Inside this issue

Shared decision making in elective abdominal aortic aneurysm (AAA) repair

Training in vascular anaesthesia – from the trainee’s perspective

Supporting critical care teaching outside the ICU

Patient Safety Update

College launches new online services

A Bulletin Debate
All consultant anaesthetists have the skills to anaesthetise patients for bariatric surgery
The President’s Statement
Guest Editorial
Simulation training to the masses
Revalidation for anaesthetists
NIAA Health Services Research Centre
The Faculty of Pain Medicine
The Faculty of Intensive Care Medicine
SAS and Specialty Doctors
Patient Perspective
Shared decision making in elective abdominal aortic aneurysm (AAA) repair
National abdominal aortic aneurysm (AAA) quality improvement programme
Research in vascular anaesthesia
Training in vascular anaesthesia – from the trainee’s perspective
A Bulletin Debate (Motion Proposed)
A Bulletin Debate (Motion Oposed)
Supporting critical care teaching outside the ICU
College supports Uganda Fellowship programme
Clinical outcome data, comparative performance reports and revalidation
Audit Recipe Book (3rd edition 2012)
As we were
Patient Safety Update
Top tips for using the eForm
The College launches new online services
Small Grants and Awards
Report of Council
Programme of events 2012
Adverts and notices

Views & opinions
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From the Editor

Welcome to the May issue of the Bulletin. I am delighted that the Vascular Anaesthetic Society has provided us with a suite of articles for this edition, covering issues such as reconfiguration, shared decision making, quality improvement programmes, research and training. A message that comes across in these articles is the need for a trainee to be proactive if they wish to specialise in this area. Four trainees have collaborated to report on how they achieved advanced training in this specialty both at home and abroad, which will hopefully encourage others to follow.

As revalidation takes two steps forward (and one back) this edition provides us with more essential information on remediation and from the FICM on how they plan to support those of you working in Critical Care. Drs Collyer and Robertson provides us with a practical example of collecting outcome data and Drs Colvin and Peden announce the arrival of the 3rd Audit Recipe Book, emphasising the shift towards quality improvement and making effective change. The importance of collecting National data cannot be underestimated too and this issue includes a Patient Safety update providing feedback and reminding us how easy it is to report incidents using the eForm. Despite government driven changes to the National Patient Safety Agency the eForm is alive and well and will continue to function. CPD is another vital area for revalidation and the College is heavily investing in new technology to support us. This issue sees the launch of the new webcasting platform widening access to College meetings and events.

One of the most powerful methods of teaching for us all is to hear feedback directly from patients themselves. This month Ms Payne, who is a member of our Patient Liaison Group, makes an impassioned plea for the creation of an ICU Patient Diary for patients who spend any length of time in a critical care unit. It has a powerful take home message I do not think we can ignore.

Three articles are included covering training issues. Firstly, Dr Kerr discusses the benefits and limitations of simulation as a training tool. I am pleased that she concludes that it complements clinical teaching and cannot replace hands on experience. We have details of courses run by the Royal College of Surgeons to teach critical care skills for use outside the ICU, which includes an appeal to anaesthetists interested in contributing to the teaching. Finally we have an uplifting report on the Uganda Fellowship programme, which has recently recruited the support of the College to help train medical anaesthetists in Uganda. The aim is to train enough doctors in the specialty that they can train both medical anaesthetists and non-physician anaesthetic officers themselves in the future.

The enthusiasm expressed in the regular NIAA column reporting on the Third UK Perioperative Clinical Research forum is infectious and I draw your attention to the advanced notice about the first UK Pain Clinical Research Forum in September. There is also valuable information from the NIAA about the availability of small grants and awards to support your research projects and I am particularly pleased to read that SEAUUK has established three new eponymous awards in recognition of Drs Greaves, Myerson and Kumar.

If you have a desire to respond to any article that you read in the Bulletin we do publish selected letters to the editor on the website. I have a feeling that this issue may generate more than usual because we have an enthralling debate about anaesthesia for bariatric surgery. Should all consultants have the skill to do these cases or do they need special expertise? I leave you to decide. If we have a good response I will choose some representative letters to publish in the November Bulletin.

Finally I would like to add my congratulations to David Zuck who was awarded the President’s Commendation in March in recognition of his entertaining ‘As We Were’ column in the Bulletin, which he has reliably submitted for the last ten years! Long may it continue.
I am putting the final touches to this President’s Statement sitting on a boat in the Beagle Channel on the way back to Ushuaia from Penguin Island. Tomorrow is Veteran’s Day in Argentina and their President is visiting Ushuaia; from her recent speeches, it promises to be quite a rally. All over town, posters proclaim Ushuaia as the capital of the Islas Malvinas.

