needs no introduction to our Fellows. It is no exaggeration to say that we would not be at this stage of our development without Doug’s dedication and strategic vision over many years. As the founding Dean, he established the infrastructure which we now take for granted. He has served pain medicine magnificently throughout his career, including a term as British Pain Society President at a time when it was expanding its membership and activities.

The RCoA now hosts the Faculty of Intensive Care Medicine (FICM) and has established a Faculties Department to handle the affairs of the FPM and the FICM. This is led superbly by Daniel Waeland. James Goodwin has joined the department as Senior Administrator and the team is also supported by Anna Ripley and Andrea Rowe. This joint arrangement is working well; it enables generic Faculty issues to be dealt with efficiently and also ensures an element of cross cover during periods of leave. This is a top quality team that plays an essential role in ensuring that the FPM responds rapidly to enquiries and delivers its aims and goals in a timely fashion.

Finally, early in the new year, the Board is having a ‘time-out day’ where we are considering the future strategy of the Faculty. If I were a management guru I would call this a blue sky session. We welcome the views of the Fellowship in this matter, so please contact us if you have any ideas for our agenda.
What SAS grade?

Dr R Laishley
SAS Member of Council

Does the SAS grade have a future?
What does the future hold for our grade? Manpower planning is notoriously inaccurate, being dependent on many intangible variables; not least the vagaries of our political masters, so good luck to the new Centre for Workforce Intelligence.

Most associate specialists will retire within the next ten years, many indeed sooner than this (SAS survey 2009). As a result of the 2008 New Contract the only remaining option for a service grade post with nationally recognised terms and conditions will be the specialty doctor (SD).

The Temple report ‘Time for Training’ has advocated a consultant delivered service. However, the recent white paper, ‘Developing the Healthcare Workforce’, has amongst its framework objectives a workforce of people who have the right skills with (sufficient) high quality education and training that supports safe high quality care, flexibility and value for money.

There are clear tensions and conflicts of interest here. In many instances the SD is able to meet the aspirations of the white paper, whilst a substantial number of influential bodies in the medical profession will be keen on maintaining the status and conditions of the consultant grade. Surely a case of governmental doublethink?

Trainee perception of the SD Grade
In the past the SAS grade has been predominantly taken up by international medical graduates (IMGs) but as this supply dries up will UKMGs fill the gap? Over the past ten years there has been a near doubling in UK medical graduate numbers and competition for consultant posts is becoming more intense. We recently conducted a survey of anaesthetic trainees seeking their perception of the SD grade as a career choice if they were unable to secure a consultant post. Unsurprisingly, the SD grade was perceived as an unpopular option – only 10% (all training grades) stated that they would consider an SD post, with a further 33% answering ‘maybe’. The main reasons cited were lack of recognised specialist status, perceived limited opportunities for teaching and training, and a relatively poor salary scale.

The IMG route has been closed and, unless the specialty doctor grade is made more attractive, a foreseeable outcome is that consultants (or at least doctors with a CCT or CESR) will increase and the SD numbers will decline. The outcome in reality is likely to depend on the balance of political will and whether any serious efforts are made to tackle these limitations of the SAS grade.

There is a need to be pragmatic and realistic though, particularly with the current economic climate. A number of employers are now advertising for non-standard posts, such as ‘Trust Associate Specialist’, in an effort to fill service gaps, and provide better incentives than the SD post and ‘value for money’ for the employer. It will be interesting to see how such initiatives develop over the next few years. The lack of any nationally agreed support for such posts is of deep concern with the potential for ‘exploitation’ at a future time.

Who will undertake OOH anaesthetic duties?
Trainees are undertaking less service commitment activity and their role in OOH operating is in question. SAS doctors currently make up around 25% of the on-call workforce (RCoA workforce survey) and, if their numbers continue to fall, providing safe OOH operating will continue to focus the attentions of employers. Some SAS doctors are increasingly seeing OOH operating occupying a greater portion of their job plans which is an obvious concern. Guidance with regard to fatigue and workforce pressures has been developed by the AAGBI.

We need to ensure that the SAS grade remains an opportunity for a satisfying career with genuine and attainable progression; not a poisoned chalice as a ‘dead end job’. Proper oversight with clinical governance from the colleges and the GMC together with trade union assistance are required.

References
1 Joint AAGBI and RCoA SAS Survey 2009. Published January 2010 (www.rcoa.ac.uk/docs/SAS_SurveyResults.pdf).
A few months ago, medico-legal advisers (MLAs) were the subject of adverse comments on doctors.net. The gist of the comments was that MLAs are failed doctors, and settle claims because they are lazy and want to save money. On behalf of all MLAs, it is time to dispel such suggestions.

The medico-legal adviser’s biography
MLAs are not failed doctors; they are registered medical practitioners who have worked in clinical practice for at least five years. Subject to this minimum requirement, clinical experience is largely immaterial. For example, MLAs coming to the Medical Protection Society (MPS) in recent years have joined as specialty trainees, GP partners, and consultants. Candidates must be clinicians of good standing and have retained their love of medicine. They must be able to demonstrate an enthusiasm for medical law and ethics, an understanding of the difficulties that doctors face in modern medical practice and an ability to communicate effectively, both verbally and in writing, and undertake a systematic, objective and balanced analysis of a problem.

MLAs work at the interface of medicine and the law, and most will have a legal qualification. However, they are doctors first and foremost. Theirs is a sub-specialty of medicine recognised by the creation of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians in 2006. Becoming an MLA is not for the disillusioned doctor looking for a way out of clinical practice.

Coping with multiple jeopardy
MLAs are on the frontline, the first port of call for doctors in difficulty. Each request for assistance is handled by an individual MLA who manages the case from beginning to end, instructing solicitors, barristers and experts should that become necessary. MLAs are project managers; however, their relationship with their client or member has many similarities to that of doctor and patient.

The MLA’s workload is heavy and reflects the unprecedented level of scrutiny for which ‘Bristol’ and ‘Shipman’ have played their part. As well as handling clinical negligence claims, MLAs deal with complaints, serious incidents requiring investigations, disciplinary actions by employers, General Medical Council (GMC) investigations, inquests, and criminal investigations relating to professional conduct.

Complaints
Complaints tend to be the first reaction to an incident, and the response is an opportunity for damage limitation; a badly handled complaint could result in a referral of the concerns to the Parliamentary and Health Service Ombudsman and/or the GMC, as well as in legal action. It could also prompt an employer, otherwise minded to deal with the issues informally, to take formal disciplinary action. Sadly, it is not always possible to prevent a complaint from escalating and, disconcertingly, this will often be unrelated to the merit of the complaint. The complainant may have taken such a dislike to the doctor concerned (usually as a result of failures of communication before, during and in the immediate aftermath of the incident) that no reasonable response will provide satisfaction.

General Medical Council
For understandable reasons, GMC referrals cause doctors considerable anxiety. It is
therefore essential that they contact their medical defence organisation (MDO) immediately on receipt of any correspondence received from the GMC, so that the process can be explained and the possible outcomes discussed. MLAs will advise on whether or not to comment on the issues, on the nature of any comments it is agreed should be provided, and when it is appropriate to do so. They will correspond with the GMC on the doctor’s behalf, and will instruct solicitors as and when it becomes necessary to do so, usually if the matter is not disposed of in the early stages.

The most complex of GMC cases can take several years to resolve and may involve any number of processes, such as interim order panel hearings and health and performance assessments. Even the simplest of cases can take a disproportionate amount of time to reach a conclusion. The named MLA will support the doctor throughout the process, and will be the first port of call for any concerns or queries they may have.

Employer disciplinaries

Employer disciplinaries cause as much, if not more, anxiety than a GMC investigation. Their number has increased significantly since the introduction of the Department of Health’s conduct and capability process Maintaining High Professional Standards in the Modern NHS (MHPS). Although this process introduced protective mechanisms for doctors aimed at avoiding extended periods of so called ‘gardening leave’ (it is not clear how successful this has been – most MLAs have examples of members who have been excluded from their hospitals for several years), it made it easier for trusts to bring disciplinary action. The process encourages informal resolution of concerns. Sadly, there appears to be reluctance on the part of the management in many trusts to follow this route. Admittedly, MDOs usually only become involved when the matter progresses to a formal investigation, so it is possible that this impression is to some extent skewed.

Disciplinary investigations tend to occur against the background of a difficult relationship between the doctor and his trust and/or colleagues, the frequent lack of objectivity of those concerned making them a challenge to handle. All MLAs would agree that employer disciplinaries require substantially more input and the greatest repertoire of skills, such as those of counsellor, mediator, negotiator, legal adviser, medical expert and advocate, than any other case type. Managing a disciplinary case file involves frequent correspondence with employers (usually to prompt a swift resolution of the issues and highlight procedural irregularities that are prejudicial to the doctor), drafting responses to investigatory reports, and representation at meetings and hearings.

Inquests

MPS has seen a significant increase in the number of requests for assistance with inquests in recent years. One can only speculate why. There have been a number of human rights judgements relating to inquests that may have prompted coroners to explore care-related deaths in greater depth. There have also been changes in the coroners’ rules which require coroners to report preventable deaths to the relevant authorities in a broader range of cases, possibly prompting coroners to summon a greater number of doctors to give evidence at inquests into care-related deaths. Then again, it could simply be that MPS members are more aware than they used to be that assistance is available for this process.

Assistant for inquests will involve liaising with the coroner and the coroner’s officer, advising on statements to the coroner, explaining the inquest process, and going through the questions that could be put to the doctor involved. To assist with this preparation, it is sometimes helpful to instruct an expert who may, in due course, be asked to give evidence at the inquest. On occasion, it may be necessary to provide legal representation; however, this can appear defensive, so is avoided if at all possible, particularly if the family of the deceased is not represented.

Inquests can be very challenging; exceptionally, it may be necessary to request a second post-mortem which requires swift action on the part of the MLA. Further, there can be significant local and national media interest in an inquest; the MLA will advise on media strategy and help draft statements for the press.

Gross negligence manslaughter

The possibility of a conviction for gross negligence manslaughter is a ‘sword of Damocles’ hanging over a doctor’s head. There is nothing worse. Anecdotally, there seems to have been an increase in the number of police investigations since the 2006 Memorandum of Understanding between the NHS, the Association of Chief of Police Officers, and the Health and Safety Executive, to report all suspected untoward deaths and serious harm to the police. Typically,
this would mean reporting deaths from anaphylaxis where the patient was known to be allergic to the medication involved. However, again anecdotally, this increased number of investigations does not appear to have resulted in a greater number of prosecutions.

MLAs are once again the first port of call. They will support the doctor through what is inevitably a traumatic process and will ensure that they have appropriate legal representation.

Claims
MPS is currently experiencing a very significant rise in the cost of claims which mirrors that experienced by the NHS Litigation Authority (NHSLA). Claims are known to increase in a recession, but this trend pre-dates 2008.

Many claims are discontinued following submission of a robust defence. The overwhelming majority of claims that proceed are settled without the need to go to trial. There are a number of reasons for this, two being particularly worthy of mention. The first is that the Civil Procedure Rules introduced in 1998 impose a clinical negligence pathway designed to encourage settlement of claims. The second is that the vast majority of the claims that are settled are done so because they contain vulnerabilities for the doctors involved. This is usually because the doctor’s actions cannot be supported as objectively reasonable due to lack of supporting documentary evidence. In such cases, with the courts tending to give the benefit of the doubt to claimants, the risk of the doctor having a public finding of breach of duty against them is high. This would cause significant reputational damage to an otherwise very competent clinician and the additional potential of a referral to the GMC. Where these vulnerabilities exist, MLAs advise of the risks and, understandably, many doctors choose to settle the matter which can often be achieved without admission of liability. MLAs only authorise settlement once the doctor involved has agreed to this course of action.

Advice and education
MLAs do considerably more than represent doctors in whatever process or processes they may be subjected to. A large part of their work is to provide advice, and thereby pre-empt problems. They provide verbal advice (by virtue of a 24-hour advice line) and written advice on legal and ethical issues. This can be the most interesting aspect of an MLA’s work, and often the most challenging because no ethical dilemma is the same and there is often no right answer. The key is to work from basic principles, and to explore different arguments and perspectives through discussions with medico-legal and legal colleagues.

MLAs do not just work on case files or give reactive advice. They have a sideline in risk management and are frequently invited to lecture and write on matters relating to medical law and ethics. It is an invaluable aspect of the MLA’s work as it provides an opportunity to discuss issues with the profession and understand the concerns of those who work at the coal face.

Being a medico-legal adviser – in a nutshell
I loved giving anaesthetics and managing my patients on ITU, but a fascination with the complexities of medical law and ethics that I developed as a consultant in charge of an intensive care unit eventually got the better of me. Being an MLA is the best job I have ever had. It is hard work; the hours are long and it involves more travel than I would like (I started to write this article on a train to the West Country) but I have had the privilege to have met and to have been able to assist some remarkable and dedicated clinicians who have found themselves in positions that they did not deserve to be in. It requires a level of commitment, focus, determination and attention to detail as great as any other job I know of – but the satisfaction in achieving a good outcome for a colleague is immense.

I hope this deals with the comments made about MLAs on doctors.net.
The medico-legal expert

The term ‘expert’ in relation to medico-legal work is widely misunderstood. Certainly, it does not mean ‘this person knows more about anaesthesia than you do’, even if many experts think that it does. What it does mean, is that ‘this person is considered an appropriate individual to advise the Court on the standard of practice that would be expected from an anaesthetist in the particular circumstances which pertain to this case’.

The standard of care which the practitioner needs to have achieved to avoid being found negligent is that which is ‘accepted as proper by a responsible body of medical men skilled in that particular art’. This is the well-known Bolam test,¹ and it is the expert’s job to represent the views of that responsible body to the highly intelligent, but medically naïve, lawyers and judge. In doing so, experts must convince the judge that their view is ‘responsible, reasonable or respectable’, and thus be able to demonstrate that they have directed their minds ‘to the question of the comparative risks and benefits’ of the chosen course of action (a test arising from the Bolitho case).²

Not all Perry Mason

Contrary to popular belief, experts do not spend most of their time appearing in court, engaged in a battle of wits with an erudite barrister. Indeed, changes to the Civil Litigation process over the last 10–15 years, especially in England and Wales, mean that fewer than 5% of negligence claims actually get as far as the courtroom. Those that do, however, tend to be the high profile, high payout cases, such as hypoxic-ischaemic birth injury, and often garner considerable media attention. Unless you are prepared, therefore, to undergo the equivalent of a Final FRCA viva, conducted by someone paid a large amount of money to make you look foolish, lasting for several hours or even days, in the full glare of the press, consider that expert work might just not be for you.

Writing reports

Most of an expert’s time is, thankfully, spent in more prosaic ways. Writing the report, whether it is supportive of the claim or not, is rarely the end of the case. There will be further queries from your instructing solicitor, ‘Part 35’ queries from the other party’s solicitors, conferences with Counsel and, increasingly, meetings with the experts from the other side to narrow areas of conflict.

Report-writing remains the core activity of the expert, however, and can be a daunting task. The instructing solicitor should have already arranged the relevant records into a sensible sequence, numbered for reference purposes, but this is all too rarely the case. Sometimes the solicitor does not have access to the expertise needed for this job, and it is not unusual to receive five or six bulky folders totalling 4,000 pages or more, in the middle of which is hidden the one-page anaesthetic record that is your goal. The report must include a time-line of relevant events, showing any areas of uncertainty or disagreement, followed by a careful analysis of whether there has been a failure of duty of care at any point and, critically, whether that failure has had a causative impact on outcome. Expert opinion on both duty of care and causation should be supported, wherever possible, by reference to scientific evidence, although judges are often more impressed by textbook recommendations than by research papers.
Report-writing is a serious and often time-consuming task. Summarising records relating to emergency caesarean section, for example, where periods of less than two minutes can determine the success or failure of a case worth tens of millions of pounds, is not something to be taken lightly. The argument cannot be over-sold; any weaknesses must be scrupulously highlighted, and the report should say nothing that cannot be defended against a line of intensive questioning from a hostile barrister. Neutrality is absolutely essential. The expert’s role is to assist the court, not his client, and a good rule of thumb is to read over the report and ask yourself whether it would have been exactly the same if you had been instructed by the other party. The Civil Procedures Rules laid down by the Ministry of Justice describe the role and duties of the expert, and particular attention should be paid to Part 35 of this document and its associated ‘Practice Direction’. 5

Putting yourself on the line
In relation to the overriding duty to provide neutral and unbiased assistance to the court, the expert has to sign a declaration at the end of the report which states, inter alia: ‘I understand that I am likely to be the subject of public adverse criticism by the judge if the Court concludes that I have not taken reasonable care in trying to meet the Standards set out above.’ This sounds bad enough and although many experts, myself included, have felt the sharp end of a judge’s tongue, even worse can follow. The General Medical Council has taken a very dim view in the past of experts who, in their view, have fallen below an acceptable standard in giving evidence. 6 In the past, the expert used to enjoy a degree of immunity from legal action brought as a result of evidence given in court, but even this has now been removed following a recent decision by the Supreme Court. 5 A more detailed summary of the impact of this ruling can be found in a recent issue of Anaesthesia. 6

So, should the life of an expert still appeal, despite these warnings, what qualities do you need? From the point of view of the curriculum vitae, you only really need to show that you maintain a clinical practice in the field under scrutiny and, ideally but not critically, that you have been doing so successfully for some time. It is much more important to have the right skill set and personality traits for this sort of work.

➤ Ability to work to deadlines – time factors can be critical when submitting reports or comments and, if you promise a response by a given date, you must be prepared to deliver on time. This can be quite frustrating, because some solicitors will hold onto material for some months before releasing it, with only a week or two to spare, but an expert who delivers late is unlikely to be instructed again.

➤ Ability to write clearly and concisely for an intelligent lay readership – as a useful test of your skills in this area, try explaining the relationship between vapouriser setting, MAC, end-tidal and arterial volatile agent concentrations to a non-medical person who is interested in anaesthetic awareness.

➤ A logical mind – the legal process may not always be particularly scientific, but it is relentlessly logical, and you will need to be as well. In particular, an expert needs to be happy working with the legal concept of ‘the balance of probabilities’, very different from the 95% confidence interval which we have been trained to recognise as a standard of proof.

➤ A thick skin – the solicitors for whom you are preparing a report will try very hard to pick holes in it, and the same will happen when you have a pre-trial conference with Counsel. However, this is nothing compared to what can happen in court when the opposing barrister gets his teeth into you.

➤ The ability to stick to your guns when you know you’re right, but to admit your error and move on when it is shown that you are wrong – lawyers hate experts who vacillate, but reserve their greatest ire for those who appear to strongly espouse an opinion throughout the pre-trial process, only to collapse like a house of cards when in the witness box.

➤ Complete control of your temper – see above.

➤ Knowledge of your limitations – nothing diminishes an expert’s standing more than when they stray outside their area of expertise (not that this stops obstetricians from giving opinions on anaesthetic practice at the smallest opportunity).

➤ A degree of anal retentiveness – when every comma counts, as it does in legal argument, then slapdash is not a good look.

Starting a career on the side
Whilst it used to be acceptable to learn on the job, nowadays some form of training is, understandably, considered useful. Bond Solon, a legal training firm, runs high quality but eye-wateringly expensive one-day
courses in report-writing, courtroom skills and civil law and procedure. Alternatively, AvMA (Action against Medical Accidents), and the Academy of Experts, also provide training, usually for a somewhat lower fee.

Once trained, how do you get your first case(s)? Unless you are fortunate enough to find yourself on AvMA’s recommended list (I have no idea how I got there), your best bet is to attach yourself to the coat-tails of an established expert. Ask them for a few cases to study and to prepare mock reports, then they may well recommend you when they are offered a case with too short a deadline, an increasingly frequent occurrence as the workload builds up.

References
1 Bolam v Friern Hospital Management Committee [1957] 2AllER 118.
2 Bolitho v City and Hackney Health Authority [1997] 4 All ER 771.
4 http://news.bbc.co.uk/1/hi/health/4432273.stm (Roy Meadow).
8 http://www.avma.org.uk.
Bullying in the workplace – a personal experience

Bullying in the workplace is very common, with 1 in 6 adults likely to suffer.\(^1,2\) It is defined as intentional peer abuse, involving force or coercion, and crucially repeated over time.\(^3\) It may be verbal or physical, but almost always also involves emotional abuse. What it is not is performance management (feedback aiming to improve actions, but perceived negatively by individuals).

Why am I writing about bullying?

I am now a well-established consultant in a happy, well-functioning department. It was not ever thus. For much of my first two years, I considered leaving not just my beloved specialty of anaesthesia, but medicine entirely. The reason was not my colleagues; they are now and were then helpful, supportive of my new position. It was not a malfunctioning department; indeed compared to many I passed through, it appeared a shining light. No, it was the actions of a single man, who for some reason I (and my colleagues) could (or would) not stand up to.

I never considered myself a prime target of bullying – I have met few people who do. Like many colleagues I trained in the school of ‘hard knocks’ with many trainers believing (as some still do) that, despite all evidence to the contrary, humiliation was the best way to teach. I came through this unscarred; finally landing my dream job.

We all know the early years of consultant posts are challenging in many ways. Unfortunately, I was also the object in the sights of a known bully. This article attempts to describe what it felt like, what helped me, and what didn’t. I think it is important that others in this position know they are not alone; but, perhaps more importantly, it is possible to come through – even working with the bully, as I now do, without fear.

The bullying took place over a two-year period at the start of my substantive consultant post (I was already a locum in the Trust). The ‘perpetrator’ was a well-known bully, who also happened to be an exceptional and experienced clinician. This is crucial; when the situation was finally addressed, I wanted to be sure an effective clinician was not stopped working. I merely wanted to continue on my career path without facing abuse. I now know this is a very common view.

Looking back, I recall what I believe was the first episode in the saga. I had been on the ward performing preoperative assessments, when I met the clinician involved. I held out my hand, introduced myself, saying I was looking forward to working together that day. You might argue it would have been better to meet prior to this, but the individual always appeared a distant, aloof and arrogant figure, with whom it was difficult to meet. What I still recall in a visceral manner is the acute embarrassment. He looked at my hand reaching out to shake his, looked around, and without a word turned his back and walked away. I was left to trail in his wake, feeling more than a little worried about how the day might go!

My fear was not unfounded. I remember little of that particular day, but many others, I suspect, were rather like it. The majority of staff in theatre breathed a sigh of relief when they saw me. They knew, for that day, they would not personally have to face the unremitting horror of his behaviour. Subtle, and not so subtle digs about my abilities, continued throughout the day.
This behaviour carried on over two years. I knew it was wrong, but could find no way to alter things. During my first two consultant appraisals I attempted to elicit help from my clinical director. The best response I got was to keep my head down, as he would retire in five years. Ten years on, I am still working with him.

Failing to get support from my clinical director, and aware it could not be good for patient safety for me to spend every night as I cycled home in tears, I approached two other colleagues. They were kind, and personally supportive, but responded by saying he was just a bully, and if I stood up to him it would stop. Although I knew this to be true (bullies generally back down if faced up to) it was the one thing I could not do. Perhaps, if I had not left it so long it might have been possible, as I know it was for a predecessor.

How did this end?
I remember the day so clearly it is as if it were only last week. I was suffering a particularly torrid day at the individual’s hands. My mask pulled up to the bottom of my glasses, the hat reaching down to the top of them – my vain attempt to hide the embarrassing tears continually running down my cheeks, whilst clearly fooling nobody. The senior trainee with me was mortified. The final straw was the bully shouting (for no apparent reason any of us could deduce) that he wanted a ‘real anaesthetist’; naming my clinical director. Silence ensued. Shortly afterwards I went to wash my face. Surely the only person in the department with no idea what had been happening, caught sight of me and went to ask the manager what was wrong. On being told I was probably just getting my usual treatment from this doctor, my senior colleague (for that is what he was) removed me from the suite, replacing me with another colleague he found in an office. Embarrassed, I was taken to the director of HR, still in my blues, with a tear-streaked face. Knowing the seniority (and abilities) of the individual, I assumed the worst. Would I be suspended, stopped from doing the job I loved, or held up to ridicule?

What actually happened next was, for me, a model of good practice. I spent an hour with the HR director, who reassured me I should never have been subjected to this behaviour. I was told (against my will) to write a report of what had been going on, and to bring it back the following day. This I did, only to be faced with a one-hour interview with the CEO, who also apologised unreservedly for the situation. He behaved (to my undying gratitude) as though unaware of the tears, again flooding down my cheeks. A similar apology from the medical director followed and began to allay my fears. The requirement for the bully to attend behaviour modification training reassured me the Trust was not just letting it pass.

Bullies may themselves have problems causing their behaviour – sometimes forgotten in the rush to support the victim. It is often said that bullies are cowards at heart; they may certainly be insecure – something not helped by the incredible focus on individual outcomes. This may lead to lashing out at the less powerful – frequently newcomers into a situation. Behaviour only changes with evaluation and support. As the individual being bullied, it is important to realise that responses cannot, and should not, be about revenge; rather about changing aberrant behaviour patterns.

Of course, it would be facile to suggest things changed overnight. There were challenges to be met for us all. The on-call rota needed to ensure I did not have to work with the individual involved. Lists needed switching so I could maintain my skills working with other clinicians – this impacting (for several years) on colleagues rarely any keener to work with the individual. And then I had to face down my clinical director’s suggestion it should be written on my appraisal that the individual’s specialist group had lost faith in me because of my behaviour (to me bullying by proxy – another well recognised phenomenon). However, we met all these challenges robustly, and I believe are a better department for it.

How did I come through?
Perhaps the single most important thing was discussions with consultants from other trusts who had suffered similarly. I could see it was possible to survive and continue to follow your dream, even without support from within (which came later). What it was not, was discussion with family – feeling such a failure for being in this position, I felt unable to talk about this with them. Again, I now know this is not uncommon when consultants are bullied. Two close (non-medical) friends knew, and socialising with them proved invaluable. What I didn’t do, but am aware is not uncommon, is to drink to excess, or consider suicide – I wouldn’t let him beat me like that.

What now?
Our Trust now has a bullying and harassment helpline, designed to provide support to all staff, even if they do not wish to make a formal complaint. I, along with several others (medical and non-medical)
have undergone relevant training. The line has an answer-phone, which is responded to within 24 hours. We provide on-going support and advice. My most common advice is to keep a daily diary (just a couple of lines). Write down both good and bad days – you may find the bad days are fewer than you thought and this alone can help. If it does not, you will have the evidence if you ever want to show it to anyone (yours to decide, not to be imposed). This evidence may prove crucial should the situation follow the formal complaints route (as mine did). In this case, evidence from all sides is treated equally. Total transparency in the investigation means the availability of contemporaneous data is incredibly helpful. Those being bullied often fear they will be disbelieved and so fail to retain evidence until very late in the series of events, delaying resolution.

Perhaps most importantly I do not try to hide what happened to me. People laugh as I arrive; telling each other they will have to behave now the ‘bullying adviser’ is around. This has brought the issue out of the dark cupboard, into open discussion. Indeed, three other consultants I have supported as they dealt with similar issues, walked up to me, rather than phoning the helpline. I have also spoken to consultants outside my Trust with similar problems, who know my history.

By these mechanisms we support staff as they deal with difficulties in their workplace. Openness regarding bullying should make it less likely, as bullies rely upon the presence of multiple bystanders failing to challenge their behaviour. This is rarely because the latter approve, but rather they worry any intervention will only make matters worse – usually erroneous. Early intervention in a robust, informal, non-threatening manner is likely to lead to the best outcomes.

**Conclusion**

I wrote this in response to the request of a Council member who heard me discussing the situation. I hope bringing it into the open may make it easier for others to get the support they need in their trusts. I am in no doubt that the situation is as common in medicine as workplace audits in the wider world suggest. If it is happening to you I suggest you talk to someone you trust and keep a diary. Most importantly, remember the bully is doing this, not you, but you can come through to work happily within the same department, however it may feel now.

I have asked that my name not be printed, to maintain confidentiality for others. This story is not about revenge; it is about moving on with support. Clearly, I am happy to respond directly to approaches made via the College and will happily speak openly to anyone. This was a horrible episode, now behind me, which informs in a very positive manner my current activities. For me it has certainly been the case ‘that what doesn’t kill you makes you stronger’.

**References**

1. Workplace Bullying Institute


The Medical Defence Union (MDU) is the UK's leading medical defence organisation. MDU medico-legal adviser, Gaynor Whiter, explains how the MDU assists anaesthetists when they face an ethical dilemma, or their care of patients is called into question.

How the MDU helps anaesthetist members

Statistically, there will be very few anaesthetists who, however conscientious and careful in their clinical practice, will go through their career without receiving a complaint or a claim for compensation from a patient for alleged damage. Some may even face a GMC fitness to practise investigation. Almost all will, at some point, have an ethical or medico-legal dilemma about which they need prompt informed advice.

At times such as these, members of the Medical Defence Union can call upon an expert team of doctors, lawyers and claims handlers for assistance and support.

Complaints

MDU research shows that, in the last few years, the MDU has assisted anaesthetists in responding to over 350 complaints from patients. The most common causes for complaint are as follows.

- Damage to teeth and lips.
- Nerve block insufficiency or complications, especially in relation to the eye.
- Positional damage; for example, ulnar nerve palsy or eye damage when prone.
- Communication issues.
- Consent issues – for example, performing a procedure under local rather than general anaesthetic when the patient was consented for the opposite, or failure to warn patients of the common sequelae following anaesthetic, or that local anaesthesia may proceed to general, such as in obstetric cases.
- Awareness ranging from vague memories lasting for a few seconds, to full episodes of awareness.
- Drug errors.
- Aspiration of stomach contents, resulting in admission to ITU.
- Misplaced needles, or endotracheal tubes, including failed intubation.

Whether the complaint relates to the member's NHS or private practice, the MDU can provide help – for example, with finalising the report on the circumstances leading to the complaint. This is especially important when the member has a concern that their practice may be questioned.

Clinical negligence claims

Claims for clinical negligence arising within the NHS are usually handled by the NHS Litigation Authority (NHSLA). However, when a claim arises from independent practice, or the doctor needs assistance beyond that provided by their hospital, the MDU can act on behalf of the member.

The MDU is the only long-standing medical defence organisation that provides its eligible members with a contract of insured indemnity which guarantees support in defending claims for clinical negligence* and discretionary assistance for matters falling outside the terms of the policy.

*Subject to the terms and conditions of the policy.
Only around 2% of claims handled by the MDU run to trial. The majority are successfully defended, or are settled with the member’s agreement. However, anaesthetists who find themselves in court will be judged by the standards of practice of ‘a reasonable body of anaesthetists’ and, if that anaesthetist has a special skill, then the comparison will be made against a practitioner with that same skill. This is the Bolam test, which is very widely used in clinical negligence cases to determine the standard of care owed to a patient by doctors.

If the court holds that the anaesthetist failed to reach that reasonable standard, there will be a breach of duty of care. In order for a claim to be successful, the patient also has to prove that the breach of duty caused them loss. If this is proved by the patient, then the patient will be entitled to be compensated for that loss by monetary means (damages).

The MDU’s experience of anaesthetic claims is that more than half relate to dental damage. Careful discussions with the patient should be recorded in the notes prior to surgery, particularly where a difficult intubation is anticipated. This simple action can help to ensure that, if such a complication occurs, the claim will not succeed.

The MDU offers the following advice to anaesthetists about how to minimise the risk of a complaint or claim:

- Carry out a thorough preoperative assessment, exploring with the patient the investigations and treatments proposed, and the complications that might arise. Listen to patient concerns, ask for and respect their views, and encourage them to ask questions, checking that they understand the information and the risk of any significant potential sequelae.

- The experience of the MDU suggests that complaints within the specialty show that anaesthetists should always consider discussing the following with patients:
  - The type of anaesthetic, including extent of local anaesthetic blocks, and checking the side on which they are to be sited.
  - The possibility of a conversion of local to general anaesthetic, especially in obstetric cases.
  - Allergies to anaesthetic and other drugs.
  - How the patient is to be positioned during anaesthesia, and common postoperative complaints.
  - Airway assessment and discussion about the vulnerability of teeth, lips and soft tissue during intubation. This is particularly important if the anaesthetist anticipates difficulties, but is a general point that should be discussed with every patient.
  - It is important to realise that if you have not discussed a complication that may be significant to that patient and that treatment, and subsequently this occurs, there may be a breach of duty.
  - The perfect consultation amounts to nothing without a record noting what was said. If a claim arises and is challenged in court, the judge may prefer the patient’s version of events rather than yours, if nothing is recorded. Conversely, a detailed contemporaneous record is evidence (though not proof) of discussions and the consent process.
  - Resources, support and planning are essential. The MDU’s experience is that investigations into untoward incidents commonly report that they arose because there was insufficient planning, or overview, of operating list procedures. Such deficiencies may not be defensible in a claim.

**Coroner’s court**

An inquest is held when the coroner decides that a patient’s death may not be due to natural causes (for example, the incident leading to death was a fracture or other trauma, or unknown). The inquest is a fact-finding investigation of the circumstances surrounding the death, and is to establish the cause. It is not a trial. An anaesthetist who has been involved with the care of a patient may be asked to provide a report for the coroner, and the MDU can help with this.

The report must be provided promptly and comprise a detailed, chronological account of the care given by the anaesthetist to the patient who died. If several practitioners are involved, they should each describe their own part in the patient’s care. If the coroner requires the anaesthetist to attend the inquest, the MDU can help with this.

**GMC referrals**

Occasionally, a patient or public authority such as the doctor’s trust or the police may refer an anaesthetist to the GMC, and the GMC may choose to investigate the matter. The number of referrals to the GMC is growing. In 2010, a total of 5,773 referrals were made, representing around 2.5% of all registered doctors. Reassuringly, 50% of these were closed with no investigation, 26% were referred back to the employer, and less than 30% were investigated. We strongly advise anyone who receives notification of a complaint from the GMC to seek
help immediately from their medical defence organisation.

**Multiple jeopardy**

Although it happens rarely, there is the possibility that a serious untoward event can lead to a series of investigations by a number of different bodies. We call this multiple jeopardy.

Imagine the examples where the incorrect siting of a central venous pressure line into the common carotid artery goes unnoticed, or a ventilator, unknown to the anaesthetist, is not functioning correctly. If the patient is injured as a result, the anaesthetist may find himself or herself:

- Subject to a complaint, then a civil claim for clinical negligence.
- Referred to a GMC fitness to practise panel.
- Subject to a trust disciplinary inquiry.
- Summoned to give evidence at a coroner’s inquiry.
- Interviewed under caution by the police. If the patient has died, this may be in relation to a charge of gross negligence manslaughter.
- ‘Door-stepped’ by the press.

The MDU supports and defends members at all stages including, amongst other things, providing help with writing detailed reports, legal representation and advice on handling the press. Fortunately, multiple jeopardy does not arise often but, when it does, it can be a devastating experience.

**24-hour advice**

The MDU receives over 23,000 telephone calls per year from members to its freephone advisory helpline. A team of 35 medico-legal advisers (MLAs), all doctors with many years of clinical experience, are on hand to respond to members’ ethical and medico-legal dilemmas. The range of queries from anaesthetists is diverse, ranging from requests for help with complaints, claims and consent issues, or with coroner’s or trust reports. The MLAs provide informed advice and a prompt, professional service to members.

**Reference**

1. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.

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**Case study**

A 44-year-old man was listed for a laparoscopic cholecystectomy in a private hospital. The anaesthetist performed a thorough pre-anaesthetic assessment, and took the patient’s medical history, which included asthma, acid reflux and the development of a rash following administration of penicillin as a child. He had not undergone any previous surgery.

On examination, the patient was found to have a receding mandible with overbite, very limited mouth opening and a fixed flexion deformity of the neck. The anaesthetist predicted a difficult intubation and discussed his concerns in detail with the patient. He recommended an awake fiberoptic intubation under very mild sedation and warned the patient that this could cause dental damage. He noted the discussion in the patient’s records.

The anaesthetist secured intravenous access and administered cephalosporin antibiotic prophylaxis, as the surgeon had requested. Immediately, the patient developed an anaphylactic reaction, losing consciousness and showing signs of upper airway obstruction. Adrenaline was administered.

The patient’s airway needed to be secured but, in the circumstances, the use of a fiberoptic bronchoscope was no longer practicable. Instead, the anaesthetist quickly intubated using a laryngoscope. The force required resulted in damage to three upper front teeth and a lip laceration. The patient was admitted to ITU, but made an uneventful recovery.

Seven months later, the anaesthetist received notification of a claim by the patient. The allegations were that the anaesthetist had been negligent by:

- administering cephalosporin, given the known allergy to penicillin
- not informing the patient sufficiently before the operation of the potential for dental damage
- intubating negligently, causing the damage to the patient’s teeth and lip.

The MDU obtained expert reports from a consultant immunologist and anaesthetist. The immunologist confirmed a known cross-over between allergy to penicillin and cephalosporin. If the patient had reported anaphylactic reaction to penicillin then cephalosporin would be contraindicated. However, in this case, only a rash had been reported and thus it was reasonable to use a cephalosporin.

The anaesthetist expert stated that the member had no choice but to attempt intubation. Had he not done so, he would have been in breach of duty. It was, he said, entirely appropriate to make a first attempt with a laryngoscope. Given the patient’s unusual anatomy, in his view the anaesthetist demonstrated a high degree of competence in performing a rapid intubation using this method.

He added that damage to the teeth was entirely foreseeable. The records showed that this complication had been described in detail and the patient had provided informed consent to the procedure. Therefore, there was no breach of duty either in administering the cephalosporin or the intubation process. The claim against the anaesthetist was discontinued.
Anaesthetic anaphylaxis: a question of evidence

‘Dr, I am not interested in what the literature says. I am interested in your expert opinion.’

These remarks were made by a barrister during his cross-examination of a friend of mine. The case, as many do, was resolved by the judge choosing between the testimonies of expert witnesses.

While we all agree that the person who is damaged because of medical negligence or incompetence is entitled to compensation, the verdict can often be regarded by members of the medical profession as unjust. One of the reasons is that the medical and legal professions vary considerably in the way they value evidence. Doctors think in terms of levels of evidence, the best of which is a large randomised, double-blind correctly conducted clinical trial. The opinions of experts are regarded as low level evidence. The history of medicine is littered with disasters that have occurred when treatment is based on the pronouncements of experts rather than a careful analysis of the science. In the courts the opinions of experts are subjected to cross-examination, and our legal system is based on the premise that cross-examination is the best pathway to truth in court. This system must be influenced strongly by the quality of the advocates, witnesses, and adjudication.

Many of these problems are illustrated in the British case between Eastwood and Wright.

The case
The information on which the following is based comes from the transcript of the appeal cited by Harper in this journal.

The expert witnesses did not appear at the appeal and a summary of aspects of their evidence only is available.

The patient, Mrs W, had received a number of anaesthetics. She was a smoker. In 1979 she underwent a D&C. Following the use of Althesin she developed breathing difficulties which the anaesthetist treated with neuromuscular blockade and hydrocortisone. The anaesthetic notes include the entry ‘Althesin Allergy’. In 1989 she underwent a D&C without problems. In 1995 the same anaesthetist anaesthetised her for a hysterectomy. After induction with propofol and atracurium she developed bronchospasm before being taken into theatre and this resolved with aminophylline. The operation was completed. After a further uneventful anaesthetic in 1997, she was anaesthetised in 1999 with propofol and cisatracurium. There was no wheezing but her blood pressure fell suddenly requiring an adrenaline infusion. The surgery was cancelled and she was transferred to intensive care. A tracheostomy was required, leaving Mrs W with permanent and constant difficulty in breathing and considerable impairment in her ability to manage life. Subsequent investigation showed she was allergic to atracurium and cisatracurium. Atracurium, and cisatracurium are antigenically identical.

The three Justices involved dismissed the appeal by the anaesthetist believing that he should have referred Mrs W for investigation after the initial reaction, implying that she was allergic to atracurium at the anaesthetic in 1995. Therefore, if she had been investigated for allergy to atracurium and cisatracurium, an allergy would have been found, as it was demonstrated subsequently. If the allergy had been found the drugs, and consequently the adverse reaction would have been avoided.
The case led Harper to raise in this journal the question of when bronchospasm under anaesthesia should be investigated.

**Bronchospasm during induction**

Bronchospasm during induction is well recognised and very likely to be due to irritation of the airway due to silent aspiration or an endotracheal tube. The described incidences range from 0.1 to 16% of patients. The risk is almost doubled in smokers. It is suggested in anaesthetic literature that pharmacological direct histamine release may cause bronchospasm. If this occurs it is very rare. Anaphylaxis during anaesthesia has an incidence of between 1:6,000 and 1:20,000. Anaphylaxis during anaesthesia to determine whether it occurred pre-intubation, which would favour a drug reaction, or after intubation, which would favour a non-allergic cause. The administering anaesthetist believed that the bronchospasm occurred post intubation, but the judge determined it was likely that bronchospasm had occurred shortly prior to intubation.

I have previously encountered unsuccessful medico-legal claims where it has been suggested the anaesthetist could have prevented the reaction by investigating the patient prior to anaesthesia. The only valid risk factors for anaphylaxis during anaesthesia are spina bifida (latex allergy), cutaneous latex allergy, a previous anaphylactic reaction during anaesthesia, and unexplained cardiovascular collapse during anaesthesia.