During my few days on holiday in Patagonia following the 15th World Congress of Anaesthesiologists (WCA) I have met many Argentinians and found them to be polite and interesting to converse with. I have mostly talked about rugby and their beautiful country; they have mostly wished to talk about football and their beautiful country! I will leave quietly in the morning, saddened by the fact that politics can be so divisive and destructive of relationships.

Which brings me yet again to the NHS Health and Social Care Bill; what are the next steps?

As expected, following a huge number of amendments, the Bill passed through the Report Stage in the Lords, and in very quick time gained Royal Assent. Although there had been one abortive attempt by a General Practitioner member of the BMA’s Council to call an EGM of the RCoA, the requisite 30 signatures and a motion for debate did not materialise. Council maintained its position of continuing a dialogue with the Lords, mainly through the Academy of Medical Royal Colleges, in order to influence the construct of the Bill. Those Colleges and organisations that did not are now in the process of building bridges with the Government to influence the secondary legislation and implementation of the Bill. At a recent meeting at the Academy, the CMO recognised the need to rebuild relationships and stressed the need to focus on improvements for patients.

In order to assist in setting our agenda, after yet further debate in Council following a list of proposals from two Fellows, we decided to survey the views of Fellows, Members and Trainees not only on the Bill but also on six areas of concern that we had encountered frequently. The results are on the website www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/health-and-social-care-bill-e-survey-results but in summary, after one week, there was only an 18% response rate, including abstentions; 68% of respondents were opposed to the Bill.

**Commissioning**

As well as worries over commissioning for acute services, respondents were concerned about fragmentation of hospital services, the impact on education and training, patient safety and standards of care. Through the Academy, it is this College’s intention to improve the delivery of anaesthesia services, in the widest possible sense, and maintain high standards of patient care, through the commissioning process. We have already met with the new Chairman of the NHS Commissioning Board, Professor Malcolm Grant, along with David Nicholson and Bruce Keogh. A further meeting with Kathy McLean, Clinical Transitions Director in the NHS Medical Directorate, on 27 March has helped set the direction of travel, most likely through a Pan-collegiate Commissioning Advice Co-ordinating Body. This presents a unique opportunity for Colleges and Faculties to become intimately involved in setting national standards that commissioners will need to respect. As always, the devil will be in the detail; what, for example, would be the relationship with NICE?

**Education and training**

Within the upheaval and reorganisation caused by the Bill, some matters are now becoming clearer. There are likely to be 12–15 LETBs (Local Education and Training Boards) and these will each have an independent Chairman. However, the position of the Postgraduate Medical Dean within the Board, if they are not the Director of Quality and Education, is still under discussion. There is still a serious worry over the independence of their function.

Time for training (and work for the wider benefit of the NHS) remains a constant problem. The recent letter from the four CMOs, the MD of the NHS in England and the Chairman
of the GMC was extremely pleasing; a more recent letter from Harry Burns continues to emphasise the tremendous value that consultants bring to education and training. The CMO for England recognises the increasing problem but cannot offer a simple solution. If you are in such an impasse then I would be pleased to receive detailed examples of the problem to feed into the academy.

We hold active email addresses for about 85% of those registered with the College but have an active policy of not using this avenue for regular communications – we are very wary of repeated ‘spamming’ by surveys and the like. However, our new database does allow for selected mailings and we are developing the facility for you to opt in or out of these.

Returning to the WCA, I am pleased to report that British and Irish delegates were successful in obtaining a number of positions of influence within the WFSA including David Wilkinson, as the new President, Ellen O’ Sullivan, Iain Wilson, Isabeau Walker, Kate Grady and Paul Howell.

Unfortunately, the AAGBI could not hold off the challenge of the Czech Society of Anaesthesia, who were successful in their bid to host the WCA in 2020, so that Congress will be in Prague.

However, the reception at the British Ambassador’s residence later in the week eased the pain somewhat. In superlative surroundings, a large multi-national delegation enjoyed excellent food and drink as we highlighted British and Irish anaesthesia to her. I was particularly pleased to see the trainees from Uganda and they were genuinely appreciative of the financial support the College has put into their training.