We analysed 183 patients referred with bronchospasm during induction of anaesthesia. The reactions determined, by skin testing and mast cell tryptase, to be allergic were more severe and only the presence of skin changes, shock, desaturation and a duration of symptoms greater than 60 minutes were reliable indicators of an allergic cause with a multiple logistic recognition model. Interestingly, a history of asthma, difficult intubation, and difficulty in inflating the patient prior to induction were not significant independent predictors of mechanism. Transient difficulty in inflating the lungs pre-intubation is a common first sign of anaesthetic anaphylaxis.

We did not, in the study, address the question of response to aminophylline. Subsequent analysis showed that failure to respond to aminophylline without a sympathomimetic was a significant predictor of an anaphylactic cause. As a result of this study we recommended that patients who developed bronchospasm during induction of anaesthesia should be investigated if the reactions are severe, of greater duration than 60 minutes, associated with other symptoms of anaphylaxis, require sympathomimetic drugs, have difficult ventilation prior to intubation or insertion of an LMA and have an elevated MCT. We did not identify a need to investigate patients who had difficult intubation, duration of reaction of less than 60 min, responded to simple measures and whose MCT was not elevated. We recommended that these patients be given a letter describing the reaction.

On the basis of this study we would suggest that investigation of Mrs W after her bronchospasm would have been unlikely to show an allergic cause.

**The judgement**

In this case the Justices had to contend with conflict between expert witnesses. The two expert witnesses cited were both expert and from the transcript it appears that their testimony was a fair reflection of knowledge and practice at the time. I could find no fault with their evidence as described. The anaesthetist’s note said that he had been given ‘a terrible or quite a fright [sic]’ and had to use aminophylline. This suggested to the judges that the reaction was severe. One of the experts suggested in contrast that if there was a perfectly good cause for the bronchospasm and if it responded to aminophylline then investigation was not necessary. The other believed the reaction should have been investigated. A further issue was the timing of the bronchospasm: whether it occurred pre-intubation, which would favour a drug reaction, or after intubation, which would favour a non-allergic cause. The administering anaesthetist believed that the bronchospasm occurred post intubation, but the judge determined it was likely that bronchospasm had occurred shortly prior to intubation.

**Subsequent evidence**

Intrigued by the case and the questions raised by Harper we decided to use our large database of patients referred for the investigation of possible anaphylaxis during anaesthesia to determine whether clinically allergic and non-allergic bronchospasm during induction of anaesthesia were distinguishable with the available clinical information. The database contains information collected over 35 years on patients referred to an anaesthetic allergy clinic, run by the author.
not readily identifiable in the literature that is strong support for this view. In our series there are 28 patients who have had two or more anaphylactic reactions during anaesthesia for whom we have good clinical details. In each case the reactions were clinically identical. That is, there are no patients who had bronchospasm as a sole feature at one reaction and cardiovascular collapse at a subsequent one. Although hard to verify in the literature, there are a few similar cases, and my immunologist colleagues tell me that this is the usual finding in their practice.

Thus on the basis of a reaction solely involving the airway, responding to aminophylline, and followed by a reaction requiring an adrenaline infusion where hypotension was the main manifestation, we can make a very reasonable conclusion that Mrs W was not allergic to atracurium at the time of the bronchospasm and that therefore would not have been shown to be allergic to cisatracurium if she had been investigated.

**What now?**

The Appeal Court denied the anaesthetist the right to appeal. This paper suggests new information that may have altered that decision had it been known at the time.

Perhaps the reversal of many verdicts with new DNA evidence is an example which would suggest the court should revisit this case. In Australia, defence groups appear reluctant to outlay the major expense of mounting a case to clear a doctor’s good name and alleviate the psychological burden consequent upon both the mishap and the court proceedings.

If nothing else it may be that the anaesthetist involved can feel exonerated, and that, as in most cases of anaphylaxis during anaesthesia, a patient who has suffered an unpredictable event owes their life to the anaesthetist’s resuscitation skills.

**References**

Wrong sided surgery is one of the ‘never events’ that can have a devastating effect if it occurs, not only on the patients affected, but also on the staff involved. The World Health Organisation (WHO) safety checklist, introduced worldwide in 2008, is a breakthrough in promoting the safety culture in the operating room environment. It is designed primarily to promote better communication between team members and should help to prevent wrong sided surgery. However, there is little emphasis placed upon anaesthetic related procedures in the safety checklist which, also, can potentially lead to errors in itself.

Wrong sided nerve blocks: why we need an anaesthetic timeout

The wrong sided nerve block is one event that is being reported increasingly. Is this new observation associated with increased emphasis on productivity in healthcare, or a sign of improved reporting that needs to be probed further?

The National Patient Safety Agency (NPSA) never events framework, has classified wrong side surgery as a ‘never event’ but excluded anaesthetic related procedures, including nerve block.

A report by the National Reporting and Learning System (NRLS) in October 2010 identified 67 incidents of wrong site block in a period of 15 months. Even so, the full incidence of wrong sided chronic pain blocks and other pain management injection techniques is not known. Issues identified in the report included distraction of the anaesthetist, lack of a mark specific to the block, lack of anaesthetic time-out and discrepancy between operating list and mark, or consent form. Other reasons highlight that the site was marked, but either covered up by drapes or obscured when the patient was positioned. The existing WHO checklist does not address this issue, other than stating in the surgical safety checklist supporting information that; ‘The anaesthetist should only proceed with a regional block when he/she has confirmed that the site for surgery has been marked.’ So, what system based solutions can potentially prevent or reduce such incidents?

Why do wrong sided blocks occur?

Nerve blocks are often performed by anaesthetists with an assistant within the theatre suite in the UK. Although preoperative checklists are carried out by the anaesthetic team to confirm the correct side of surgery, specific checks to identify the correct side of nerve block are not consistent in practice. Procedures are performed on patients in the supine, prone or lateral positions, and sometimes the legs are crossed. When patients are positioned in many different ways, the anatomical orientation may become blurred. Further factors involve the use of additional equipment such as ultrasound, nerve stimulators, as well as the ergonomics of the set-up required by the operator. Not to be ignored is the fact that nerve blocks are an additional procedure in the planned anaesthetic technique, and are often subject to time constraints.

Of interest are the reports of wrong sided blocks in awake patients, obviously contrary to expectations. This leads one to believe that patients often do not understand the exact nature of the procedure, and so fail to interrupt the operator who is anaesthetising the wrong side. The recent reports by Safety Anaesthetic Liaison Group (SALG) reflect upon wrong sided blocks encountered in the lower limb, and eye. Surgical site marking is often not checked, not clearly visible, or hidden during block insertion. However, the true incidence of wrong sided blocks, causative factors, types of block involved, and
patient population (paediatric, elderly) encountered, are not understood yet. Moreover, it is not understood whether there is any relationship between these factors, or whether the number of incidents just reflects how commonly certain blocks are performed. All of the above may have a common theme in that wrong sided blocks can occur due to human error from brief lapse in concentration.

**Potential effects of wrong sided blocks**

The increasing use of regional anaesthesia by many practitioners in the UK could pave the way for an increase in such incidents, as has been observed in North America. The American Society of Anesthesiologists (ASA) Committee on Quality Management has reported a dramatic increase in wrong side peripheral nerve blocks, from two percent by specialty (from 1995 to 2005) to 16% in 2006. A Pennsylvania State report in March 2010 demonstrates that wrong site blocks represent 29% of all reports of wrong site procedures in the theatre, the largest cohort of wrong site procedures within a single specialty. This suggests clearly that the implementation of best practices to prevent wrong site blocks lags behind efforts to prevent wrong-site surgery. It is interesting to note such a high incidence, given that only a fraction of patients actually receive nerve blocks for surgery.

Wrong sided blocks can lead to potential harm, including a resulting need for bilateral block with risk of local anaesthetic toxicity, prolonged recovery, delay in mobilization and, more importantly, a contribution to wrong sided surgery. Moreover, undertaking procedures on the wrong side can be extremely embarrassing and stressful for the operator and the team involved. The prevention of wrong sided procedures has always been reliant upon the alertness and planning of the operator. The introduction of the WHO safety checklist has reinforced a team responsibility to reduce perioperative complications, previously practiced in only a few institutions worldwide. It is important that preventable events in anaesthesia are highlighted in this checklist to clarify any doubts, and to rectify them so that there are no assumptions made.

**Anaesthetic timeout**

The risk of wrong sided blocks in anaesthesia is thought to be rare, and there is very little guidance about its prevention. The ‘anaesthetic timeout’ is one of the most commonly quoted safety measures in the Joint Commission Standards for Universal Protocol. Essentially, it suggests a pause before the start of the procedure to verify the correct patient, procedure and site, using active rather than passive communication techniques. The timeout is carried out by the anaesthetic team, which includes the anaesthetist and the anaesthetic nurse or operating department practitioner. Doing an anaesthetic timeout could potentially eliminate 27% of the wrong site errors, as stated in a report on the evaluation of such incidents. It has been stated that any time delay from verification to block performance can negate the usefulness of this safety check. So it is important that this step is carried out just before needle insertion, to avoid errors from misinterpreting the correct side after patient positioning. If more than one procedure is to be performed on the same patient and that requires a change of position or a second operator being called to assist, it is necessary that another time-out occurs.

Once the site involved is prepared, and the anaesthetist is ready to perform the block, a timeout is requested by the operator. At this pause time, the consent form is checked again for correct patient identity, side of surgery and skin mark verified to confirm the correct side of intended nerve block. It must be done aloud so that there is clear communication between the anaesthetist and the nurse, including the patient whenever possible. To serve as a strong reminder for this safety check, it has been suggested that the nurses should handover the block needles only after the check has been carried out. This is similar to the handing of the scalpel to the surgeon only after the surgical timeout has been recorded. However, such methods of forced reminders could be seen as challenging the autonomy of the anaesthetist, and may not be
welcomed universally. Visual reminders displayed could be one way to prompt this action and encourage uptake of this safety check. Secondly, modification of the existing WHO safety checklist to accommodate anaesthetic timeout needs to be considered.

**Anaesthetic block site marking**

It is important to note that surgical site marking can often be remote from the site of the nerve block, and may be hidden once the patient is positioned (for instance prone). It is often debated that an anaesthetic written consent for procedures including nerve blocks, as well as a separate skin mark specific to the block, is warranted to improve patient safety in anaesthesia. This is not routine practice in the UK, and a 2010 survey conducted amongst 245 consultant anaesthetists in Wessex, showed that, whilst 26% of the respondents were aware of anaesthetic site marking, the vast majority (92.3%) didn’t perform it and had never considered doing so. It is interesting to note that 18 respondents (12.5%) had experienced a ‘near miss’ in the previous 12 months, only rescued because of intervention by theatre staff. This suggests that anaesthetic procedure site marking may be an important step that is often underestimated. The skin marking should be done closer to the intended block site to avoid confusion with surgical site marking. This can be performed by the operator, either during the preoperative visit, or closer to the procedure, as part of the WHO pre-induction checklist in the anaesthetic room. A site marking, visible in the transparent draped field, is essential to avoid problems arising from disorientation, right-left confusion, and confirmation bias. This method not only acts as a visual reminder, but also encourages the practice of verbal or written consent for such procedures prior to surgery. Apart from skin markers, sticking bright adhesive tapes around the concerned limb distally has been favoured in some institutions to improve visibility in all possible positions.

**More safety checks: why not?**

It may be relevant at this time to promote the use of ‘anaesthetic block site marking’ and ‘anaesthetic timeout’ as essential evidence-based best practice measures to prevent wrong sided procedures in anaesthesia (see Table 1). Having new safety protocols or alerts may not eliminate errors completely unless there is sufficient training and commitment to support implementation of such safety initiatives. Most often, it is the hasty introduction of new processes without adequate training and amendment that lends itself to protocol violations, or failure to follow protocol with subsequent errors.

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**Table 1**  
Prevention of wrong sided nerve blocks: Evidence based safety measures  
(Modified from Joint Commission standards on Universal Protocol 2009)

<table>
<thead>
<tr>
<th>I Anaesthetic block site marking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mark the site before the procedure is performed</td>
</tr>
<tr>
<td>2 If possible involve the patient in the site marking process</td>
</tr>
<tr>
<td>3 Mark is made near or at the procedure site</td>
</tr>
<tr>
<td>4 Mark is sufficiently permanent to be visible after skin preparation and draping</td>
</tr>
<tr>
<td>5 Skin markers are not the sole means of marking the site and adhesive tapes could be used to mark the side</td>
</tr>
<tr>
<td>6 The operator is ultimately accountable for the procedure – even when site marking is delegated</td>
</tr>
<tr>
<td>7 A standard marking system that is clearly evident is used consistently across the organisation, e.g. use of symbols such as ☒ or ☐ or Ρ</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II Anaesthetic time-out</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Conduct the time-out just before needle insertion</td>
</tr>
<tr>
<td>2 A designated member of the team starts the time-out</td>
</tr>
<tr>
<td>3 It should involve all team members present, who will be actively participating in the procedure from the beginning</td>
</tr>
<tr>
<td>4 During the pause time, the team agrees as a minimum, on the following:</td>
</tr>
<tr>
<td>➤ Correct patient identity</td>
</tr>
<tr>
<td>➤ Correct site</td>
</tr>
<tr>
<td>➤ Procedure to be done</td>
</tr>
<tr>
<td>5 When the patient has more than one procedure requiring change of positioning or personnel, a second time-out is warranted</td>
</tr>
<tr>
<td>6 Document the completion of time-out along with the block details</td>
</tr>
</tbody>
</table>

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**References**


6 Summary of reported incidents relating to anaesthesia. SALG, London, October 2010. (www.rcoa.ac.uk/docs/Incidents_2010.pdf)


Wrong side peripheral nerve blocks

The use of peripheral nerve blocks is at an all time high, due to recent advances in nerve location techniques and the improved ability to provide high quality pain relief after painful surgical procedures. As the use of peripheral nerve block is increasing, there is mounting evidence that the risk of performing a wrong side peripheral nerve block is also on the rise.¹

Although the consequences of performing wrong side blocks are not as dramatic as wrong side surgery, or other complications of regional anaesthesia (such as nerve damage and local anaesthetic toxicity), the chances of these complications occurring increase, and certainly put the patient at risk of inappropriate pain relief.²

There are no reports of malpractice claims against anaesthetists in the UK for performing a wrong sided peripheral nerve block.³ However, it is quite possible that the situation may change in future.

Introduction of the WHO surgical safety checklist has proven to be an effective tool in improving patient safety in the perioperative period, with a reduced chance of performing wrong site surgery.⁴ However, recent reports suggest that, with the current format of the safety checklist, wrong sided nerve block may still occur. The Universal Protocol launched by the Joint Commission in the United States of America is primarily aimed at the prevention of procedures at the wrong site or on the wrong patient.⁵

Why we need to address this problem
In the last few years, the national media in the UK has reported many preventable medical errors, and these always capture the public attention.⁶ Data from the National Patient Safety Agency (NPSA) suggest that wrong site nerve block is more common than wrong site surgery.⁷

Incidence:
The Safe Anaesthesia Liaison Group (SALG) has reported 67 wrong site blocks performed in a period of 15 months, as reported to it by the NPSA.⁸ Previously, the NPSA’s comment upon the need for implementation of the WHO surgical safety checklist identified 56 wrong site events, out of which 27 were regional blocks.⁹

A review of several databases revealed that wrong site anaesthesia related adverse events may be more common than the published literature suggests.⁸

In 2007, the American Society of Anaesthesiologists committee on quality management, reported a dramatic increase in wrong site blocks, from 2% to 16% of all reported sentinel events related to anaesthesia.⁹

In a retrospective analysis of 48,941 chronic pain procedures, Cohen et al¹⁰ identified 13 cases of wrong site blocks (incidence 0.027%). Worryingly, in 52.4% of the procedures there were multiple lapses in following protocol.

Complications:
A wrong site block is potentially harmful to the patient. There is an inherent risk of nerve damage and local anaesthetic toxicity, and even progression to the wrong site of surgery.¹ Patients may be subjected to inappropriate pain relief. Furthermore, there may an increased anaesthetic induction time, increasing the stress level for the anaesthetist.
Preventable malpractice claim

Unlike the other complications of regional anaesthesia, wrong site block is a preventable complication and carries a risk of claim of malpractice. Although there are no reports to date, this cannot be ruled out in future.

Safe surgery – a public health priority

The WHO has declared safe surgery a public health priority, and has developed ten essential objectives for safe surgery.11 The first two state:

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from anaesthetic administration, while protecting patient from pain.

Why are we at risk?

There is a typical time lag between initial verification (sign in), and the time of actual performance of the block, and if this time lag increases, the possibility of wrong site selection increases, even if the initial site verification is correct.

1 Lack of a formal consistent check system

The surgical safety check list has proven to be effective in reducing morbidity and mortality associated with surgery, including wrong site surgery. However, its current format has many elements, and is not specifically oriented in prevention of wrong site nerve block. The ‘time out’ occurs in the operating theatre after the block is performed, rendering it ineffective in prevention of wrong site nerve block.

2 Reliance on site marking done by surgeons

Site marking is a useful tool to prevent wrong site procedure, if its basic principles are used correctly. It is well known that, to be effective, site marking should be done by the professional who is either performing the procedure or is present at the time of the procedure, is as near as possible to the procedure site, and is visible at the time of performing the procedure.

Peripheral nerve blocks are often performed away from the surgical site, and surgical site marking may become obscured by any change in positioning and drape cover.

3 Concept of laterality

Regional anaesthesia introduces the concept of laterality in anaesthesia. It is possible to select the wrong site when working under pressure from factors such as time delays and distractions, leading to failure in effective communication with other staff present.

4 Procedural Factors:

Unanticipated changes and mistakes in operating lists and patient requirements, multiple procedures, and changes in patient position, may contribute to wrong site selection.

5 False sense of security with awake patient:

There is a false sense of security amongst anaesthetists that it is not possible to perform wrong side nerve blocks in patients who are awake. However, the literature suggests that this is not the case.12 The patient may not understand the ‘correct site’ for the block. They are likely to be anxious, confused and may not wish to contradict the clinician performing the block.

6 Use of the surgical consent form for the final check

Errors in written consent obtained by surgical colleagues are possible, and may contribute to wrong site selection. Whilst it is not common for anaesthetists to check the surgical consent form immediately before the nerve block, a consent form signed by the patient and the anaesthetist may be a useful document enabling a final check immediately before the nerve block, although this is not normally practiced.

How can we prevent wrong side nerve blocks?

Similar to the wrong site of surgery, wrong site nerve block is a preventable medical error. Its multi-factorial aetiology means that we need to apply a standardised stepwise approach to eliminate it completely. The standard elements for prevention of a wrong site procedure are incorporated into the WHO surgical safety checklist. The Universal Protocol launched by The Joint Commission of United States of America is a similar approach, but is specifically designed for prevention of the wrong surgery on the wrong patient, or by the wrong surgeon.5 It is based on the consensus of experts from relevant clinical specialties and professional disciplines, and is endorsed by more than 40 professional organisations. It is based on prevention theories which drive safety culture in high risk industries such as aviation and nuclear weapons.

The three key elements for prevention are:

1 Pre–procedure verification (Sign in)

The aim of pre-procedure verification is to ensure that all the information is available prior to start of the procedure, and that it has been reviewed and consistent with patient expectations. Any discrepancies must be addressed by active communication within the team, and should involve the patient.

The ‘sign in’ part of the WHO surgical safety checklist provides an opportunity for the anaesthetist to confirm with the patient about the correctness of the site while the patient is still awake.
2 Site Marking
The aim of site marking is to identify clearly the proposed site of the procedure at the time of starting the procedure. Site marking is an established tool to prevent wrong site surgery. Its use was first formally advocated by the Canadian Orthopaedic Association in 1994. It was introduced as a standard procedure to prevent wrong site surgery through two simple concepts; sign your site and operate through your initials. The consensus was that the operating surgeon can prevent wrong site surgery by checking his own mark immediately before starting the procedure. The mark will help to identify the procedure site clearly and unambiguously at the time of performing the procedure. In order to be effective, site marking must be:

➤ performed by the professional responsible for the planned procedure.
➤ made at, or near, the site of the procedure.
➤ visible clearly at the time of performing the procedure.

Usefulness of surgical site marking in identifying the site of nerve block is limited, because it can be away from the proposed site of the nerve block. It can become invisible due to drapes, cloths or change in positioning. We are more likely to forget a site marking which is done by someone else.

Marking of peripheral nerve block sites by the anaesthetist has been advocated, but is not commonly practiced. The main reason for this is time pressure at the time of the pre-anesthetic visit. However, site marking can be performed in the anaesthetic room whilst performing the initial verification (WHO sign in). It gives an additional opportunity for the anaesthetist to discuss any issues related to the proposed nerve block.

The anaesthetist can choose the best site for the mark, and whilst this is fresh in the memory, it serves as a reminder to check again immediately before performing the nerve block.

3 Time-out
Time out is a brief pause to be taken immediately before the procedure. This is time for final verification of the correct site, correct procedure and correct patient. It is incorporated in the WHO check list, and is used to control multiple elements that can potentially contribute to morbidity and mortality associated with surgery. Since this time out happens after the nerve block is placed, it cannot be a safeguard against wrong site nerve block.

A 'time-out' taken immediately before the nerve block will allow the anaesthetist to control any factor that may potentially lead to a wrong site selection, such as distraction, time pressure and change in positioning. This time out also gives an opportunity for the anaesthetist to make a final check for local anaesthetic preparation and the integrity of nerve identification equipment, thus preventing errors associated with it.

Summary
Wrong site nerve blocks will continue to happen unless a stepwise process of verification, marking and time-out is used. We have developed a guideline and an alert card, in order to introduce the stepwise process outlined above into clinical practice at our institution (see Appendices).

An alert card attached to the nerve identification equipment is a simple cost effective measure to prevent wrong-site nerve block

Acknowledgments
We wish to thanks Dr R Pollard and Dr J Haldar who encouraged us to develop a simple solution for this persistently reported critical incident.

References
13 Wrong site surgery Advisory Statement-AAOS. Available at: www.aaos.org/about/papers/advismt/1015.asp.
15 Harris B, Torlot K. Site marking for peripheral nerve blockade to reduce the incidence of incorrect side regional anaesthesia. Anaesthesia 2009;64:122.
Wrong-site nerve block is a preventable medical error. There is a time lag between initial verification at the time of WHO sign in to the actual performance of nerve block. During this time, multiple factors challenge the integrity of the existing system and create an atmosphere where wrong-site selection becomes a possibility.

This guideline is based upon the principles of the WHO surgical checklist and the universal protocol for prevention of wrong site procedures.

1  Pre anaesthetic visit
   **Aim:** To obtain consent for a correct site nerve block.
   **Action:** After review of clinical notes, confirm with patient about the planned surgical procedure. Discuss and obtain consent for the proposed nerve block.

2  WHO: sign in – Verification on arrival in the anaesthetic room
   **Aim:** To verify that the correct patient is having the correct nerve block at the correct site.
   **Action:** At the time of ‘sign in’ of the WHO Surgical Safety Checklist, conduct a verification process by involving the patient and anaesthetic nurse practitioner. Verify the consent form. Ensure a correct marking is in place for the final check.

3  Marking
   **Aim:** To ensure a clearly visible marking at the time of nerve block.
   Site marking is effective, if it is placed by the professional responsible for the particular procedure, is as near as possible and is clearly visible at the time of the planned procedure.
   **Action:** There are two options.
   a  **Use surgical site marking** If the anaesthetists believes that it will be clearly visible at the time of nerve block, use it for the final check.
   b  **Use an additional anaesthetic marking** If the surgical site marking is unlikely to be visible at the time of nerve block, e.g. change in position for nerve block, then an independent marking can be placed by the anaesthetists. This can be done in the anaesthetic room at the time of initial verification while patient is still awake.

4  Time-out
   **Aim:** To perform a final check immediately before the start of the nerve block.
   **Action:** Immediately before the nerve block, take a brief pause and confirm the patient and the nerve block. Involve the anaesthetic nurse practitioner in the process. Use marking and consent form for the confirmation.
   Time-out is repeated if the same patient is having a second nerve block at a different place.
In the mid-1930s, Sir Farquhar Buzzard, Regius Professor of Medicine, wished Oxford to have a Centre for Postgraduate Medicine with chairs of medicine, surgery, and gynaecology and obstetrics. Lord Nuffield offered a donation of £1,250,000. During a casual conversation with Lord Nuffield at the Huntercombe Golf Club, Dr Robert Reynold Macintosh, a very successful London anaesthetist, remarked: ‘I see they have forgotten anaesthetics again.’

Lord Nuffield decided a chair of anaesthetics should be added as part of his benefaction. The University of Oxford did not regard anaesthetics as an academic subject, but finally relented. Then, Lord Nuffield announced that he had increased his benefaction to £2M (worth £100M today).

**Early days**

Lord Nuffield wanted Dr Macintosh to be the Nuffield Professor of Anaesthetics, and head of the first independent department of anaesthesia in the UK, in Europe, and in the Commonwealth. There had already been several professors of anaesthetics in the USA, but they were not heads of independent departments. The Henry Isaiah Dorr Chair of Anaesthesia at Harvard, endowed as an independent department in 1917, was filled by Henry Beecher only in 1941.

During his tenure of the chair (1937–1965), Professor Macintosh’s main concerns were to increase the safety of anaesthesia through better training, to lay the scientific foundations of anaesthetic practice, for instance, the book ‘Physics for Anaesthetists’, and to develop equipment that would allow the safe delivery of anaesthesia. Training courses were attended by many anaesthetists from the UK (including many anaesthetists in the armed forces), Europe, and the Commonwealth. Many became heads of department.

The equipment developed in Oxford was adopted rapidly worldwide, and its manufacture facilitated by links with local engineering firms. Under physicist Dr Epstein, ably seconded by Mr Richard Salt, the first anaesthetic technician, a range of prototype equipment (laryngoscopes, endotracheal tubes, vaporisers, ventilators) was built.

As the senior anaesthetist in the Royal Air Force during the Second World War, Air Commodore Macintosh contributed to the testing of life jackets and many other projects related to the war effort. His assistant, Dr Pask, volunteered to be thrown, fully anaesthetised, into a swimming pool to...
As a Nuffield Trustee and the first clinician to have been elected to the General Board of Faculties, Professor Crampton Smith was much involved with the running of the university. He was also a member of the Board of the Faculty of Anaesthetists of the Royal College of Surgeons. He retired at the end of 1979, a few months after the opening of the second phase of the John Radcliffe Hospital.

**The 80s and 90s, years of rapid expansion**

In 1980, Professor (later Sir) Keith Sykes took up the chair. He had a considerable reputation as a researcher, teacher, and innovator at the Royal Postgraduate Medical School at the Hammersmith Hospital. He established a new laboratory for the study of the pulmonary circulation, especially of pulmonary hypoxic vasoconstriction. His book ‘Principles of Clinical Measurement’ formed the basis of training in clinical measurement relevant to anaesthesia and intensive care, and quickly became essential reading for candidates sitting the Primary FFARCS examination.

In the mid-1980s, with Dr Hahn and the local firm Penlon, he initiated the development of a computer-assisted anaesthetic machine (Penstar) where gas mixing, ventilatory parameters, and alarms were microprocessor controlled. Although a prototype was constructed and successfully used to deliver anaesthesia, increasing costs stopped the project.

During his tenure, the research strength of the department increased considerably. This was facilitated by the appointment of Dr Henry McQuay as Clinical Reader in Pain Relief, and of Dr John Sear as Clinical Reader in Anaesthesia. Dr Sear carried out many clinical and experimental studies of the pharmacokinetics and
pharmacodynamics of intravenous anaesthetic agents and opiates.

Research students, fellows and senior researchers from the UK and abroad joined the department; multiple grants were awarded from the Medical Research Council (MRC), Engineering and Physical Sciences Research Council (EPSRC), British Heart Foundation (BHF), Wellcome Trust, European Academy of Anaesthesiology, and other scientific foundations. All of these increased the scientific standing of the department.

Professor Sykes contributed greatly to the training of junior anaesthetists, and to the teaching of medical students. He was adviser in anaesthetics to the Department of Health, a respected member of the Board of the Faculty of Anaesthetists of the Royal College of Surgeons, an FRCA Examiner, and a member of the Clinical Medicine Board.

He received a knighthood in 1991 and retired a few months later.

Professor Pierre Foëx then took up the chair. His major interests were experimental and clinical applied cardiovascular physiology and pharmacology, especially the effects of myocardial ischaemia on cardiac function. In collaboration with Dr Sear, studies of arterial hypertension and silent myocardial ischaemia expanded. Research continued to be supported by grants, studentships and fellowships from MRC, BHF, Wellcome Trust, European Academy of Anaesthesiology, and the Venner Group. Collaboration with Dr D Terrar in the Department of Pharmacology led to studies of the effects of anaesthetics on ion channels.

The appointment of Dr Duncan Young to a clinical readership secured the future of respiratory research. As an intensive care consultant, Dr Young was instrumental in the expansion of high quality research in intensive care and later became Director of Research for the Intensive Care Society.

The secondment of Dr Michael Halsey (MRC external staff) led to the development of computer-assisted molecular modelling of the configuration and electrostatic fields that are responsible for the anaesthetic potency of inhalational agents, and later, under Professor Sear, of intravenous agents.

Drs Hahn and McQuay were given the title of Professor (in the ‘recognition of distinction exercise’). Three NDA members became members of the Academy of Medical Sciences, Professor Foëx and Dr Young as founding fellows, and Professor Hahn by election.

Professor Foëx retired in September 2002, having been a member of Council of the Royal College of Anaesthetists, FRCA Examiner, Vice-President of the European Academy of Anaesthesiology, university representative on the Oxford Radcliffe Hospital Trust Board, and Civilian Adviser to the Royal Air Force. Among many contributions to the NDA, his passion for maintaining a close integration of the clinical and research arms was critical at a time when academic anaesthesia was under considerable threat nationally with many anaesthetists not opting for an academic path.

Modern times
Professor Clive Hahn was appointed Head of Department in October 2002 pending the election of a new Nuffield professor. He maintained close collaboration with the clinicians, especially with the honorary senior clinical lecturers, and expanded their number considerably. He worked hard with the Regius Professor of Medicine to reappoint the Nuffield chair. He also worked closely with Dr Douglas Wilkinson, the clinical director of the NHS wing of the NDA, to create new NHS funded research fellowships to attract young overseas anaesthetists to the NDA – to the benefit of both the academic department and the clinical service. He further developed his research, devoted to a large extent to mathematical modelling of the respiratory system, whilst continuing with the development of biosensors and systems to test biosensors. Mathematical models of oxygen and carbon dioxide transfer were developed and tested during in vivo experiments. His work was, and still is, supported by grants from the Wellcome Trust, EPSRC, National Institute of Health Research (NIHR) and other grant giving bodies. During this period, Dr Sear was awarded the title of Professor.

In 1936 anaesthesia was not recognised as an academic subject. Lord Nuffield was convinced it was, and he was right.
Academic pain research

In December 2006 it was decided that two Nuffield chairs would be created: one for Professor Irene Tracey as Professor of Anaesthetic Science, and the other for Professor Henry McQuay as Professor of Clinical Anaesthetics. Both took up their appointments in April 2007. These elections made the department a major centre for pain research and neuroimaging. Professor Irene Tracey, as a basic scientist and as Director of the Oxford Centre for Functional Magnetic Resonance Imaging of the Brain (FMRIB) (a world-leading multidisciplinary neuroimaging laboratory comprising over 100 scientists and clinicians), brought both her scientific expertise and large pain research team to the NDA. Further, direct benefits resulting from the NDA being more closely affiliated with the FMRIB Centre and Clinical Neurology (where FMRIB was based) allowed new interactions and opportunities for anaesthetists within the NDA on the John Radcliffe Hospital site. She continues as Director of FMRIB, while holding the Chair in the NDA. Her research interests are directed at gaining an understanding of the central mechanisms that contribute to the development and maintenance of acute and chronic pain experiences, as well as their relief via pharmacological and psychological means. With this appointment the NDA had an influx of senior postdoctoral research scientists and graduate students, and injection of considerable research funding. Further, it allowed the NDA to become more embedded and visible to other departments within the university, creating new synergies and research opportunities.

Professor Henry McQuay, already a long-standing member of the department, together with Professor Andrew Moore (a long-term collaborator) continued to bring considerable experience in chronic pain management, and in evidence-based medicine, exemplified by their publications in *Bandolier*, a very successful independent journal about evidence-based healthcare. A major development under Professor McQuay was the creation of a simulation centre within the NDA (OxSim, now Oxford Simulation Teaching and Research Centre [OxSTaR]). All medical students, an increasingly large number of foundation and anaesthetic trainees, consultants in many specialties, GPs, nurses, and paramedics, benefit hugely from the centre, now under the direction of Dr Helen Higham. This development has greatly increased the ‘visibility’ of the department.

During 2007, the department moved into state-of-the-art laboratories and office space in the ‘West Wing’ of the John Radcliffe Hospital, following the closure of the old Radcliffe Infirmary site.

In 2010, when Professor McQuay retired, Professor Tracey became Head of Department, and her first role was to steer the NDA towards a new format within the university system. From 2009, the Medical Sciences Division has been reorganising groupings of departments into stronger research led themes. This is to aid and ensure international research excellence in key areas that could also be more financially sustainable, as we go forward with growth. One of these reorganisations led to the creation of a Nuffield Department of Clinical Neurosciences, within which sit four sections: Nuffield Division of Anaesthetics, Nuffield Laboratory of Ophthalmology, FMRIB Centre, and Clinical Neurology. There are considerable research synergies already between these sections but, by having one joint administration and a collective management group, we can develop these further and provide a stronger and more coherent research infrastructure for clinicians and researchers. Critically, this development has meant that we are better able to deliver on the academic aspirations for anaesthetic related research in the coming decades, and provide a truly internationally competitive research environment for trainees.

Over a relatively short time period Professor Tracey has built up the number of postdoctoral research fellows and graduate students, and has attracted to the NDA a number of MRC, Wellcome Trust and Marie Curie independent senior investigators, who are developing their own research teams. In addition, there is now a cadre of young anaesthetists funded via competitive prestigious fellowships, for instance, Dr Kyle Pattinson. The NDA has been awarded several anaesthetic clinical fellows and one anaesthetic clinical lectureship that will further enable its growth. Professor Tracey is passionate about developing and growing academic anaesthesia through these young trainees. These efforts have been greatly supported by the clinical consultant body, who have been tremendous in creating a positive and supportive culture for their juniors, as well as by several senior clinical fellows (Drs Duncan Young, Jaideep Pandit, Rhys Evans, Andrew Farmery, Douglas Wilkinson, and Helen Higham).

Therefore, with this increasingly large number of clinical and basic science academics, and the new opportunities
afforded within clinical neurosciences, the division will continue to flourish.

**From the past to the present**

Since 1937, there has been close collaboration between clinicians and academics. NHS consultants have contributed enormously to the research output of the department. Many have been College tutors, regional advisers, members of Council of the AAGBI, or the Anaesthetic Section of the RSM. Many were lecturers on RCoA courses and/or FRCA examiners. Unfortunately, space precludes listing them and their contributions.

In the early days, the department was responsible for the delivery of anaesthesia at the Radcliffe Infirmary and the Nuffield Orthopaedic Centre. After WW2, the Churchill Hospital was added. In 1972, the Maternity Unit opened (John Radcliffe phase 1). In 1979, the John Radcliffe Hospital (phase 2) opened, and medicine, surgery, accident and emergency, and paediatrics moved to the new hospital. At that time, the department assumed responsibility for anaesthesia on four major sites, with two adult intensive care units, one for neurosurgery at the Radcliffe Infirmary, and one for adult intensive care at the John Radcliffe Hospital.

The opening of the West Wing in 2007 saw the transfer of most of the specialties still located at the Radcliffe Infirmary (neurology, neurosurgery, plastic surgery, ENT, ophthalmology) to this new building. Paediatric services also moved to the newly built Children’s Hospital on the John Radcliffe site.

In 2009, the Cancer Centre at the Churchill Hospital opened, and newly built theatres started to deal with all elective gastrointestinal surgery, in addition to urological surgery, renal transplantation, kidney-pancreas transplantation, and day care surgery. This work is now supported by an intensive care unit.

Currently, almost all branches of surgery are represented. Specialist groups and site-defined groups have evolved to facilitate communication, improve care, and support clinical audit and research as well as training in specialist areas, over and above regular training for junior and senior specialist trainees.

Over the years, increasing workload and increased specialisation led to the formation of eight consultant on-call groups. Another development was that of an acute pain service. Unsurprisingly, the number of consultants has increased from 14 in the late 1960s, to nearly 100 in 2011. As the Horton General Hospital (Banbury) joined the Oxford Radcliffe Trust in 1998, all the anaesthetists working there became members of the department.

Over the 75 years of its existence, the Nuffield Department of Anaesthetics has contributed extensively to the training of anaesthetists through courses for the Primary and Final FRCA, Clinical Measurement, Anaesthesia in Difficult Locations, and Regional Anaesthesia, in addition to departmental meetings. There is, therefore, a close relationship between NHS and university members of the department. The NDA has fulfilled its role in education and training, and few can dispute that it will continue to make outstanding contributions to research. Anaesthesia is undoubtedly an academic specialty, and it owes a huge debt to the foresight of Lord Nuffield.

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**Acknowledgements**

In 1987 Mrs J Beinhart wrote ‘A History of the Nuffield Department of Anaesthetics, Oxford 1937–1987’ (Oxford University Press); I used her work for the period before 1970. After 1970 are mostly my recollections of the development of the department. In this task I was greatly helped by Professor Tracey, Professor Hahn, and Dr Dyar.

The photographs used in this article are courtesy of:

- Oxford Radcliffe NHS Trust (Lord Nuffield)
- Nuffield Division of Anaesthetics (Professor Sir Robert Macintosh)
- Royal College of Anaesthetists (Professor Irene Tracey).
For all her eagerness to go on Operating Room, Cherry felt a little panic too. She remembered sensational things she had read, or seen in the movies – fearful things, secret masked figures in white with sharp eyes, and hints of cruel instruments and lurking death. Could Operating Room really be like that? Her classmates had brought back such weird, conflicting reports.

Cherry got over her nervousness in the first five minutes. This was no dire half-world – this was the sane efficient hospital going about its miraculous business. Surgery was simply a more miraculous branch of medicine, its daring equalled by its skill and by its strict techniques.

The white-tiled Operating Rooms were furnished with a high long table under a powerful center light, with smaller wheeled tables for adrenalin, hypodermics, morphone, and for sterile trays of instruments, solutions, and gauze. The air was warm and smelled faintly of soap and ether, and daylight flooded in through enormous windows.

‘May I assist at an operation today?’ she eagerly asked the graduate operating nurse, who smiled and handed her a list of the day’s scheduled operations. ‘Read this, come into my office, and I will show you the various surgical instruments and tell you how they are used and how to sterilize them.

Then you may,’ she continued with an amused smile at the bewildered Cherry, ‘set up a nurse’s table for a tonsillectomy.’ It was an anticlimax.

‘But not assist at an operation?’

‘No, for the first few days you will set up tables, make supplies and drains to use in the O.R., and generally keep your eyes open. You will be a “dirty” nurse – not sterile – you’ll be a messenger who goes in and out of the O.R. without contaminating anything. Later on I will teach you how to put on a sterile gown, set up a sterile instrument table, and help drape a patient. After that the Supervisor will assign you to jobs helping the surgeons.’ Cherry looked woebegone. ‘But right now you can watch an operation – in there.’ She pointed to a swinging door with a high glass window.

Cherry found that this Operating Room had seats built up to a swinging door with a high glass window. Right now you can watch an operation – in there.’ She pointed to a swinging door with a high glass window.

Wot? No anesthesiologist? By 1944 that wonderful Avertin (bromethol), a profound respiratory depressant, would have been used as a basal narcotic, not as the sole anaesthetic. (Happily, Dr. Wylie turned out to have a heart of gold at the other end of those steely fingers, Cherry graduated with flying colours, and the whole class volunteered for the Army Nursing Service.)


David Zuck
History of Anaesthesia Society
The Science Museum Wellcomes Anaesthesia

Anaesthetists are rightly proud of the specialty’s strong foundation in the basic sciences. Most of us have enjoyed the faces of medical students in theatres when the direct clinical relevance of all that tiresome physiology and pharmacology finally dawns on them. Surprising, then, that public exhibitions on anaesthesia to date have tended to focus on its fascinating history – but ignored the equally fascinating science.

That may be about to change. In September 2012 a new exhibition, Senseless: Anaesthesia, Consciousness and Pain [working title], supported by the Wellcome Trust, will open in the Antenna Gallery at London’s Science Museum. The gallery is run by the museum’s contemporary science team and is exclusively devoted to science news. So much so, in fact, that their exhibition development typically starts in earnest only six months before opening day – so as to capture the very latest developments.

Fewer frocks this time
For those of a certain vintage, ‘visitor interaction’ at the Science Museum means fingers stabbing at the red button to make the piston go up and down inside the glass case. In the new digital age, things have moved on a bit. At time of writing, the current Antenna show, Trash Fashion, is about recycled fabrics and clothing (Figure 1), while upstairs in the main gallery is the magnificent Who am I? exhibition. Both involve a stimulating range of exhibits; computer-generated interactives, objects used to tell stories, contemporary art and – most relevant for Senseless – items created by potential museum visitors. This last category is relatively new to the museum world but will be one of two innovative aspects of Senseless.

Exhibition development will start in March 2012 at the museum’s Dana Centre. Opened in November 2003, the centre represents another departure from childhood memories of the museum. It runs a busy programme of events, many in the evening, about subjects relating to ongoing museum exhibitions. These opportunities for adult visitors to discuss science with experts, while clutching a glass of wine rather than a toddler’s hand, are understandably popular.