The AAGBI promoted the e-SAFE educational DVD on its stand during the meeting. The DVD is a joint venture of the AAGBI, RCoA and WFSA with support from the BJA and e-LA. This promises to be an extremely successful collaboration and an incredible learning resource, particularly for resource-limited countries.

I have been informed by Professor Fang Gao, University of Birmingham, that Dr Matt Wilson, a consultant anaesthetist from Sheffield, has received a prestigious NIHR Clinician Scientists Award in Anaesthesia. His work on the use of remifentanil for pain relief in labour is apparently the first such anaesthetic award, as opposed to a project in perioperative medicine, critical care or pain medicine. I am pleased to see the continued growth in academic anaesthesia through the NIAA and other routes and hope it bodes well for the future of our specialty; anaesthetists should by no means feel inferior in the academic field.

To that end, I was delighted to be able to open the NIAA HSRC UK Perioperative Care Research Forum held on Monday 12th March 2012 at the College. Rupert Pearse produced an excellent programme for a day that was fully booked, stimulated debate and encouraged collaborative working. Many of us see the academic future for anaesthesia being enhanced by studying the whole gamut of perioperative care and patient outcomes and I commend the group’s work.

The first joint meeting of the Welsh Advisory Board and National Specialty Advisory Group was held in February; Kevin Storey and Charlie McLaughlan attended what was a positive meeting and the groups agreed to merge permanently. The group elected a new Chairman, Dr Ian Johnson, along with a Deputy, Dr Andy Bagwell. The Chairman or his Deputy will attend Council as a co-opted Member to speak for issues relating to Wales. I look forward to working with them. This initiative follows the successful Scottish model whereby political and specialty-specific debate takes place in a harmonious atmosphere; England could certainly learn from them.

Rather depressingly, I cannot report any progress on Clinical Excellence Awards, though it is expected there will be a 2012 round and further consultation on the DDRB report. Whether the problem lies with the machinations of the Bill occupying Mr Lansley’s time, the furore over pensions or differences between the devolved nations remains to be seen. It will, of course be up to each individual to decide how they respond to the BMA's ballot but I do fear that industrial action will be yet another nail in the coffin of professionalism.

Finally, I must apologise for not detailing in the last Bulletin two new members of Council who attended their first meeting in March. My warmest congratulations go to Dr Ramana Alladi, Elected SAS Member (first term) and Dr Sumit Gulati, Elected Trainee Member. I have no doubt both will contribute fully.
We are writing to every employer in the NHS to urge you and your Board to look favourably on requests from doctors for absence to undertake national work of benefit to healthcare systems across the UK.

The government and statutory agencies such as NICE, the Committee on Human Medicines and the General Medical Council, as well as professional organisations such as the Royal Colleges, all rely heavily on senior members of the profession for their expertise and experience in a whole variety of roles. The part-time work they undertake alongside their clinical duties contributes a great deal to the quality of patient care, medical education and the effective running of the health service.

We understand that in the current climate there is considerable pressure on local resources and that you will need to take account of that and ensure that contractual commitments are applied appropriately. However, we hope you will regard such activity by your senior clinical staff as an investment in the system and a reflection of the high standards in your organisation. The experience gained by the individual will also often be of direct benefit to the unit in which they work.

Of course, a large number of NHS organisations already support this activity, and we are keen to see that continue, but if there is more encouragement you can give, we believe that would bring significant benefit. We would be grateful if you could bring this to the attention of the members of your Board.

If you have any comments or questions please contact Joanna Szreder via jszreder@gmc-uk.org who will pass them on to us.

Yours sincerely

Sir Harry Burns
Chief Medical Officer Scottish Government

Dame Sally Davies
Chief Medical Officer UK Government

Dr Tony Jewell
Chief Medical Officer Welsh Assembly Government

Sir Bruce Keogh
Medical Director National Health Service (England)

Dr Michael McBride
Chief Medical Officer Department of Health and Social Services (Northern Ireland)

Sir Peter Rubin
Chairman General Medical Council
It is an honour to write this guest editorial for the RCoA Bulletin on behalf of the Vascular Anaesthesia Society of Great Britain and Ireland (VASGBI). We are at a pivotal time in the provision of vascular surgery in the UK, with changes affecting every aspect of surgery and anaesthesia. Some of these are the result of developments affecting all operative surgery. The drive to improve audit of surgical outcome such as Dr Foster¹ and the changes introduced by the GMC concerning the way revalidation will occur are two; however, others are more specific to vascular surgery.

Dr M Stoneham
Consultant Anaesthetist
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The starting point for the changes in vascular surgery and anaesthesia was the publication of the VascuNet report in 2008 by the European Society for Vascular Surgery demonstrating that the mortality of elective abdominal aortic aneurysm (AAA) surgery in the United Kingdom was higher than that of other contributing countries.² This realisation that we were the ‘dirty man of Europe’ triggered a cascade of changes in aortic surgery. A most important subsequent observation was the recognition of the close relationship between surgical outcome and the volume of surgery done by individual hospitals and, to a lesser extent, surgeons.³ Some small volume units performed well: others had unacceptably high mortality. This was the principal driver for change for the centralisation process.

Technological advances in surgery have also been a driver for change with the introduction of endovascular surgery. All three of the major open vascular operations – AAA, carotid endarterectomy (CEA), and infrainguinal bypass grafts (IIBG) – may now be performed radiologically by the percutaneous insertion of wires into arteries and the deployment of stent grafts to dilate (CEA, IIBG) or to line the aneurysm (AAA). The relative differences in outcome between stenting and open procedure varies between these three operations. Patients with lower limb arterial stenoses are now only offered open surgery if angioplasty (stenting) is unsuccessful. For patients with carotid stenosis, the cardiac mortality of stenting is lower but this is counterbalanced by a higher incidence of stroke. Currently, for young, asymptomatic patients, stenting is the best option whilst older symptomatic patients benefit from CEA.⁴ For AAA, the 30-day mortality of endovascular aneurysm repair (EVAR) is considerably lower than open repair; however, this survival benefit is lost after ten years due to late endovascular complications,⁵ thus it is still under debate as to which is the optimal technique. Age, co-morbidity and patient choice all affect which procedure will be done. One can only imagine that, as time goes on, stent grafts will continue to improve.

The next major change is the introduction of a screening programme for AAA. AAA repair is performed to reduce the risk of aneurysm rupture, which accounts for 2% of deaths in males >65. A nationwide ultrasound screening programme is now being rolled out in which males >65 will be offered a single abdominal ultrasound to detect AAA and subsequent referral onto a vascular surgeon if positive. This will undoubtedly lead to larger numbers of younger (less co-morbidity) patients presenting for AAA repair. It is unclear what proportion will be treated open or by EVAR.

The final change is that, at the time of writing, vascular surgery has had its application for specialty status approved.
likely that vascular anaesthetists in DGHs will lose their vascular lists. For administrative, management, geographical and logistical reasons, it also seems unlikely that those same anaesthetists will follow the patients (and surgeons) to the Vascular Centre.

For vascular anaesthetists in the Vascular Centre, there will also be changes in practice. A multidisciplinary team meeting (MDT) is an integral part of the management of patients with AAA with anaesthetic input required. As part of the QIP, all patients undergoing AAA repair, open or EVAR, need to be seen by a consultant vascular anaesthetist preoperatively to assess risk and optimise management plans.

For anaesthetic trainees, we need to ensure that those who wish to become designated vascular anaesthetists receive the required training. Currently, advanced training in vascular anaesthesia is not mandatory for intermediate or higher trainees but ‘optional’. Those seeking training in vascular anaesthesia therefore have to actively apply for and get appropriate training. There are also advanced training modules, fellowships and out-of-programme experience (OOPE) available. We (the VASGBI) intend to create an online resource that assists trainees who wish to get appropriate training in vascular anaesthesia.

Two other problems are relevant. First, what to do if no vascular anaesthetist is available? The majority of Vascular Society (VS) Council members when questioned stated that they would rather cancel elective major vascular surgery if appropriate anaesthetic expertise were unavailable. The implication is that, for these Vascular Centres, we must provide cross-cover of elective operating lists.
Job plans for consultant vascular anaesthetists will need to have ‘flexible’ sessions to achieve this. The other question is whether there needs to be a consultant vascular anaesthetist on-call rota. The opinion of the VS is that, with extra day-time vascular lists, and with the reduction in patients presenting with ruptured AAA due to aortic screening, this would be unnecessary. We will have to wait and see. We are not aware that any hospital currently has such an on-call arrangement but obviously this may change.

These are exciting times for our subspecialty. The GMC has indicated that CPD will become an important part of revalidation. The VASGBI has an annual scientific meeting – this year it is in Portsmouth on 10/11 September 2012 at which at least 50% of the content will be CPD based. We encourage all those interested by design or fate in becoming vascular anaesthetists to join the VASGBI at www.vasgbi.com. I hope to see you in Portsmouth in September.