The construction of Senseless will start with four such events. Joining respondents from the Dana mailing list will be patients and relatives from Guy’s and St Thomas’ NHS Foundation Trust. They will review a collection of potential exhibition material provided by a national network.
of anaesthetists, pain specialists, researchers, artists, ethicists and patient representatives. With the help of network members, and the Antenna team, the public attending the Dana events will choose the areas to be developed further and included in the exhibition. The potential audience will be, effectively, the co-creators.

More conservative readers of this article who feel that this is all a bit trendy, and that a speedy return to a traditional model is likely, may be in for a shock. In 2014, the Science Museum opens its new, multi-million pound Treasure Galleries, in which audience co-creation is likely to play a major role. The museum sees Senseless as a significant testing ground.

The Antenna team are also hoping to include two exhibits in Senseless that are actually created by some of those attending the Dana Centre development events. This is not without precedent (Figure 2). One very popular temporary exhibit developed for Who am I? was all about sleep. It was created not by experts, but by teenage members of the public – although teenagers as a group might arguably claim some special expertise in this area. For Senseless, the plan is to develop one exhibit with adults, and another with 13–14 year olds.

Audience co-creation? User-generated content? All this means the precise content of the show is, as yet, unknown. The ideas in the section below are simply that – ideas. It is pretty certain, though, that Senseless will contain fewer frocks than the current exhibition.

### So what IS it going to look like?

All this said, it would have been hard to convince anyone to fund Senseless without giving them some idea of what to expect. A steering group (Table 1) met in February this year to discuss some ideas with the Science Museum before a final funding application. In general it was felt that exhibits should fulfil some of the following criteria. They should:

- be exciting
- be generally topical
- relate to current research
- be referable to visitors’ existing experience
- have a strong visual element
- have the potential to illustrate more general scientific principles.

With these requirements in mind, four broad areas emerged from the meeting, along with several ideas for individual exhibits (Table 2). These are nothing more than suggestions – the

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**Table 1**

Original steering group for ‘Senseless: Anaesthesia, Consciousness and Pain’ exhibition

- Dr Peter Venn (Chairman of Communications Committee, RCoA; Editor RCoA Bulletin)
- Mrs Kate Rivett (Patient Liaison Group, RCoA)
- Dr Steve Yentis (Council member, AAGBI; Editor-in-chief Anaesthesia)
- Ms Trish Willis (AAGBI Heritage and Records Manager; Curator, The Anaesthesia Museum)
- Professor Tim Hales (Director, Centre for Neurosciences, University of Dundee)
- Professor Jerry Lambert (Centre for Neurosciences, University of Dundee)
- Professor Andrew Rice (Director, London Pain Consortium)
- Professor Irene Tracey (Director, Oxford Centre for fMRI of the Brain; LPC member)
- Professor Tony Dickenson (Professor of Neuroscience, Physiology and Pharmacology; LPC member)
- Dr James Barron (Consultant Anaesthetist; Medical simulation facility at St Thomas’ Hospital)
- Dr Mike Grocott (Consultant Anaesthetist, Director, Surgical Outcomes Research Centre UCL/UCLH)
- Dr Martin Smith (Honorary Professor, Brain Monitoring Research Group, National Hospital for Neurology & Neurosurgery, UCLH)
- Ms Deborah Padfield (Artist-in-Residence, UCL)
- Dr Brijesh Patel (Clinical Research Training Fellow, Imperial College London)
- Dr Amit Pawa (Consultant Anaesthetist, St Thomas’ Hospital; London Society for Regional Anaesthesia representative)
- Dr Rob Linton (retired Consultant Anaesthetist)
The impact of the exhibition on public perceptions of the specialty ... is likely to be significant

Table 2
Possible subject categories and topics for individual exhibits in ‘Senseless’

**Anaesthesia and consciousness**
- Narrated video of induction of anaesthesia
- fMRI for anatomical correlates of consciousness
- Distinction between sleep, coma and anaesthesia
- Awareness and depth of anaesthesia monitoring
- Consciousness-enhancing drugs and the military

**Molecular mechanisms of drug action in anaesthesia**
- Drug–receptor interactions
- Structure/activity relationships
- Recombinant receptors and knock-in/knock-out mice
- Sugammadex

**Pain**
- Chronic pain in military amputees
- Acute pain in sporting injuries
- Recreational use of analgesics
- Novel sources for analgesics, e.g. ziconotide

**Reducing risk and complications**
- Anaesthetic simulators
- Doppler guided fluid administration
- Near infra-red spectroscopy
- Ultrasound guided nerve blocks

Table 3
Excerpt from Wellcome Trust Society Award guidelines

**Society Awards projects should cover at least one of the following areas:**
- Examine the social, cultural, historical and ethical impact of biomedical science
- Encourage new ways of thinking about biomedical science
- Encourage high quality interdisciplinary practice and collaborative partnerships
- Investigate and test new methods of engagement, participation and education

**They should also aim to:**
- Stimulate interest, excitement and debate about biomedical science through various methods
- Support formal and informal learning about biomedical science
- Reach new audiences not normally engaged with biomedical science, as well as continuing to target existing audiences

final range of subjects presented for possible selection at the development events may be completely different. It all depends on you. The available physical exhibition space, however, requires the final product to have a reasonably narrow focus – and eagle-eyed readers will have spotted that there are few intensive care topics in the table. This is mostly because of the nature of the Wellcome Trust award (see next section).

Events associated with the exhibition, and the museum website, will give some scope for increasing the breadth and depth of subjects presented in the gallery. As well as two post-launch evening events at the Dana, the museum proposes to run a few Talkaoke sessions in the gallery during opening hours. Talkaoke is another recent development in the museum world – a sort of round table discussion between visitors, facilitated by a researcher in the middle (Figure 3).

**Who’s paying for all this, and why?**
The budget for the exhibition and related events is about £250,000. The majority is funded by a Wellcome Trust Society Award, the theme of the awards being Grey Matters: Brain, Science and Culture. The Science Museum is contributing a substantial sum and the project is also hoping to attract additional sponsors.

The fact that this is a Society Award is significant. Looking at the award guidelines (Table 3), it is easy to see why the Science Museum views Senseless as the ideal opportunity to test a new method of exhibition development. For the anaesthetic profession too, the exhibition presents a unique chance to engage with the public outside the confines of direct clinical care.

The College has long been committed to this sort of engagement and is preparing to take full advantage of Senseless. In particular, this will involve the Communications Committee and the Patient Liaison Group, chaired respectively by Dr Anne Thornberry and Mr Charlie McLaughlan. The Association is represented by Council member, Dr Felicity Plaat, and Nicole Bates, Marketing and Communications Manager. Plans are afoot to construct a web-based, publicly accessible FAQ database about anaesthesia and pain medicine. This will be prepared largely
in advance of the exhibition, using existing data on patient enquiries held by the College.

The impact of the exhibition on public perceptions of the specialty, and the knowledge we can gain from any public dialogue that results, is likely to be significant. The Science Museum estimates that more than a million people will see Senseless in person. The museum website, which will have a new section devoted to Senseless, has more than 10 million visits each year. If it goes well, there is the prospect of further funding to tour the exhibition to other UK venues.

**Get involved**

This is not a dry academic exercise. Every one of the 15,000 fellows of the College has the potential to make a contribution – to join the clinical and research network supporting the exhibition. It won’t work without you.

We need:

- Your ideas for topics or exhibits.
- Volunteer anaesthetists, pain specialists and researchers to engage in dialogue with the audience in the exhibition development events in March 2012, to participate in the Talkaoke discussions in the gallery and to speak at post-launch, Dana Centre evening events in late 2012.
- Volunteers to help write answers for the FAQ database.
- To find out what patients are asking you about anaesthesia and pain medicine.
- To find out what you would like to know from all those visitors to the exhibition and website. Should we be establishing their concerns about anaesthesia? Finding out how would they like us to respond to these? Asking what they feel about our research priorities?
- To know what messages you think we should be trying to get across to the public about research and the profession. Anaesthetists are real doctors? The Royal College sets standards to improve patient safety? Anaesthesia is really safe?

During the application process, we convinced the Wellcome Trust that the anaesthetic profession has the resources to respond to the challenges posed by this opportunity. This was an easy job because we believe it ourselves.

Please email us at amorley@rcoa.ac.uk.
NCEPOD – then and now

The National Confidential Enquiry into Perioperative Deaths (NCEPOD) was established in 1988, and its aim originally was to examine the quality of surgical and anaesthetic care delivered to patients. It was acknowledged by the profession that perioperative deaths were an important source of information about the quality of care, and that there was room for improvement.

This was first demonstrated in a report published in 1987, entitled 'A Confidential Enquiry into Perioperative Deaths' (Figure 1), which was funded by the King’s Fund and Nuffield Research.

NCEPOD reviewed samples of patients who had died within 30 days of a surgical procedure. Since then NCEPOD has published more than 30 reports, all of which are still available, and the majority can be downloaded from the NCEPOD website (www.ncepod.org.uk).

In 1999, following the publication of 'A First Class Service: Quality in the New NHS', funding for NCEPOD (in England and Wales) became the responsibility of the National Institute for Clinical Excellence (NICE). In April 2002, NCEPOD was asked to extend its analysis of perioperative death, and also to review the care received by medical patients, those in primary care, and ‘near misses’. To reflect this extension to its remit, NCEPOD changed its name to become the ‘National Confidential Enquiry into Patient Outcome and Death’ in late 2003.

Essentially, NCEPOD was set up by the medical profession for the medical profession, and is supported by the relevant medical royal colleges and specialist associations who form the NCEPOD Steering Group. This multidisciplinary group ensures that all have an equal say in the work undertaken, but maintain the distance required so that the work does not directly overlap with professional regulation, training and revalidation, which remain key responsibilities of these ‘parent’ bodies. NCEPOD aims to optimise the care received by patients by highlighting areas where services provided can be improved. The peer review method used in most studies provides a detailed analysis of the care given to the patient by professionals working in the same area of practice, and an independent decision is reached as to why their outcome may have been suboptimal – or not as the case may be.

As a measure of effectiveness, NCEPOD keeps a record of the known demonstrable impact of each report. For more recent reports, where the Department of Health has responded with planned action, and other specialist organisations have worked with NCEPOD,
the impact felt has been much sooner after publication of a report than previously. For example, in 2009 the Renal Association was constructively involved with implementation of the changes recommended by the NCEPOD report ‘Adding Insult to Injury’, and this evidence was used as part of a successful bid to NICE to provide an acute kidney injury guideline, that is currently being developed.

In a similar fashion, the recent short lived working party, formed independently by this College (and now involving the AAGBI, Age Anaesthesia, the Patient Liaison Group, and others) in response to ‘An Age Old Problem’ (December 2010), promises to effect real changes in the care of the elderly, and we look forward to seeing the conclusions and further recommendations from this group.

Whilst it is known that action is also implemented at a local level after the publication of a report, this has been much harder to gauge. However, demonstration of participation in the confidential enquiries has been part of the NHS Quality Accounts in England and, as such, should be seen as important by trusts.

Study design and the peer review process
Each year NCEPOD makes an open invitation for the submission of study ideas, and a rigorous selection process ensues, involving a large group of clinicians and researchers. Studies are generally selected according to their clinical importance, but must also be suitable in terms of the required methodology and, in the case of typical peer review work, will be limited generally to a maximum of about 2,000 cases. The study protocol is elaborated by a relatively small group, which includes experts from the area being studied, and questionnaires are designed and then trialled. Clinical advisors are recruited, and provide the ‘bed rock’ of the study, in that they then review the clinical material in detail, and evaluate the quality of care with peers. This same group is the first to review the accumulated data, and comment upon their credibility.

Following further review by the steering group, a report is produced in two drafts which are circulated widely to between 30 and 40 advisers, experts, and all permanent NCEPOD staff. Comments received are taken very seriously by the authors. The final product is circulated in embargoed form to relevant bodies and individuals, one month before simultaneous publication and launch.

NCEPOD collects data from all hospitals in England, Wales, Northern Ireland, the Channel Islands and the Isle of Man, and includes NHS and large independent sector hospital groups, as well as many of the smaller private hospitals. A hospital’s medical director is ultimately responsible for the participation of their hospital(s), but the day to day running of studies within each site is delegated to an NCEPOD local reporter. This role was filled by a pathologist or an anaesthetist historically but, more recently, has been the remit of someone in clinical governance or clinical audit. To aid the local report, NCEPOD has relatively recently introduced the role of an NCEPOD ambassador – a senior clinician who can better liaise with their clinical peers for either identifying cases or filling questionnaires. Clinicians who have many years’ experience of NCEPOD, either from completing questionnaires or acting as advisors, and want to remain involved, have generally fulfilled this local champion role. So far, 40% of acute trusts have named local ambassadors.

Clinical input into NCEPOD
It is the clinical input provided to NCEPOD that ensures the professions take the work seriously. Clinicians form the steering group act as directors of the company, sit on expert groups to steer individual studies, act as advisers to review all of the data obtained, and write the recommendations for publication. Currently, two RCoA Council members are on the steering group (Dr Anna Batchelor and Professor Ravi Mahajan), and Dr Douglas Justins is both a trustee and honorary treasurer of the organisation. NCEPOD also currently retains seven ‘clinical co-ordinators’, some of whom have a small number of funded sessions and work more permanently with the organisation. The funding for these sessions has become increasingly difficult to maintain over the last year. Co-ordinators chair meetings of clinicians, provide input to study design and, latterly, review, process and present the study results in both the report and subsequent presentations. All clinical staff work with at least two non-clinical researchers who ensure that data collection and analysis are carried out under standard robust mechanisms. In addition, NCEPOD liaises with the Clinical Operational Research Unit at University College London (UCL) to obtain mathematical advice for each study.

Lay representation is included on the expert group that designs the study, on the steering group and, where appropriate, lay people speak at the launch. Representative bodies such as the Patients Association are invited to report launches.
Relationships

Beyond the personal clinical input into NCEPOD, there is a wide network of agencies who assist NCEPOD in developing studies, disseminating findings, and promote the work of NCEPOD generally. This includes the Department of Health and, in particular, the national clinical directors, who have given tremendous support to many of our previous studies. NCEPOD liaises with NICE to use their guidance as part of the dataset studied, and to discuss how findings can be developed into new guidance. On a formal footing, the relationship with external regulators ensures that trusts are encouraged to act upon the findings. The NHS Litigation Authority considers participation as a key part of compliance with the Clinical Negligence Scheme for Trusts (CNST).7

Confidentiality

Confidentiality is taken very seriously at NCEPOD. This relates to patients, relatives of patients, hospitals, and all healthcare professionals involved in caring for the patient. Data received by NCEPOD are held according to a detailed list of information security policies, handled according to the associated procedures. More information on anonymisation procedures and compliance with ethical regulations is provided on the NCEPOD website.

Whilst confidentiality is very important to NCEPOD, there does need to be a mechanism that allows the relevant ‘body’ to be notified if patients are believed to be at risk of harm. NCEPOD has an established ‘cause for concern’ policy which has been ratified by the GMC and the medical royal colleges on the steering group.

Reports

As an important outcome of each study, NCEPOD produces a full report, and an executive summary which condenses the key findings and recommendations. Recommendations are focused on the groups that should be acting upon them. In a recent review of cosmetic surgery facilities, NCEPOD produced an additional document aimed at patients with regard to the questions they should ask when considering surgery. Usually, there is a national meeting to launch the findings. Reports are sent to local reporters to disseminate, and also sent to the medical director and chief executive. A checklist, toolkits and organisational data feedback are also produced, to allow the trusts to see how they compare, whilst implementing their own audit cycle.

Twenty-two years on from its first national report on paediatric surgical and anaesthetic care, NCEPOD has just completed a two-year review of peri-operative care in children between birth and 18 years, alongside an extensive organisational survey. The report ‘Are We There Yet?’ was published on 27 October, and includes a study of peer reviewed deaths within 30 days of surgery in babies, children and young people – one of the largest in this age group. NCEPOD concludes that the general standard of care is good, but it is sad to reflect that there were still remediable factors apparent. Most children had multiple co-morbidities, were extremely sick and were transferred to specialist centres, generally for complex surgery. Nevertheless, there were deaths included in this series after seemingly straightforward and relatively minor surgery. As with all our studies we hope that there are lessons applicable to care of babies and children who survive. Despite recommendations from NCEPOD, the Children’s National Service Framework (NSF), and, most recently, the Children’s Surgical Forum, the report recognises that there is much to be done to ensure that networks of care for surgery and anaesthesia function optimally. We would hope that the recommendations of the latest report are widely embraced, interpreted with care and acted upon constructively.

Governance and accreditation

NCEPOD has undergone several formal reviews over its history, some commissioned externally and several internally. Most recently (2010), it was required to bid for a continued place in the changing health marketplace when DH England, through the NPSA, subjected the work of the confidential enquiries to tender. NCEPOD has survived this process but, in common with the rest of the NHS, must do so with a markedly reduced budget (by approximately 30% this year). It is now under the umbrella of the Health Quality Improvement Partnership (HQIP). This has been an unsettling time but, happily, the launch of the two most recent reports was not disrupted, and two further reports (cardiac arrest procedures and bariatric surgery) are on schedule. We would commend you to attend the launch days for all reports which offer excellent CPD. If you are not able to attend personally, keep an eye on the NCEPOD website, which is regularly updated. As well as the reports, slides from the launches, and associated publications, the website advertises opportunities to participate in studies from inception onwards.

Summary

Anaesthetists have contributed hugely to NCEPOD over the last 20 years, and the programme of work continues to have relevance to all members of this College. The survival of independent clinician led bodies that interrogate practice, provide detailed analysis and review, and suggest mechanisms for improvement, requires our most active support. Dare we suggest that ‘use it or lose it’ is the order of the day?!
Dates and details of publication dates and launches

➤ ‘Are We There Yet?’ – a review of perioperative deaths in children 0–17 years, and the organisation of surgical services for children.
27 October 2011

➤ ‘Knowing the Risk’ – a review of perioperative care in patients over 16
9 December 2011

Royal College of Surgeons of England

References

1 ‘A Confidential Enquiry into Perioperative Deaths’. Kings Fund 1987
5 An Age Old Problem – a review of the care received by elderly patients undergoing surgery. NCEPOD November 2011 (www.ncepod.org.uk).
Addiction and anaesthetists

Despite efforts to raise awareness and improve education on the subject, talk of addiction still makes for an awkward topic of conversation.

Amongst doctors in general, there is a probable lifetime prevalence of substance abuse of 10–12%.¹ Studies specific to anaesthetists suggest an incidence of addiction of between 1–2% over the various survey periods.²⁻⁴ Anaesthetists are over-represented in treatment centres which deal solely with addicted doctors in the USA.⁵ This is due to the significantly higher numbers of anaesthetists abusing intravenous opiates than other specialties,²⁻⁵ and the rapid downhill course and profound dependence necessitating in-patient management. Sadly, the risk of drug-related death remains higher in anaesthetists than in all other specialties, peaking in the first five years after medical school graduation.⁵

Worse than one realises

Bryson found that 62% of American programme directors had experience with at least one substance abusing trainee.⁶ In 64%, the drug of choice was fentanyl, 16.3% for alcohol, 12.6% midazolam, 10.4% opioid tablets, and propofol in 8.1%. Wischmeyer found a five-fold increase in propofol abuse in anaesthetic trainees over a ten-year period, peaking at a level of 18% with a mortality of 28%.⁷ Similar mortality (26%) was reported in inhalation agent abusers.⁸ These figures would be unacceptable as outcomes in any other treatable disease.

This year, the American Society of Addiction Medicine has redefined addiction emphasising that it is a primary brain disorder and not a behavioural problem.⁹ Substance abuse can be described as the continued use of a drug despite negative consequences; addiction or dependence occurs when cessation of intake causes physical withdrawal symptoms.

Background

That some individuals are more prone to developing addiction is generally agreed. There is no single determining factor, but usually a combination of biological, psychosocial and environmental factors – a mixture of nature and nurture.

Alcohol is the most common substance of abuse in all doctors. Drinking will surprisingly continue despite negative consequences such as job difficulties, relationship breakdowns, financial problems, loss of driving licence; the alcoholic is driven by an irrational compulsion to continue, and frequently results in despair to the point of suicide. Fortunately, the depression associated with active alcoholism often abates when sober.

Access and familiarity with a substance play a significant part, exemplified in that anaesthetists are more likely to abuse drugs than alcohol, to abuse narcotics, and to abuse drugs intravenously.⁵⁻¹⁰ Fentanyl can lead to physical addiction in as little as six weeks of use, but more commonly comes to light after at least six months. Consequently, the sequelae of opiate addiction are seen in a much younger age group than alcohol abuse.