References
1 www.drfosterhealth.co.uk.
Simulation training to the masses

Simulation is well established in aviation and the military. It is now becoming increasingly common in healthcare, with anaesthetists pioneering simulation as an educational tool in the 1980s. The Chief Medical Officer has called for an increase in the use of simulation in training in healthcare. The Simulation Steering Group within the College is currently considering how to incorporate simulation into the training curriculum. This article explores the uses and benefits of simulation as a training tool.

Model training
Simulation should present a clinical scenario to which the learner performs a skill or demonstrates management of the scenario as they would in a real clinical situation. Usually the learner receives feedback on their performance and should use this to improve future performance, not only in the simulator, but also in clinical practice.

It provides an opportunity to perform in a safe environment, either a new skill prior to clinical practice, or an infrequently encountered situation. Not only would the patient feel reassured that this wasn’t the very first time, but it should also improve patient safety.

Many parallels have been drawn between anaesthesia and the aviation industry, where they have been using simulators to learn to manage difficult and unusual aviation crises. Pilots practise difficult landings to prepare them for real life situations, not only refreshing knowledge and skills, but enabling better performance under pressure and stress reduction. When crisis hits, you don’t want to be doing this for the first time (with shaky hands!). Having a pre-rehearsed method of dealing with a difficult situation makes it easier to fall into that practice in a stressful time.

Simulation is indeed not identical to real life – it merely simulates it. The more authentic the experience in the simulator, the better the reflection of real-life behaviour. This means it has to look real, work, and produce a real response in the learner. This includes not only having real staff and a realistic manikin, but the environment and the real equipment and drugs so that the scenario plays out in real time, and provides useful learning points – for example where the dantrolene is kept, and how to draw it up and administer it. One of the most real simulation sessions to which I have been was a crash call to resus to find a child manikin, with the real ED team and real time to draw up drugs and get help. The highest fidelity simulators can reproduce a patient’s physiology, except for the colour and skin temperature, e.g. METI-Man™ but lower fidelity simulators, e.g. Resusci Anne, or an actor, all have a place in simulator training.

Practice makes perfect
While simulation training has been shown to improve cognitive and behavioural skills in the simulator, it is difficult to measure whether these transfer to changes in clinical practice. The aviation industry has widely accepted standards for training and assessment. Healthcare simulation is currently lacking evidence and standards to provide confidence in its role in training. It has been demonstrated that in-flight simulators improve pilot skills. A study by Bruppacher et al found that training anaesthetists to wean a patient off cardiac bypass in the simulator improved their performance in clinical practice.

Simulation provides a controlled environment, so the teacher can offer training opportunities to meet the learning needs. Training currently occurs as an apprenticeship, learning from the
opportunities that arise – there may not be a central line or a double lumen tube to do on the list, and we hope there will not be a malignant hyperpyrexia! Simulation provides standardised training, and can fill gaps unmet by traditional clinical teaching without stressing or harming patients, at a time to fit curriculum needs.

The simulation scenario can be paused at any time to allow a ‘teaching moment’, permitting the learner to reflect on the consequences of an individual action, or to explore their thoughts and plans.

The difference between competence and mastery of a skill is achieved by deliberate practice. This is defined as ‘the opportunity to tackle a well-defined task with an appropriate difficulty level for the particular individual, informative feedback, and opportunities for repetition and correction of errors’ until a polished performance is achieved.

In clinical practice, deliberate practice is difficult to achieve, as a skill is usually only performed once on each patient, from start to finish. This is ideally suited to practice in the simulator, where, for example, intubation can be practised repeatedly without having to wait for the surgery to finish, and the next patient to be induced.

Crew (or crisis) resource management can also be learnt in the simulator. Anaesthetic non-technical skills such as team skills, leadership, communication and situational awareness can all be learnt during team simulation. Practising good non-technical skills has been shown to reduce mortality.

**Just toys for grown-ups**

‘Wasted time that could have been better spent on a training list’

There is a risk of this if simulation is done for the sake of it, without a properly set up, well run session with learning objectives. Simulation has been shown to complement, but not duplicate, clinical setting learning. Sometimes, this is a candidate centred issue – that they are unwilling to immerse in the situation. Authenticity helps the learner feel this is a real situation.

‘Feedback is poor’

Poor feedback may be received if the trainer is not competent in providing feedback. This is a key part of simulation – trainees expect to receive feedback, and constructive feedback is necessary to allow ongoing improvement.

‘It’s not like real life’

Candidates are expecting something to go wrong, and so may be extra vigilant, and may not behave as they would in a real clinical environment.

Much of our clinical information is gathered from the end of the bed – how does the patient look? Are they cold and clammy? Have they gone blue – none of these are detectable on most manikins. This compromises the authenticity of the situation.

‘It only makes you better in the simulator’

This has been a criticism of some simulation training, but there is evidence that skills learnt in the simulator do transfer to the clinical setting. Simulation can be costly, not only in the initial outlay of equipment, but also in time and resources required to train the trainers, and release the learners from clinical duty. We must be sure that the benefits of simulation outweigh the cost. A recent College survey demonstrated that most schools of anaesthesia in the UK have access to simulation equipment.

**Goals and gains**

Firstly, be clear on the objectives: what are you trying to achieve? Performance of a practical skill? Management of a rare event? Team skills? Non-technical skills? Objectives need to be relevant to the curriculum, and relevant to the stage of the individual learner.

Feedback is the most important part of simulation. Rarely is formal feedback given about the trainee’s performance post-hoc in the clinical setting. To learn from the experience, there must be objective feedback on the performance. Video playback of the session prompts the facilitator, provides evidence of behaviour and demonstrates the wider vision that the learner may have missed. There are many models on which to structure feedback, which are beyond the scope of this article. There is a move away from Pendleton’s rules (what went well, what went badly), and more towards opening up a conversation to reinforce good practice and identifying areas for improvement.

Simulation is not a one off exercise. To improve, there must be reflection on the feedback and the opportunity for repeat performance, either in the simulator, or in clinical practice. This aids rehearsal and perfection of performance, and keeps knowledge and skills fresh.

Simulation can be useful in teaching the following:

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**Trainees’ Topics in Anaesthesia**

- **Just toys for grown-ups**
- **Goals and gains**
- **Cost**

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DOPS and A-CEX assessments may be performed on a simulator. It may form part of revalidation in the future. There could be an assessment role for simulation in gaining competence prior to first patient practice, or before going on the on-call rota.

In conclusion
Can it replace clinical teaching? No. Simulation should be used to complement clinical teaching and bridges classroom learning with real life. Simulation training avoids the use of patients for skills practice and can prepare anaesthetists for critical incidents. Whilst it is prudent to have practised skills prior to performing on real patients, the infinite diversity of patients who present for surgery means we will never be able to train doctors without clinical exposure.

References
6 Anaesthetic Non-Technical Skills (www.abdn.ac.uk/iprc/ants).

Trainees’ Topics in Anaesthesia

- Non-technical skills, team building.
- Rare events – failed airway, anaphylaxis, malignant hyperpyrexia.
- Skills and drills training – team management of a haemorrhaging parturient.
- Deliberate practice of practical skills – CVP insertion, intercostals drain insertion, cricothyroidotomy.
- Human Factors – understanding how errors have occurred and how to avoid them.
- Individual customised learning – allows each candidate in the simulator to develop their skills based on their own learning needs.

Testing testing?
There is an increasing need for simulation in healthcare practice with reduction in training hours and increasing new technology. The need to demonstrate professional competence suggests there could be a role for assessment.

Simulation is already used in assessment in several areas of healthcare practice – the life support courses require demonstration of practice in a low-medium fidelity assessment.

Professional competence includes not only knowledge and skill performance but team working, patient care and professionalism. All these aspects can be demonstrated and assessed in the simulator. The GMC uses simulation for poorly performing doctors, not only to assess competence, but to highlight specific areas for improvement.

Simulation is already part of the RCoA curriculum. Candidates for the Primary OSCE examination face a critical incident simulation station. Some
Remediation and revalidation

Dr L Brennan
Council Member and RCoA
Revalidation Lead

Mr D Liu
RCoA Revalidation Project Manager

The new processes associated with revalidation – strengthened appraisal with its emphasis on an individual doctor being able to produce an adequate portfolio of supporting information – will be a prerequisite for a responsible officer to make a positive recommendation to the GMC to issue a licence to practise. Although it is anticipated that the vast majority of the profession will revalidate without any difficulty, it is inevitable that some doctors will be identified with whom there are concerns relating to their clinical performance, health or conduct amongst other possible issues. Managing these problems through remediation, reskilling and rehabilitation therefore becomes an important consideration. A lack of clarity about remediation and how employers will manage doctors struggling to revalidate due to performance concerns was seen by the House of Commons Health Select Committee as a major flaw in the GMC’s plans for revalidation. From a College point of view, neglecting to tackle these performance issues is obviously not an option as they could impact on patient safety.