Anaesthetists have a lower overall incidence of addiction than psychiatrists and emergency physicians,¹⁰ but it is the aggressive nature of fentanyl addiction and the high mortality that bring attention to our speciality.

Behavioural changes are probably the most common indicators of substance abuse. Addicts become very adept at hiding and covering up both diversion of drugs from theatre and problems outside work. When signs of illness become noticeable at work, for instance weight loss, the process is very
advanced. Consequently, even small changes in a doctor’s behaviour, if persistent, may be the tip of an iceberg, and should be taken very seriously.

**Intervention**

All of this can lead to a difficult situation, especially if dealing with a close colleague, and is one for which there is very little in the way of training. With behavioural changes or repeated absences due to hangovers, it may not be easy to appear sympathetic. A badly conducted intervention can produce an adverse result, and there is a real risk of self-harm following such an occasion. Sometimes, the doctor is actually relieved to have been called to task, typically being someone who is aware that they have a problem and is struggling with the relentless monotony of daily drug use. An angry or defensive response is much more difficult to deal with. These meetings should not be conducted on a one to one basis.

Patient safety is obviously the primary concern. It is suggested that clinical directors, College tutors and others, go to the meeting armed with names and phone numbers of appropriate institutions and contacts (see below), and should have already been in touch with occupational health and/or an addiction psychiatrist prior to the meeting.

If patient harm has occurred, the GMC should be contacted. Otherwise it is a decision for the team looking after the doctor concerned. Opiate abuse is a frequent reason for reporting but, in fact, reporting is not mandatory. The GMC is aware that addicted doctors go under their detection ‘radar’. Where all the conditions that may have been imposed on registration (for instance, attendance at various help groups and meetings – see below) are being addressed, the GMC will often suggest managing the problem at local level. Knee jerk suspension is not the rule, although it is usually the consequence of non-alcohol addiction problems.

Reporting a colleague to the police for theft (for instance, using drugs obtained from work) leads to houses being searched, court appearances, and much additional stress. A criminal record can cause problems with visa and mortgage applications. An addict is only usually dishonest in the context of their active addiction and, once well again, will not exhibit an ongoing probity issue. Any doctor who has appeared in court for any offence is automatically reported to the GMC.

There is a very real suicide risk after intervention, and suspected addicts should not be ‘home alone’ afterwards. A call to the British Doctors and Dentists Group (BDDG) can provide a colleague to talk to, and one who knows how the addict feels.

**Recovery**

It is important to appreciate that just putting the drink or drugs down doesn’t instantly result in a cure. Being left with many of the feelings and problems that caused drinking in the first place will lead to a relapse if not addressed. Centres that produce good results are usually based on the ‘twelve step model of recovery’, which starts during time spent as an in-patient, and involves attending AA or Narcotics Anonymous (NA). NA is not exclusively for narcotic users, but acts for any drug problem. For those who don’t ‘take to’ AA or NA, there are other groups such as SMART recovery (www.smartrecovery.org.uk). The value of being supervised by a complete ‘programme’ or practitioners health programme (PHP), as opposed to a spell in a treatment centre, is in the continuous monitoring of the process. This is so important. Many addicts strangely quite welcome hair testing as an extra safeguard (perhaps the one positive of being under GMC review!). Also important are regular ‘aftercare’ groups, psychiatric, psychological, and even financial help and advice. It is important to allow time on the rota where possible for these appointments – the GMC often requests evidence of attendance.

**Return to work**

Continuing training in anaesthesia remains a controversial topic. Of programme directors surveyed, 43% believed that trainees should be allowed to continue in post, and 30% were against. Some studies have shown that relapse rates for anaesthetists are not significantly different from those of other physicians, and no relapse-related patient harm occurred in two long-term follow up studies. Data are lacking about what happens to trainees who leave anaesthesia for another specialty, and whether this reduces the risk of relapse. Early reports of poor outcomes have tended to colour the picture – Menk reported that only 34% of trainees returned to anaesthesia, with a 16% mortality as a result of suicide or relapse. Better results come from doctors managed by a PHP, where recent results have been more encouraging – 76% of anaesthetists remaining abstinent and in anaesthetic practice over a five-year follow up.
Probably the best indicators of relapse risk came from an 11-year follow up by Domino, of 292 addicted doctors.11 The three outstanding factors were:

1. intravenous opiate use
2. family history of addiction
3. co-morbid psychiatric diagnosis.

Results suggest that anaesthetists using major opioids, but with no other risk factors and no history of previous relapse, are probably good candidates for return to their specialty. Having two of these factors should raise the question of changing specialty.

Several directors of treatment centres with a particular interest in anaesthetists have designed the Medical Professionals Addiction Recovery Inventory (MPARI).12 This looks at many work and life aspects, and is being developed as a tool to aid in risk stratification for anaesthetists (in addition to Domino’s criteria). Results from Atlanta (Paul Earley personal communication) and use of the MPARI tool are encouraging, suggesting that, with aggressive follow up and monitoring, we might eventually expect the recovery rates for opiate-addicted anaesthetists to be similar to those of other specialties.

Summary
There is no place for a ‘one rule fits all’ and each case must be managed on an individual basis. It is hoped that the very encouraging results from the first two years of the UK’s Practitioner Health Programme (Dr C Gerada personal communication) continue, and that similar centres will be funded outside London.

Unfortunately, despite greater regulation and an increase in education on chemical dependency, the incidence of opiate abuse has not decreased.3 Publications such as those from the American Society of Anesthesiologists13 would be a welcome inclusion in our anaesthesia training curriculum, and the College should openly recognise the problem with a view to further activity on what is an important part of both education and patient safety.

Useful contacts
The Practitioner Health Programme (PHP)
http://www.php.nhs.uk
0203 049 4505

This confidential service has been available to doctors with addiction and other health problems in the London area since 2008. Following in-depth assessment, if in-patient de-toxification is thought necessary, this takes place at a centre outside London, but is funded by the NHS. Follow up and monitoring are multidisciplinary and rigorous. Plans for expansion outside London will hopefully be successful, because feedback and results so far have been extremely good.14

The British Doctors and Dentists Group (BDDG)
www.bddg.org

London: 07825107970
Outside London: 07976717211

This is a network of doctors and dentists who have themselves recovered from addiction, and are well again. They meet on a monthly basis at one of 18 groups covering the UK. Following initial contact, callers may be put in touch with someone near their home who can introduce them to their local group. Problems can be discussed at these meetings that may not be appropriate to discuss at Alcoholic Anonymous (AA), for instance, the GMC and work issues. Most find the meetings very helpful.

Those close to addicted doctors suffer too, and the BDDG has a families’ group who can be contacted on 07714331725.

Sick Doctors Trust (SDT)
www.sick-doctors-trust.co.uk
0370 444 5163*

The SDT is an independent addiction-specific charity established in 1995, which provides a 24-hour confidential helpline manned by doctors experienced in addiction, mostly recovering addicts and alcoholics themselves. It provides help and support to doctors who think they may have a problem with substance abuse. Callers may remain anonymous if they wish. Help offered includes referral for assessment, advice about treatment centres when appropriate, and an introduction to long-term befriending and support services. The helpline also accepts calls from family members or friends as well as concerned colleagues.

*Note change of number since publication of the AAGBI Welfare resource ‘glossy’.

GMC
0161 923 6402

The GMC can be contacted to discuss performance issues, or to seek advice about raising concerns about a doctor’s health.

BMA Doctors for Doctors
08459 200 169

Although this is not an addiction-specific service, it may provide help with employment issues which may arise.

References


13 Berry AJ, Polk SL. Chemical Dependence in Anesthesiologists: What you need to know and when you need to know it. *ASA 2002; Committee on Occupational Health of Operating Room Personnel Taskforce on Chemical Dependence* (http://anestit.unipa.it/mirror/asaa/ProfInfo/chemical.html accessed 24.7.11).

The 2010 curriculum has now been in use for over a year, and nearly all CT1 to ST5 trainees in anaesthesia are using it since commencement of the last August rotation. Implementing the curriculum has been a big challenge across all schools of anaesthesia, as they adjust their programmes to comply with the concept of spiral learning, and with the need for all trainees to complete 12 months of advanced training.

So, why the change?
When the Postgraduate Medical Education and Training Board (PMETB) became responsible for the regulation of postgraduate medical education and training in 2005, they introduced standards for curricula and assessment. The colleges were granted limited time to produce curricula that met some of these published standards, and which had to be approved before the commencement of the August training programme in 2007. This College then had until December 2009 to demonstrate that the curriculum also met the remaining standards.

Back to Basics
With this requirement in mind, the College decided to take the opportunity to review the whole anaesthesia training programme. The review considered which units of training should be included, which should be omitted, which ones should be combined, and what the new structure of the training programme should look like. Council was keen on the concept of spiral learning, in which a trainee initially studies a unit at a basic level, but returns to that unit after completing other clinical learning to build upon knowledge and skills already achieved. So, from the outset, spiral learning was going to be the central theme of the 2010 curriculum, and it was decided to complete a wholesale rewrite, although the four levels of training and milestones of the examinations would be retained. Advanced training would also become compulsory for two reasons. Firstly, it would continue to be the focus of a special interest area and, secondly and more importantly, the essential learning outcomes would constitute good preparation for consultant practice.

Rewriting the curriculum
The curriculum rewrite project was launched under the leadership of the medical secretary at that time, Dr Peter Nightingale. A number of senior anaesthetists offered to take on the role of lead editors for different units of training, and set about the task of writing a syllabus for each unit of training to the required training level. This process took many months. Once the draft syllabi were submitted to the College, a curriculum working group was established to work through the submissions and refine them before finalising the content. This working group was chaired by the new medical secretary, Dr Andy Tomlinson.

It was during this phase that some units were renamed and others disappeared as they were merged. For example, anaesthesia and the elderly was merged into orthopaedics because this is where trainees were likely to see the majority of elderly patients at the basic level. Inter-hospital transfer was rewritten as a standalone unit, having been hitherto part of trauma and stabilisation. Diagnostic imaging and ‘miscellaneous’ were merged into ‘non-theatre’ to cover anaesthetics outside the operating theatre. Some new general duties units such as orthopaedics were introduced, because these are typical of
the cases that trainees will experience in their basic training. The College also wanted to ensure that trainees developed their airway management skills from basic to complex across the training programme by achieving set competencies. This is the reason that airway management is a mandatory unit of training in the higher level general duties cluster.

Whilst working on the content of the basic level, Dr David Greaves proposed that the basic level be divided into two distinct phases: basis of anaesthetic practice, and basic anaesthesia. The basis of anaesthetic practice would form the first part of training leading towards the Initial Assessment of Competence, and basic anaesthesia would cover the remaining basic level training. This proposal was accepted. The intention at this time was that the anaesthesia component of the Acute Care Common Stem (ACCS) curriculum would mirror the anaesthesia curriculum. However, due to parallel working, this did not occur and had to be changed in 2011.

It was during the working group meetings that the core clinical learning outcomes were first considered. Defining the learning outcomes was easy, because they provide a general overview of what the trainee is expected to achieve for each unit of training. Workplace based assessments had a poor reputation due to the box ticking perception, which had its origins in the foundation years requirement of undergoing a number of assessments over a period of time. Concern was also expressed that a trainee’s progress was determined by passing a number of workplace based assessments only. It seemed important to reintroduce the professional judgment aspect of assessment. For professional judgement to be deemed fair and transparent, there had to be a nationally recognised standard that the trainee could be measured against.

For professional judgement to be deemed fair and transparent, there had to be a nationally recognised standard that the trainee could be measured against, and accorded as either ‘satisfactory’ or ‘unsatisfactory’. A standardised question asked about the minimum that a trainee should be able to do for a particular level of training for a particular unit. The answer to this question created the minimum standards that were expected, and they became the core clinical learning outcomes. It must be stressed that this is the minimum, and that the majority of trainees will achieve a higher standard. The clear message is that a trainee may pass the individual workplace based assessments that constitute a snapshot in time, but not pass the unit as a whole because that is dependent upon the totality of performance against the core clinical learning outcomes, as assessed by the professional judgement of the clinical supervisors. Trainees should be made aware of this fact.

Other key decisions were taken for vascular and obstetrics. Vascular surgery was moved from the general units to the additional units list in the 2007 curriculum due to problems of delivering the unit across the UK. The curriculum must be designed in such a way that any mandatory part of the curriculum must be deliverable in all approved training programmes. Because vascular anaesthesia could not be delivered across all schools, it was moved. On this basis, it was decided that vascular would be an optional unit at the intermediate level, and optional within the general duties cluster at the higher level. Intermediate vascular was limited to knowledge only, and is included at the intermediate level so that it can be tested in the FRCA Final examination.

In the 2007 curriculum, obstetrics was a key unit at the higher level and was therefore mandatory. In the 2010 curriculum, obstetrics is only mandatory at the intermediate level. The reason for this is that it was believed that for the majority of anaesthetists, the skills and knowledge gained at the intermediate level is sufficient, and that skills would be maintained if necessary through being on-call. It is, however, becoming apparent that changes to on-call practice may necessitate a review of mandatory obstetric training and/or on-call requirements. Those trainees who have an interest in obstetric anaesthesia can complete obstetrics at the higher level as part of their general duties, and then complete advanced training.

With advanced training becoming mandatory, the number of special interest areas was increased to match the requirements of the NHS and career aspirations of trainees. New units were introduced into advanced training such as hepato-biliary, transfer medicine, and sedation (including conscious sedation in dentistry). Even though one of the goals is preparation for consultant practice, the advanced year does not have to be the final year. The point at which a trainee completes the advanced year is dependent upon how individual schools manage advanced training.

The role of the FRCA Final Examination was considered and, in order to increase the scope of knowledge that could be tested, it was decided to move some higher level knowledge into the intermediate level. This affords the examiners a wider range of possible questions, but
it also allows knowledge to be tested that would not otherwise be tested by examination.

The requirement to include general and professional competences in the curriculum was the basis of Annex A. In the 2007 curriculum there were broad requirements for management, teaching and training, academic practice and research. The 2010 curriculum formalised these areas with distinct learning outcomes, including audit for each level of training, and can be found in Annex G.

Workplace based assessments (WBA)

Workplace based assessments have become a component part of the assessment system. During the rewrite, there was an assessment working group running in parallel. This working group introduced the new format of the workplace based assessment tools, and introduced the concept of satisfactory or unsatisfactory assessment. The new tools have now been in use for over two years.

The original College proposal for WBA was that the number and type completed should be dependent upon the trainee and their school, the theory being that the trainee who is doing well needs less assessment than the struggling trainee. In the case of the struggling trainee, the assessments formally identify the areas of poor practice and requirements for improvement. This assists the educational supervisor and acts as a mechanism of self directed learning for the trainee. Unfortunately, the PMETB insisted that the College must specify a minimum, which is why a minimum of one of each has been mandated.

Approvals process

The curriculum was submitted to PMETB in December 2009 for an ‘approvals panel’ meeting in February 2010. The approvals panel consisted of a number of clinicians (none were anaesthetists) plus a lay member. The purpose of the panel is to determine whether the curriculum meets the 17 standards for curricula and assessment. The College had to submit a document with the curriculum which listed the 17 standards, and the location within the curriculum where the standard was met. The panel used this document to help them with their assessment. The panel do not comment on the clinical content. The College was given an hour to answer questions about the curriculum and then they completed their assessment. The College was informed of the approval three weeks later.

It was during the panel process that PMETB stated they would not accept the Irish College’s Fellowship examination as a test of knowledge for a Certificate of Completion of Training (CCT). After the panel meeting, the College negotiated with PMETB to recognise the Irish examination credit for those trainees who would transfer to the 2010 curriculum. At the same time, the College had to demonstrate that the first four years in the 2007 and 2010 curriculum were fundamentally the same in content and outcomes. This enables those trainees who transfer from the 2007 to the 2010 curriculum to maintain recognition of the units already completed, after completing their training on the 2010 curriculum. With agreement from the PMETB about the transfer of units of training and examination credits, the implementation plan was defined in consultation with all the schools of anaesthesia.

The future

The curriculum is a living document and will continue to change over time. Changes to units of training, additional units of training, corrections and changes to programme rules, will mean that new iterations of the curriculum will become necessary. Pre-hospital emergency medicine was approved as a sub-speciality area for anaesthesia and emergency medicine in 2011. The transfer medicine unit was written with this possibility in mind and, as a result, trainees who have completed ACCS will be able to complete the CCT in eight years. Trainees who enter core anaesthesia will have their programme extended by six months.

The College Assessment Working Party is currently reviewing assessment and will engage with stakeholders in future developments of the assessment system, including the need for formative feedback and some flexibility in the use of workplace based assessment tools, similar to that originally envisaged by the College.

And finally

The College would like to thank all the contributors to the curriculum rewrite, whether as unit of training editors or members of the curriculum rewrite working group, and those whose contributions have made the rewrite possible. Furthermore, thanks are due to Dr Andy Tomlinson for leading from the front throughout the project. A full list of contributors can be found in appendix 1 of the curriculum document.
Core Training in the 2010 curriculum
A survival guide

After the growing list of hurdles that require jumping when obtaining a medical degree, there comes the foundation programme. For years, a houseman (or woman) would often arrange their first job by impressing a particular consultant. Today, application is through a national recruitment process, to a programme involving six consecutive four-month posts.

Although anaesthetics and critical care feature in some foundation programmes, beyond this, the opportunities for tasting what it is like to become an anaesthetic trainee are limited, and most trainees will progress directly to a core training post governed by the 2010 curriculum.

This curriculum is the latest in a series of significant changes to education and training in anaesthetics since the adoption of competency-based training in 2005. The curriculum is a challenge for trainees and consultants alike, and prompted the authors to write something about the lessons we have learned from our local experience.

Core training
Core training consists of two possible choices of programmes. A ‘direct anaesthesia’ trainee completes 21 months of anaesthesia and three months of intensive care medicine (ICM). Alternatively, the acute care common stem (ACCS) route involves a two-year programme comprising six months of acute medicine, six months of emergency medicine, six months of ICM, and six months of anaesthesia. ACCS trainees exiting the programme into anaesthesia then undertake a further 12 months of anaesthesia to achieve a similar level of competence to that of their direct entry colleagues before being eligible to apply for ST3 posts.

Annex B of the curriculum deals solely with basic level training (confusingly, basic level training occurs within core training posts) and it is important for core trainees to get to grips with this.

In brief, within two years a core trainee is expected to:

➤ complete ‘the basis of anaesthetic practice’ (the old initial assessment of competence)
➤ pass the Primary FRCA
➤ complete the remainder of ‘basic anaesthesia’ (15 units of training or modules)
➤ engage with audit, teaching, management and research at an appropriate level
➤ provide supporting evidence in the form of multiple satisfactory workplace-based assessments.

For ACCS trainees this window is reduced to 18 months of anaesthetics. The totality is no easy task, and doubts have been raised amongst trainees and trainers alike as to the achievability of these targets for many trainees.

So, is there any advice that can be offered which could help trainees meet the challenges of navigating the new curriculum and get the most out of core training, whilst, at the same time, achieve all of the competencies and get all of the paperwork completed?

At the time of writing, one of the authors is about to finish his 3rd year of core training via the ACCS route, and offers some practical advice.

There is a school of thought that proposes that good trainees will get through regardless of the system that they are presented with, and that the ability to do so is a surrogate for their organisational skills and motivation. Certainly, our consultant trainers never
had to contend with the current mountain of assessment paperwork. Being a ‘good trainee’ these days involves being very organised, and being prepared to engage with a fairly bureaucratic process.

The 12 commandments of training

Firstly, motivation and planning are crucial; you need to view the entirety of core training as a unit rather than compartmentalising it into modules. At the outset, familiarise yourself with all of the requirements. Failure to do this will result in missed opportunities to gain competencies, and to get paperwork signed. For example, anaesthetising a seven year old child for a routine tonsillectomy is relevant for at least four units of training: paediatrics, ENT/maxillofacial/dental, airway, day case and, who knows, possibly critical incidents if you have a testing day!

Know your local area and the opportunities that it presents. Find out what goes on in each hospital. For instance, if your hospital doesn’t have an emergency department, you are unlikely to achieve your trauma and stabilisation competencies whilst there. If it does, see what you can achieve, for example, by shadowing a more senior trainee running a trauma call in the emergency department. Likewise, no labour ward implies that you won’t be doing your obstetric placement there.

Be your own boss. No one is going to organise your training for you. Educational supervisors and College tutors are there to guide you, but the onus is upon you to ensure that you are getting not only enough but, just as importantly, the right training. Keep an accurate and thorough logbook, not just the bare minimum. There are numerous smartphone apps that allow you to do this as you go. This allows you to keep a track of your case mix. If you anaesthetise an interesting or challenging case, then photocopy the charts (ensuring strict data security) and find a consultant to do a case based discussion (CBD).