The College is actively involved in discussions with national bodies as to how these concerns should be managed. This article highlights current areas of work and thinking in regard to remediation.

Department of Health report
Remediation is the responsibility of local employers with national bodies such as the medical royal colleges and faculties playing a fully supportive role. This has been confirmed by a Department of Health report on remediation published in December 2011 which recommends that colleges should develop guidance and provide assessment and specialist input into remediation programmes. This quite rightly recognises the responsibility and expertise of colleges in setting the specialty standards of practice for the profession, against which effective remediation programmes can be devised and performance measured.

Other recommendations in the report, which we have interpreted as possibly impacting on the work of this College through our provision of advice, guidance and services, include:

➤ Remediation should continue to be locally focused but needs to be strengthened in two ways: through developing internal capacity (trained staff, mentors) and ready access to external (possibly College) expertise.

➤ Recognition that there are different levels of concerns and remediation, and there should be increased emphasis on the prevention of low level concerns from escalating to a level requiring a full remediation programme. The College may be asked to provide advice on addressing a low level concern raised as part of the appraisal process.

➤ Clinical governance and information management systems in employing institutions should be appropriately developed to help identify doctors who have a clinical competence and capability issue and are in need of low level remediation.

➤ When remediation needs to be escalated beyond local confines (i.e. a trust or health board cannot resolve the problem), a single organisation, possibly the National Clinical Assessment Service (NCAS), will manage the case and, in turn, co-ordinate and improve consistency of high level remediation nationally. NCAS has already approached several colleges, including the RCoA, in regard to provision of specialty knowledge and input in remediation at a national level.

Academy working group on remediation
Amongst the colleges and faculties there is a need for consistency as to their involvement in remediation. It would not be ideal if, for example, a responsible officer were able to obtain specialist advice on a remediation issue from one College, but not from another if they deemed it as not being their remit to do so. With this in mind, the Academy of Medical Royal Colleges (AoMRC) has set up a working group on remediation with the RCoA being represented by Dr Anna-Maria Rollin, former Vice-President and the current Professional Standards Advisor.

Two of the key objectives for the working group are to define the principles of college engagement in remediation and come up with a framework covering aspects of process common to all colleges. Another main
The objective is to define the principles, processes and mechanisms for the quality assurance of remediation. As already stated, remediation is the responsibility of employers but for it to command the confidence of the medical profession and public alike we believe that independently validated systems of quality assurance must be in place. In addition, as recognised in the Department of Health report, remediation can be time consuming and expensive and therefore it is important that its effectiveness is robustly evaluated.

The working group will also encourage sharing of knowledge and good practice in dealing with remediation issues. Some colleges, for example, have mentoring schemes to support doctors in difficulty. NCAS sees mentoring as an essential feature, and is nearly always an element, of any of their remediation programmes. Other examples of good (and possibly ineffective) practice in remediation will no doubt be uncovered by the working group.

The working group is expected to report later this year. In the meantime, colleges will be asked to submit evidence including any information and guidance currently provided in the specialties. If you do have any thoughts or suggestions at this stage please do email them to us.

Current RCoA work on remediation

Remediation has been a longstanding issue for the College through its Professional Standards Directorate and our work with the AAGBI through the Joint Committee on Good Practice (JCGP). The JCGP is currently revising ‘Good Practice: a Guide for Departments of Anaesthesia, Critical Care and Pain Medicine’ and will include an informative chapter on the management of the poorly performing doctor.

The Anaesthesia Review Team (ART) service is offered by the College to help resolve concerns with anaesthetic practice which have been raised in a trust or health board. These concerns can stem from an individual anaesthetist, team or whole anaesthetic department. The purpose of ART is to provide an independent professional opinion and produce recommendations to address the problems identified. In order to provide this service the College will need to be invited by an employer – sometimes this invitation is issued after the employer has taken advice from the GMC or NCAS. The College will only accept the invitation on the basis that the issues relating to individuals are below a level that would clearly require referral to the GMC for fitness to practise machinery.

Therefore the College already has a framework in place to support remediation. Any future enhancements to this framework will be dependent on the recommendations made by the AoMRC working group on remediation. We have speculated slightly and are currently considering the ability of anaesthetic departments to offer remedial placements to doctors external to their organisation as one of the criteria in the College’s developing framework of strengthened appraisal and process of robust evaluation.