The Primary FRCA examination – make arrangements to sit it as soon as you can. At the very latest, you should attempt it in June of your CT1 year. You are disadvantaging yourself if you don’t. The drive to learn should come from the novice period where everything is completely new, and the learning curve is steep. Don’t detach your clinical work from the sometimes dry material of the ‘primary’. When holding a new piece of equipment, ask yourself how you think that it works, read up on the physics that underpins its working.

Have an idea of the likely learning opportunities and assessments you might be able to complete before you join an operating list. Meet with consultants as early as you can beforehand. You can then talk about how to get the most from the list, and they may be less stressed and more prepared to agree to help. Ask for feedback. You may need to stimulate this by being specific, ‘Were there any problems with my aseptic technique?’; ‘Were you happy with the way I prepared this procedure?’

Things happen opportunistically all the time, from which you can learn in clinical practice. If you are familiar with the curriculum, record some of these events and put them towards the required units of training.

Don’t limit yourself to one operating list in a day. With agreement from the consultant or group of consultants with whom you are working with, you may be able to make use of learning opportunities elsewhere. You may be able to step out and perform a rapid sequence induction or a spinal in the next theatre, but ask politely first! Behaving in this way takes tact and diplomacy, but it is possible to see and do a lot in one day with this approach. Many hospitals use computerised systems for booking theatre cases, allowing you to plan ahead. This is common in other countries and some advocate this method of learning where time is of the essence. Some of my colleagues would go to a hand list in the morning after a nightshift, and perform one regional block before going home!

Keep a spreadsheet: have a column with each unit of training, and a row with the assessments that need completing. I used Dropbox®, so that I could access it on the move. Don’t forget about parts of the curriculum like child protection and infection control.

Whilst doing your ICM unit of training, aim to get the following units of training completed: trauma and stabilisation, sedation, transfer, remote site anaesthesia and aspects of acute pain. This will leave a lot more time to get the other, more bulky, units achieved whilst doing anaesthesia.

When on-call, try to get exposure to as many opportunities as possible. Add experience and cases to ongoing units of training such as trauma and stabilisation, remote anaesthesia, for instance. Consider on-call time as a learning opportunity, and not just as service provision (see below).
Don’t forget all the other bits – when you attend your Annual Review of Competency Progression (ARCP), you are also expected to have participated in audit, been involved in teaching, shown evidence of management activity, attended courses (ALS, APLS, ATLS), and shown evidence of an interest in certain sub-specialties, which may also help in preparing for ST3 interviews.

Engage with the school and take time to work out how it functions. If there is a website, have a good look around it. Find out when educational supervisor and College tutor meetings, and ARCPs, are expected to take place. Identify and, if possible, fill out the paperwork you’ll need; whilst trainers are there to help, they commonly look after many trainees, and time can be limited. So, it is a good idea to have collated and read any information given to you, and familiarised yourself with the curriculum. Not only will this make your trainers feel that you are meeting them half-way, it will maximise the value of your meetings. If you get half an hour with the College tutor, you don’t want them to spend it telling you things you could have read for yourself.

Don’t forget to have a life! This is really important; the examination is a hard slog, and getting all of the above done can seem daunting and exhausting at the start, but it is possible (just!). Without some sort of balance outside work, you can easily become burnt out. Timetable or schedule rest (or exercise) so that it is protected. Plan and book your annual leave well in advance; time off after the examination is a good idea. Some people find study groups helpful, and some schools appoint mentors to support trainees.

**The ‘out-of-hours’ problem**

Multiple factors are to blame for the apparent decrease in trainee numbers and the clinical experience to which they are exposed. The Working Time Directive (WTD) and other pressures have resulted in hospitals finding frequently that there are not enough trainees to staff rotas. Hospitals get around this in different ways. Some employ non-consultant career grade doctors to cover the shifts, whilst others rely on locum doctors. Trainees spend less time undertaking elective lists, whilst proportionately more time is spent in the hospital out-of-hours. There is a perception that ‘out-of-hours’ has meant service provision and not much training; however, my experience at a large teaching hospital has been quite the opposite. The workload and experience itself are different from those found in the day-time, and there is often greater responsibility for assessment and decision making placed upon the trainee. In addition, with senior trainees and often consultants being present out-of-hours to provide service, these can be great opportunities for some one to one teaching. I am not saying that I had in-depth discussions about respiratory physiology at 3.00 am, but seeing and doing cannot be overemphasised as an important means to learn in a craft-based speciality such as anaesthesia. The transition from core trainee to intermediate trainee is made smoother by having direct senior support whilst working out-of-hours.

In conclusion, it may transpire that the RCoA and GMC decide to lengthen core training to three years in the near future, and in the authors’ view this would certainly make the programme much less intense.

The first author wishes to make it clear that he does not support the assessment burden that is currently placed on core trainees, but has written this article in an attempt to support them in their quest to achieve these targets. What does seem clear is that many trainees and trainers feel that the current system of workplace-based assessments is not yet right. The College has responded to this concern by establishing a working party in order to refine and support an assessment system which is appropriate for ourselves, our regulator, and the public.

**Thanks**

The first author wishes to thank all of his senior trainers and in particular the SpRs who have trained him out-of-hours.

**Conflicts of interest**

Dr J Plumb: none.

Dr A Norris: currently Head of School for Nottingham and East Midlands and has had input into the 2010 curriculum and the working party on assessment.
The e-Learning Anaesthesia (e-LA) project has proved a great success for UK trainees and has won a number of awards. This innovative approach to delivering education has transformed the ability to learn about anaesthesia by breaking the curriculum down into short, easy to study, online sessions accessible through the internet.

In many parts of the world there are major shortages of anaesthetists to teach others. The International Relations Committee (IRC) of the AAGBI has looked into the possibility of e-LA being utilised internationally, but difficulties with the cost of licensing and internet access have made this difficult worldwide.

Following an approach by the IRC, discussions were held with the RCoA and Department of Health’s e-Learning for Healthcare, to see if a number of selected sessions could be put on to a CD-ROM or DVD to create a specific e-learning facility to assist training in other countries. Permission to use about 45 existing e-LA sessions was granted. However, it was recognised that working conditions in other countries are very different from those in the UK and that additional learning materials would need to be written to complement the e-LA content.

The leads of the project, Dr Tei Sheraton (Newport), Dr Ollie Ross (Southampton) and Dr Ed Hammond (Exeter), have expanded the original vision and incorporated additional e-learning sessions using video clips to demonstrate techniques such as the use of ketamine, spinal anaesthesia, and managing emergencies such as total spinal anaesthesia – a commonly fatal complication in many countries.

The finished DVD will contain around 70 self-learning sessions and will concentrate on demonstrating good clinical practice. The DVD will run on computers without requiring internet access, making it practical for remote schools of anaesthesia. We have been delighted by the support from the World Federation of Societies of Anaesthesiologists who have granted permission to include back copies of Update in Anaesthesia and Anaesthesia Tutorial of the Week on the DVD; in addition, Oxford University Press has allowed the use of back copies of Continuing Education in Anaesthesia Critical Care and Pain.

The DVD is targeted at doctors new into anaesthesia but other anaesthesia providers will find much useful material in the package. Also, UK doctors planning to work in developing countries will find some of the principles and techniques described useful.

We are absolutely delighted with the concept, which will result in many more anaesthetists receiving high quality educational materials despite having no access to the internet. The AAGBI and RCoA would like to thank sincerely all those who have contributed to the concept and its production. The DVD will be launched in Buenos Aires at the World Congress of Anaesthesia and distributed free of charge to delegates from developing countries.

Anyone interested in receiving a copy of the DVD, or arranging for one to be sent to colleagues overseas, should contact Sophie Lieven at the RCoA at slieven@rcoa.ac.uk.

AAGBI AND RCOA E-LEARNING DVD FOR INTERNATIONAL ANAESTHESIA

Anaesthesia nurses in Liberia
Report of Council

At a meeting of Council on Wednesday, 21 September 2011 Dr D Gardiner, Dr T Jovaisa and Dr D S Kumar were all admitted to the Fellowship ad eundem. Dr P Nightingale was admitted as President for the year 2011–2012. Dr J-P van Besouw and Professor J R Sneyd were admitted as Vice-Presidents for the year 2011–2012. Dr Andy Tomlinson was presented with a Past Vice-President’s Medal.

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

Regional Adviser
There are no appointments or re-appointments this month.

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

College Tutors

North Thames Central
*Dr Y Amin, National Hospital for Neurology and Neurosurgery
*Dr A R Gaunt, Harefield Hospital
*Dr J R Prout, Royal Free Hospital

North Thames East
Dr S Nikolic, St Bartholomew’s Hospital (Acting Tutor covering for Dr N Zimbler)

North West
Dr R Clark, Manchester Royal Infirmary (in succession to Dr A Pichel)
Dr K Maclennan, Manchester Royal Infirmary (in succession to Dr P Foster)

South East Scotland
*Dr I de Beaux, Royal Infirmary Edinburgh

South Thames East
*Dr M Rao, Guy’s and St Thomas’ Hospital

South Thames West
Dr G P Thorning, St Helier Hospital (in succession to Dr J Blair)

Kent, Surrey, Sussex
Dr D S Sethi, Darent Valley Hospital (in succession to Dr P Vyakarnam)

West Midlands North
*Dr J D Holbrook, Burton Hospital
*Dr T J Parker, Staffordshire General Hospital

Head of School
Dr A Norris, Nottingham and East Midlands (NEMSA) (in succession to Dr B Riley)

Council noted recommendations made to the GMC for approval, that CCTs/CESR (CP)s 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 Joint CCTs/CESR (CP)s in Anaesthesia and Intensive Care Medicine.

Anglia
Dr Michael Chin Han Lee
Dr Muralidhar Thondebhavi Subbaramaiah
Dr Michael James Irvine
Dr Alistair George Steel
Dr Famaila Alagarsamy
Dr Vinodkumar Singh
Dr Pejman Davoudian*
Dr Anand Sharma
Dr Christopher Nutt
Dr Ajit Bhat

London

South East
Dr P S Theron
Dr M Vaghela
Dr M K Narayanan
Dr Sajith Chakithandy
Dr Timothy Fredrik Gordon Liversedge
Dr Aalia Sange
Dr Alastair Lowe*
Dr Timothy Hughes*
Dr David Pang
Dr Chirag Patel

North Central
Dr Nicola Lisa Jones*
Dr Husam Hazim Majeed Kaskos
Dr Astri Maria Valpuri Luoma
Dr Saurabh Nagpal

Bart’s and The London
Dr Saad Abubakr Anis
Dr Shaman Jhanji*

Imperial
Dr Jaspal Singh Bhular
Dr Grant Michael Stuart
Dr Carmen Philippa Owusu-Ansah
Dr Thaventhiran Prabhahar
Dr Preeti Nirgude

(left to right) Dr Dale Gardiner, Dr Tomas Jovaisa and Dr Dhushyanthan Kumar
St George’s
Dr Jonathan Bryan Springett
Dr Sharief Haraf
Dr Peter Westhead
Dr Colin Bigham*
Dr Manoj Ravindran
Kent, Surrey, Sussex
Dr S Ward
East Midlands
Leicester
Dr Aditya Pratap Singh
Dr Priya Gauthama
North West
Dr Shalini Khanna
Dr Christopher Morgan Sherwood
Dr Puneet Ranote
Dr Alan David Ashworth
Dr Michael Francis Pollard
Dr Nicholas Charles Doree
Northern
Dr Ryan Sean Hynd
Dr Helen Melsom
Dr Sarah Metcalfe
Dr Rosslyn Thistlewaite
Northern Ireland
Dr Christopher James Dafydd Gowers*
Dr Rosemary Margaret Hogg
Dr Kieran O’Connor
Dr Shiva Kumar Arava
Dr Derek Adrian Hrabovksy
Dr Samuel Neville James Lamont
Oxford
Dr Simon Anthony Tunstill
Dr Carl Jeremy Morris
Dr Sam Soltanifar
Dr Edwin George Bone
Dr Louise Dodd
South West Peninsula
Dr Richard Lloyd Eve*
Dr Rachel Anne Johns
Dr Katherine Anne Holmes
Tri-Services
Dr Katherine Woods
Wessex
Dr Michelle Louise Scott*

West Midlands
Birmingham
Dr Timothy Michael Day-Thompson
Dr Santhosh Gopalakrishnan
Stoke
Dr Paul Andrew Jones
Dr Neil Robert Abeyesinghe
Dr Shashank Agarwal
Dr Richard Andrew Lightfoot
Dr Robert William O’Brien*
Warwickshire
Dr Carol Louise Bradbury
Wales
Dr Susan Williams
Dr Sonia Flory
Dr Lucy DeLloyd
Scotland
East Scotland
Dr Peter James O’Brien*
Dr Lesley Crichton
West Scotland
Dr Jennifer Anne Edwards
Dr Anand Thillaisundaram
Yorkshire
West Yorkshire (Leeds/Bradford)
Dr Dipesh Odedra
Dr Catherine Elizabeth Farrow
Dr Harry Murgatroyd
Dr Rajesh Puthenmadhom Menon
Dr Sennaraj Balasubramanian
East Yorkshire (Hull/York)
Dr Jaiganesh Sivaprakasam
South Yorkshire (Sheffield)
Dr Vijay Kumar
Dr Ajay Hasmukh Raithatha*

Election to Council 2012
IMPORTANT NOTICE
Please refer to the College website for details of the election to Council.
www.rcoa.ac.uk/election
Deaths

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

Dr J P Brookes, Aberystwyth
Dr R J Brooks, Halifax
Dr J L Canton, Swansea
Dr M Ducrow, West Midlands
Dr A B Eastwood, Bradford
Dr M Greene, Manchester
Dr M E Haw, Yorkshire
Dr J Inkster, Newcastle-upon-Tyne
Dr N A Woodward, Stratford upon Avon

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.

Appointment of Fellows to consultant and similar posts

The College congratulates the following fellows on their consultant appointments:

Dr K A Brennan, Leeds General Infirmary
Dr L Edger, Central Middlesex Hospital
Dr S Flory, University Hospital of Wales, Cardiff
Dr J A Golding, North Tyneside Hospital
Dr G Graham, Guy’s and St Thomas’ NHS Foundation Trust
Dr R Hogg, Belfast Health and Social Care Trust
Dr K D Johnston, Leeds Teaching Hospital NHS Trust
Dr S P Murray, Homerton University Hospital NHS Foundation Trust
Dr J Nariani, The Christie Hospital, Manchester
Dr D R Nethercott, Bolton NHS Foundation Trust
Dr T Prabhahar, North Middlesex University Hospital
Dr S A H Razvi, Barnsley District General Hospital
Dr M S Scanlan, Chesterfield Royal Hospital NHS Foundation Trust
Dr P S Shetty, Luton and Dunstable Hospital
Dr R Thistlethwaite, Sunderland Royal Hospital

Nomination for one Consultant vacancy closed on 24 August 2011. The College received one nomination for the vacancy and therefore no ballot is required. Dr Kenneth Stewart is returned unopposed.

Contact information:
Ms Sophie Lieven
PA to Chief Executive
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London
WC1R 4SG
tel: 020 7092 1612
e-mail: slieven@rcoa.ac.uk

Election to Advisory Board for Scotland 2012

Nominations for one Consultant vacancy closed on 24 August 2011. The College received one nomination for the vacancy and therefore no ballot is required. Dr Kenneth Stewart is returned unopposed.

Contact information:
Ms Sophie Lieven
PA to Chief Executive
The Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London
WC1R 4SG
tel: 020 7092 1612
e-mail: slieven@rcoa.ac.uk

Appointment of Members, Associate Members and Associate Fellows

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

**Associate Fellows**

**August 2011**
Dr Deepak Mathur
Dr Iona Schmidt
Dr Sandeep Verma

**September 2011**
Dr Atul Kishore Kapoor
Dr Sudhakar Rao Marri
Dr Argyro Zoumprouli
Dr Elisa Bertoja

**New Associate Members**

**August 2011**
Dr Pavol Palcovic
Dr Naleen Kumar Thota

**September 2011**
Dr Muhammad Asim Butt
Dr Petson Mathew Parakkal
Dr Senthil Kumar Thanikasalam
Dr Heather McAllister

**New Members**

**August 2011**
Dr Priyakam Chowdhury
Dr Kala Rajya Luxmi Basnyat

**September 2011**
Dr Shirjel Rizwan Alam
Dr Hamad Latif

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.
Anaesthetists as educators: an introduction
9 November 2011 (code: A12)
RCoA, London
Registration fee: £210 (£160 for RCoA registered trainees)
LIMITED AVAILABILITY

FPM: Acute pain medicine: hot topics
11 November 2011 (code: A78)
RCoA, London
Registration fee: £155 (£125 for RCoA registered trainees and affiliates)

Research methodology workshop
15 November 2011 (code: C43)

Airway workshop
16 November 2011 (code: C65)

Joint Clinical Directors’ meeting
17 November 2011
RCoA, London
By invitation only

Recent advances in anaesthesia, critical care & pain management
22–24 November 2011 (code: C11)
The Lowry, Manchester
Registration fee: £470
LIMITED AVAILABILITY

FPM Fourth Annual Meeting: Pain management in special situations
30 November 2011 (code: B08)
RCoA, London
Registration fee: £175 (£125 for RCoA registered trainees and affiliates)

Anaesthetists as educators: delivering in the workplace
30 November – 1 December 2011 (code: C80)
RCoA, London
Registration fee: £405 (£305 for RCoA registered trainees)
LIMITED AVAILABILITY

CDP study day: General topics
1 December 2011 (code: C79)
RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

Primary FRCA masterclass
12–15 December 2011 (code: D70)
RCoA, London
Registration fee: £280

Final FRCA revision course
9–13 January 2012 (code: A82)
RCoA, London
Registration fee: £350

FPM: Current concepts in pain medicine
25–27 January 2012 (code: B28)
RCoA, London
Registration fee: £455 (£365 for RCoA registered trainees and affiliates)

Airway workshop
1 February 2012 (code: B53)
RCoA, London
Registration fee: £250 (£190 for RCoA registered trainees and affiliates)

Recent advances in anaesthesia, critical care and pain management
1–3 February 2012 (code: C68)
RCoA, London
Registration fee: £470

CDP study day: neuro-anaesthesia and intensive care
8 February 2012 (code: F38)
RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

Anaesthetists as educators: delivering in the workplace
20–21 February 2012 (code: C84)
RCoA, London
Registration fee: £405 (£305 for RCoA registered trainees)

Children in the district hospital: essential care
24 February 2012 (code: C67)
RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

Airway workshop, Cardiff
7 March 2012 (code: C96)
Marriott Hotel, Cardiff
Registration fee: £250 (£190 for RCoA registered trainees and affiliates)

HSRC Peri-operative Care Research Forum
12 March 2012 (code: B13)
RCoA, London
To register your interest in the event please visit www.niaa.org/niaa_events
AIRWAY WORKSHOPS

Date and location:
1 February 2012, London (code: B53)
7 March 2012, Cardiff (code: C96)
18 April 2012, London (code: C12)
12 May 2012, Edinburgh (code: C73)

Registration fee:
£250 (£190 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organisers:
Dr R Bhagrath, Dr T Turley, Dr A McNarry and Dr V Cunningham
LIMITED AVAILABILITY

Previous workshops have proved to be very popular – early booking is advised.

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

- Fibreoptic handling skills and techniques for awake FOI (2A01)
- Uses of new/established supraglottic airways (IC02)
- Rescue techniques including cricothyrotomy (2B02)
- Extubation, follow-up and case scenarios (IC01 + 2)
- Video laryngoscopy (IC01 IC02 2A01)

Teaching and practice are conducted in small groups with six to eight workshops.
# ANNUAL MEETING 2012

## QUALITY AND OUTCOME IN ANAESTHESIA

### Date and venue:
14–15 March 2012 (code: A03)
Royal Institute of British Architects,
66 Portland Place, London W1B 1AD

### Registration fee:
£425 (£320 for RCoA registered trainees and affiliates)
Approved for 10 CPD credits (5 per day)

### Event organiser:
Dr J Hardman

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### Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>9.00 am</td>
<td>Registration and refreshments</td>
</tr>
<tr>
<td>9.30 am</td>
<td>Welcome and introduction by Dr P Nightingale, President, RCoA</td>
</tr>
</tbody>
</table>

#### SESSION 1: AVOIDING ERRORS

- **Checklists: do they improve outcome?**
  - Dr I Walker, London

- **Drug errors in anaesthesia**
  - Speaker to be advised

#### SESSION 2: IMPROVING OUTCOME

- **Guidelines for anaesthetic care: support or constraint?**
  - Dr A Smith, Lancaster

#### SESSION 3

- **CLOVER LECTURE**
  - Evidence, research and all that stuff
    - Dr S Yentis, London

- **2.05 to 2.25 pm**
  - RCoA Annual General Meeting

- **AWARD OF THE COLLEGE MEDAL**
  - Dr T Clarke, Newcastle

- **RANK LECTURE**
  - Perioperative improvement of high risk surgical patients
    - Professor G Marx, Germany

---

### Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>8.40 am</td>
<td>Registration and refreshments</td>
</tr>
</tbody>
</table>

#### SESSION 4: QUALITY TEAMS

- **Modern anaesthesia training: is it good enough?**
  - Dr A Mclndoe, Bristol

- **Communication and team-working**
  - Speaker to be advised

- **Delegation and non-medical providers of anaesthesia**
  - Speaker to be advised

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>5.20 pm</td>
<td>Close of meeting followed by a drinks reception</td>
</tr>
</tbody>
</table>

#### SESSION 5: ASSURING QUALITY

- **Measuring and recording outcome**
  - Dr P Murphy, DH Informatics Directorate

- **Using quality indicators in anaesthesia**
  - Dr J Benn, London

- **Is a consultant-delivered service feasible or desirable?**
  - Dr W Harrop-Griffiths, London

#### SESSION 6: LITIGATION AND CONSENT

- **Lessons from litigation**
  - Speaker to be advised

- **Is ‘informed’ consent possible? Is it desirable?**
  - Dr S White, Brighton

#### SESSION 7: CONTROVERSIES IN QUALITY CARE

- **Epidural block for surgery: gold standard or debased currency?**
  - Professor T Wildsmith, Dundee

- **Regional anaesthesia for all**
  - Professor P Hopkins, Leeds

- **Intra-operative fluid infusions: how much is too much?**
  - Professor D Buggy, Dublin

#### SESSION 8: HIGH RISK SURGERY

- **Assessing fitness and predicting outcome**
  - Dr J Carlisle, Torquay

- **Paediatric cardiac anaesthesia: balancing risk and outcome**
  - Professor A Wolf, Bristol

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>4.35 pm</td>
<td>Refreshments and trade exhibition to close</td>
</tr>
</tbody>
</table>

PROGRAMME SUBJECT TO CHANGE
ROYAL COLLEGE OF ANAESTHETISTS
ANNUAL CONGRESS

Date and venue:
3–4 May 2012 (code: D10)
The Institute of Engineering and Technology, London

Registration fee:
£300 (£200 for RCoA registered trainees and affiliates)
Approved for 10 CPD credits (5 per day)

Event organiser:
Dr R Moonesinghe

Overview
We look forward to welcoming you to our Annual Congress on 3 and 4 May 2012. We have built on the success of our inaugural Congress last year, to bring you another lively and interesting two days of educational lectures, workshops and poster presentations.

We have a full programme of scientific content across the two days delivered by high profile national and international speakers from inside and outside anaesthesia. In recognition of the London Olympics, we are including sessions on exercise and fitness, and leadership and teamwork. For the second year running, the British Journal of Anaesthesia have agreed to publish the best abstracts in a forthcoming issue.

This year, in response to feedback received, we have including a series of practical workshops to run parallel to the lectures; these will be on cardiopulmonary exercise testing and cardiac output monitoring. We expect the demand to be high for these and places will be limited, so you are advised to book early.

We hope you will enjoy the new venue too, which is set beside the River Thames in a Central London location on the Embankment.

We have hired the Riverside Room for a drinks reception at the end of the first day and I am sure you will welcome the opportunity to network with colleagues in a relaxed atmosphere, while enjoying the panoramic views.

Full details of the educational programme are included opposite. I look forward to seeing you in May.

Dr Ramani Moonesinghe, RCoA Council Member

Programme

THE EMERGENCY DEPARTMENT AND BEYOND
- Stabilising the critically ill child
- Trauma resuscitation
- Care of the injured brain

QUALITY AND SAFETY
- Safe sedation
- Awareness and the National Audit Project 5
- Using national networks to improve patient outcomes

CLINICAL SCIENCE
- Frederick Hewitt Memorial Lecture – mechanisms of pain and analgesia
- Magnesium: the once and future ion
- Permissive hypoxaemia

CANCER
- Anaesthesia and long-term cancer outcomes
- Cancer pain management
- Improving ICU outcomes for cancer patients

CRITICAL CARE
- The critically ill parturient
- National strategy for management of severe hypoxic respiratory failure
- Unbundling sepsis

LONDON 2012
- Can exercise training improve surgical outcome?
- Genetics of human fitness and clinical outcome
- The Olympics and population health improvement

LEADERSHIP AND TEAMWORK
- Session of guest speakers from outside anaesthesia on training and developing skills in leadership and teamwork

RCoA Annual Congress: call for abstracts
A special opportunity for new Fellows and Members of the College to present free papers. We would like to invite submissions under the following categories:
1. Audit
2. Research

Abstracts may be selected for podium presentation or as poster displays. Full details of abstract submissions can be obtained by email from: drowlanes@rcoa.ac.uk.

Prizes will be awarded for the best presentations and abstracts will be considered for publication by the BJA after the Congress.

Deadline: Monday, 6 February 2012

PROGRAMME SUBJECT TO CHANGE
RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Date and venue:
1–3 February 2012 (code: C68)
RCoA, London

Registration fee:
£470
Approved for 15 CPD credits (5 per day)

Event organisers:
Professor P Foëx and Dr J-P van Besouw

Day 1
■ Welcome and introduction
■ College and professional affairs
■ Doctors in the dock
■ Quality and outcomes
■ Mechanisms of anaesthesia
■ Pain relief: what is new for 2012?
■ Hypertension: still a problem?
■ Surgery in the patient with coronary stents
■ Haemodynamic monitoring
■ Ultrasound guided blocks
■ Blood Salvage: conservation during surgery

Day 2
■ What has changed in the delivery suite?
■ Saving mothers’ lives
■ Grown-up congenital heart disease in obstetrics
■ Paediatric emergencies for the generalist
■ Bariatric surgery and afterwards
■ Burns management
■ Renal failure: how to manage?
■ Postoperative cognitive dysfunction
■ Safe sedation: defining the risks and who should be doing it

Day 3
■ Anaphylaxis: best management
■ Management of severe asthma
■ Recognition and management of the difficult airway
■ ABC or CAB: what is best in resuscitation?
■ Advances in trauma management
■ UK International Emergency Trauma Register: how can we help?
■ Percutaneous cardiac interventions: new avenues, new opportunities
■ Arrhythmia management in 2012: Optimising high risk patients: how, where and why?

CHILDREN IN THE DISTRICT HOSPITAL: ESSENTIAL CARE

Date and venue:
24 February 2012 (code: C67)
RCoA, London

Registration fee:
£200 (£150 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr L Brennan

Day 1
9.00–9.30 am
Registration and refreshments

■ Welcome and introduction
Dr Liam Brennan, Cambridge

■ Preoperative dilemmas (2D02)
Dr Nicola Barber, Cambridge

■ Common paediatric syndromes (2D02)
Dr John Purday, Exeter

■ ENT anaesthesia in the DGH (2D02)
Speaker tbc

■ Discussion

Day 2
■ The Child in ED – common problems (2D01)
Dr Ffion Davies, Leicester

■ Transport of the critically ill child (2D07)
Speaker tbc

■ Discussion
Dr Liam Brennan, Cambridge

Workshops:
■ Vascular access techniques (2D03)
Dr Peter Murphy, Liverpool

■ Airway emergencies (2D02)
Dr Stephanie Bew, Leeds

■ Regional blocks (2D02, 2D05)
Dr Graham Bell, Glasgow

■ Consent – What to do when the child says no (2D02)
Dr Andrew McLeod, London

4.30 pm
Close
CPD STUDY DAY: FLUID MANAGEMENT

Date and venue:
17 April 2012 (code: C19)
RCoA, London

Registration fee:
£200 (£150 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr R Pearse

9.00–9.30 am
Registration and refreshments

Welcome and introduction
Dr Rupert Pearse, London

Session 1 – Understanding fluid requirements
- Current concepts of fluid therapy
  Dr Rupert Pearse, London
- The pathophysiology of fluid therapy
  Dr Shaman Jhanji, London

Session 2 – Peri-operative fluid choosing the dose
- Getting the maintenance fluid right
- Goal directed approach for volume replacement

Session 3 – The type of fluid
- Targets for blood transfusion
  Dr Duncan Wyncoll, London
- Crystalloids and colloids: is there still a debate?

Session 4 – KEYNOTE LECTURE
Fluid resuscitation in children: The FEAST Trial

4.00 pm
Close

CARDIAC DISEASE AND ANAESTHESIA SYMPOSIUM

Date and venue:
9–10 May 2012 (code: F47)
RCoA, London

Registration fee:
£425 (£320 for RCoA registered trainees and affiliates)
Approved for 10 CPD credits (5 per day)

Event organisers:
Professor P Foëx and Dr H Higham

Day 1
Preoperative assessment of the cardiac patient
- Lesser known features of current European guidelines
- Reducing peri-operative risk in non-cardiac surgery: should we screen for cardiac disease?
- Cardiopulmonary testing (CPX) for all?

The adult with congenital heart disease
- Overview of grown-up congenital heart disease
- Anaesthesia for non-cardiac surgery in the grown-up with congenital heart disease

The patient with chronic heart failure
- Pathophysiology of heart failure
- The role of inotropic support
- Anaesthetic management of patients with heart failure/heart transplant

Complex problems in common patients
- Heart disease in pregnancy
- Pacemakers, internal defibrillators and cardiac resynchronisers: anaesthetic challenges

KEYNOTE LECTURE
- Pharmacological prevention of perioperative cardiac complications: evidence from large trials

Day 2
The surgical patient with coronary disease
- Pathophysiology of coronary heart disease
- Do percutaneous interventions protect the surgical patient?
- Antiplatelet drugs: cardiologists friends, surgeons foes

Valvular heart disease
- Pathophysiology of valvular heart disease
- Anaesthetic management of the patient with valvular heart disease

KEYNOTE LECTURE
- A personal journey into improving outcome

Controversies and challenges
- Cardiac surgery: is it still necessary?
- EVAR and its challenges
- Better Health with or without surgery?
- Optimising high risk patients: how, where and why?
CURRENT CONCEPTS IN PAIN MEDICINE

Date and venue:
25–27 January 2012 (code: B28)
RCoA, London

Registration fee:
£455 (£365 for RCoA registered trainees and affiliates) - for all 3 days;
single, double and triple day rates apply
Approved for 5 CPD credits per day

Event organiser:
Dr S Gupta

The next 3-day ‘Current Concepts in Pain Medicine’ course will run from the 25–27 January 2012. The course is mapped to the pain medicine curriculum and is suitable for consultants, trainees planning for the FFPMRCA examination and anyone wishing to update their knowledge on basic science and current understanding of the practice of pain medicine. In the past trainees wishing to consider a career in pain medicine and also consultants and trainees in palliative care have found this course helpful. The first day is designed to benefit pain medicine trainees planning to take the FFPMRCA examination. The 2nd and 3rd days should interest both trainees and practicing pain specialists. The course is designed so that delegates can attend any one or all three days and there will be plenty of opportunity for discussion and interaction with the faculty during the course. The programme can be found on the RCoA website.

The topics on the first day will include:
- Epidemiology of pain (3E00)
- Neurobiology of nociceptive and neuropathic pain (3E00)
- Pharmacology of drugs used in pain medicine (2E02, 2E03)
- Anatomy in relation to pain medicine (3E00)
- Neurological assessment in medicine (2E03)
- Musculoskeletal assessment in pain medicine (2E03)
- CBT and other commonly used psychological interventions in pain medicine (2E03)

The topics on the second day will include:
- Assessment and management of chronic inflammatory conditions (3E00)
- Pain and opioid addiction (3E00)
- Chronic post surgical pain (3E00)
- Evidence for precision diagnosis and management of spinal and radicular pain (3E00)
- Pain in non-surgical inpatients (3E00)
- Pain medicine and the elderly (3E00)
- Brain fog and pain – tackling the functional syndrome dilemma (3E00)
- Chronic pain and MDT? When is it appropriate to ask for help? (3E00)

The third day is devoted to Updates in Pain Management and will include:
- Updates on Neuromodulation (3E00)
- Updates on the role of ultrasound in chronic pain management (3E00)
- Updates in cancer pain management (3E00)
- Updates in the management of CRPS (3E00)
- Updates in the management of chronic urogenital pain (3E00)
- Updates in the management of abdominal pain (3E00)
### Terms and conditions
- Additional copies of this form can be downloaded from [www.rcoa.ac.uk/docs/meetings.pdf](http://www.rcoa.ac.uk/docs/meetings.pdf).
- Members of the Senior Fellows Club can attend events 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 credits for a full day and three credits for a half day, with the exception of FRCA revision courses, which carry a maximum of 15 credits, for non-trainees only.
- Lunch is included in the registration fee unless otherwise indicated.

### Booking and payment
- Bookings will be accepted by post or fax only 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.

### Application Form

**Your details**
- Full name:
- College Reference Number (CRN):
- GMC Number:
- Address: [ ]
- Postcode: [ ]

Please ensure you complete your full postal address.

- Is this your main mailing address? Yes [ ] No [ ]
- Telephone:
- Email:
- Hospital:

**Event details**
- Date: [ ] [ ] [ ] [ ] [ ] [ ]
- Code: [ ]
- Event Title: [ ]
- Registration fee: £ [ ]

**Payment details (please use BLOCK CAPITALS)**
- A cheque is enclosed made payable to The Royal College of Anaesthetists.
- I wish to pay by the following debit/credit card:
  - [ ]
  - [ ]
  - [ ]
  - [ ]

Cardholder’s name: [ ]

Signature: [ ]

Card number: [ ]

Valid from: [ ] [ ]

Expiry date: [ ] [ ]

Issue number: [ ]

Security code: [ ]

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[Please complete this form in BLOCK CAPITALS and return to the Finance Department at the RCoA or via fax (020 7092 1733).]
Applications are now invited for Foundation Fellowship of the Faculty of Intensive Care Medicine (FICM).

Applicants for Foundation Fellowship must be substantive UK consultants with a sessional commitment to Intensive Care Medicine. Applicants must also be in good standing with one of the FICM parent Colleges.

Applications for Foundation Fellowship will be accepted from 1 January to 31 December 2011.

Other categories of membership, including those for trainees, are currently under development and will be announced during 2011.

An application form, along with further information on the application process and Fellowship criteria, can be found on the FICM website. Please read these criteria carefully before applying.

www.ficm.ac.uk
23rd Anaesthesia, Critical Care & Pain
General Practice
Plastic Surgery
Radiology
Trauma & Orthopaedics

Val d’Isere
Jan 30 - Feb 2 2012

Lectures | Workshops | Guest speakers
Multidisciplinary sessions | Short paper competition | CME approved

www.doctorsupdates.com

Anaesthesia Section of the RSM
Upcoming meetings

- 23–25 January 2012
  • Sedation techniques
    Day meeting • Venue: RSM
  - Friday 3 February 2012
    The four professors
    Day meeting
    Location: Glasgow
  - Friday 9 March 2012
    How do we make every second count?
    Joint meeting with the Society for Education in Anaesthesia UK
    Day meeting • Venue: RSM

Places are limited so please apply early
Registration fee: £240,
includes a copy of SBA-Basic Sciences book,
breakfast, lunch & refreshments
For further details please contact Rachel Davies,
email: rachel.davies2@uhcw.nhs.uk
tel: 024 7696 8722

How do we make every second count?
Training the next generation in troubled times

The SEAUk Annual Scientific Meeting
organised jointly with the Royal Society of Medicine

Venue:
The Royal Society of Medicine, London

Speakers include:
• Professor Sir John Temple, Chair, Research and Development Council
• Professor Sir Peter Rubin, Chair, General Medical Council
• David Guile, Institute of Education, University of London
• Janet Grant, Professor of Education in Medicine, Open University

For more information:
email: anaesthesia@rsm.ac.uk or 020 7290 3947
Bulletin advertising

The Royal College of Anaesthetists’ Bulletin is published bi-monthly and distributed to over 15,000 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.

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

Non-commercial advertising rates are listed below and are valid from July 2011. Please see the Bulletin pages of the website for specific commercial rates, deadlines and further information on discounts available.

- **Quarter page (85 mm by 124 mm)**: £250 +VAT
- **Half page (85 mm by 252 mm)**: £495 +VAT
- **Full page (175 mm by 252 mm)**: £795 +VAT

www.rcoa.ac.uk/bulletin
Primary Courses 2011/12

OSCE Weekend 9-11 Dec. 2011
Viva Weekend 16-18 Dec. 2011
OSCE/Orals 6-13 Jan. 2012
MCQ 14-20 Jan. 2012
OSCE Weekend 20-22 April 2012
Viva Weekend 27-29 April 2012
OSCE/Orals 4-11 May 2012
MCQ 19-25 May 2012

Final Courses 2011/12

SAQ Weekend 24-26 Feb. 2012
Booker 26 Feb.-3 March 2012
Private SAQ Weekend 2-4 March 2012
SAQ Weekend 9-11 March 2012
MCQ 11-17 March 2012
Viva Revision 27 May-1 June 2012
Viva Weekend 15-17 June 2012

For further information on courses, please see our website:
www.msoa.org.uk

Contact us:
Telephone: (0151) 529 5811
E-mail: david.strong@aintree.nhs.uk

THE SELECTIVE COURSE

In preparing for the Primary Examination, many candidates find there are areas of theory that have been poorly taught or not understood in sufficient depth.

We have assembled a Consultant faculty of subject matter experts who will use didactic lectures, questions and answers, homework, demonstrations, MCQs and handouts to illuminate their subjects.

Places are available for external candidates planning to take the Primary MCQ in June 2012. Mersey Deanery candidates are all encouraged to attend.

We expect that topics covered will include:

- Acid-Base
- Anatomy Lower Limb
- Breathing Systems
- CVS
- Damping
- Diathermy/Electrical Hazards
- Exam Gems
- Extreme Physiology
- Life Support
- Metabolism
- Mechanics of Respiration
- Oxygen/CO2 Transport
- Pharmacokinetics
- Receptors
- Renal
- Respiration
- Statistics

Candidates should be close to the Primary Examination - this will be a high level course where sound basic knowledge will be assumed.

Course cost is £400

Homework menu will be provided to applicants.

The week long course (19-23 March) will be held at The Liverpool Medical Institute in Central Liverpool

Lunches and refreshments, car parking will be included.

NOTICE

The SAQ Writers Club

Candidates for March and September Final SAQ Papers are invited to join The SAQ Writers Club

Please see website for details.
## Contact information

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
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<tbody>
<tr>
<td><strong>Chief Executive</strong></td>
<td>Kevin Storey</td>
<td></td>
<td>020 7092 1612</td>
</tr>
<tr>
<td><strong>Deputy Chief Executive and Director of Professional Standards</strong></td>
<td>Charlie McLaughlan</td>
<td></td>
<td>020 7092 1613</td>
</tr>
<tr>
<td><strong>Director of Education</strong></td>
<td>Sharon Drake</td>
<td></td>
<td>020 7092 1613</td>
</tr>
<tr>
<td><strong>Director of Training and Examinations</strong></td>
<td>Richard Bryant</td>
<td></td>
<td>020 7092 1613</td>
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</tbody>
</table>

| **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**                     |                    |                               |                 |
| **Continuing Professional Development**       |                    | cpd@rcoa.ac.uk                | 020 7092 1729   |
| **e-Learning Anaesthesia**                    |                    | e-LA@rcoa.ac.uk               | 020 7092 1542   |
| **Faculties Manager**                         | Daniel Waeland     | fpm@rcoa.ac.uk                | 020 7092 1727   |
| **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   |
| **Revalidation Project Manager**              | Don Liu            | revalidation@rcoa.ac.uk       | 020 7092 1699   |
| **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   |
| **Press enquiries**                           |                    | media@rcoa.ac.uk              | 020 7092 1692/1693 |
| **Website**                                   |                    | website@rcoa.ac.uk            | 020 7092 1692/1693 |

| **Training and Examinations Directorate**     |                    |                               |                 |
| **Examinations Manager**                      | Graham Clissett    | exams@rcoa.ac.uk              | 020 7092 1525/1526 |
| **Training Manager**                          | Craig Williamson   | training@rcoa.ac.uk           | 020 7092 1552/1553/1554 |
| **e-Portfolio Project Manager**               | Lorna Kennedy      | e-portfolio@rcoa.ac.uk        | 020 7092 1551   |
| **Equivalence**                               |                    | equivalence@rcoa.ac.uk        | 020 7092 1651/1653 |
| **Intensive care medicine (adult and paediatric)** |                | ficm@rcoa.ac.uk               | 020 7092 1651   |
| **International Programme**                   |                    | ip@rcoa.ac.uk                 | 020 7092 1552   |
| **Regional Adviser and College Tutor appointments** |                |                                | 020 7092 1573   |
| **SAS and Specialty Doctors**                 |                    |                                | 020 7092 1552   |
| **Quality Assurance**                         |                    |                                | 020 7092 1652   |

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**The Royal College of Anaesthetists**
Churchill House 35 Red Lion Square London WC1R 4SG 020 7092 1500 www.rcoa.ac.uk info@rcoa.ac.uk