The future extent of the problem (and therefore possible workload for the College) is difficult to estimate. Figures abound from the Department of Health, GMC and NCAS as to the number of doctors who have some sort of clinical competence and capability issue, being referred to national bodies and participating in local remediation programmes. A possible scenario with the launch of revalidation is that the number of doctors identified as being in difficulty could increase, due to the process of strengthened appraisal and closer evaluation of clinical performance.

Return to clinical practice

Although not linked with remediation, but certainly with revalidation, we would like to mention the recently published AoMRC working party report on return to practice (see: www.aomrc.org.uk). As a result, Dr Carolyn Evans, our representative on the working party, is organising a College conference − Returning to Work: How to Succeed − on 21 June 2012. Revalidation perspectives will be covered, through a talk by Dr Una Lane (GMC Director for Continued Practice and Revalidation), as well as other issues including elements of an effective return to work programme. The conference is aimed at both medical and non-medical staff especially those, e.g. from human resources, involved in designing local return to work programmes.

To keep up to date with our work on revalidation please visit our website: www.rcoa.ac.uk/revalidation. Please email your comments to: revalidation@rcoa.ac.uk.

References
The third UK Perioperative Clinical Research Forum (UKPCRF), held at the Royal College of Anaesthetists on Monday, 12 March 2012, was oversubscribed with over 120 delegates and contributors crammed into the College lecture theatre. There was a real feeling of enthusiasm and growing momentum amongst those who attended and this was reflected in the range of studies discussed, many of which were seeking participating centres. Delegates came both from major teaching centres and from research active district general hospitals, and for the first time the perioperative research nurse community were significantly represented.

The forum was chaired by Dr Rupert Pearse (Barts and the London) and comprised a morning of presentations on a range of topics including the future of perioperative medicine research, perioperative medicine and implementation science, prioritising out ideas with funders, securing research network funding and the challenges of equipoise and collaboration. After the lunch-break, a series of short presentations on individual studies (see Table) prompted enthusiastic discussion about the relative merits of observational and experimental approaches for addressing important questions in perioperative medicine.

The UK contribution to the European Surgical Outcomes Study (EuSOS) was a cause for particular celebration: UK centres contributed more than 20% of total study recruitment across 28 nations with more than 10,000 patients recruited from 79 sites during the week-long study period in April 2011. This success is a reflection of the widespread enthusiasm for the study amongst UK researchers (despite the lack of accrual related financial support from the Comprehensive Local Research Networks) as well as the effective co-ordination of the study by the HSRC administration team.

The afternoon concluded with a presentation on ‘Working with related themes: surgery and anaesthesia’ by Mr Omar Faiz, a senior academic surgeon from Imperial College London, an update on the NIAA and HSRC and a final discussion session to explore ongoing development of the UKPCRF. Suggestions for future UKPCRF events included ‘Dragon’s Den’ style opportunities to present new ideas to a broader audience.

The venue for the UKPCRF has alternated between in-London and out-of-London venues: the first meeting was held at the Royal College of Anaesthetists, the second at the Nowgen Centre in Manchester and the third back at the RCoA.

The fourth meeting of the UKPCRF will be held in Birmingham on Wednesday, 13 March 2013, and will be chaired by Professor Fang Gao.
**News from the FPM**

**Professor D J Rowbotham**  
Dean

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**e-learning project lead appointed**

I reported in the last *Bulletin* that the Department of Health has awarded funding to the Faculty of Pain Medicine (FPM) and British Pain Society for the development of an e-learning programme on pain management for all professionals in the NHS. I am very glad to announce that Ian Goodall (Chelsea and Westminster) has been appointed to lead this project working with the e-learning team within the College. This is a very demanding and prestigious project. We are grateful to Ian for taking it on; he will receive our full support and will be approaching many of our Fellows for their input.

**A new strategy for the Faculty**

The FPM Board Strategy day was held on 27 January 2012. This was very successful and has led to many work streams, each one led by Board members. Topics include: a clear definition of what we deliver as pain medicine specialists (aimed at non-specialist healthcare professionals, commissioners and the public); provision of material on our website to support Fellows in local negotiations with the local Clinical Commissioning Groups; pain in children; future role of acute pain in the FPM; strengthening patient and public involvement; facilitating research and audit; review of local training delivery and assessment and FPM guidelines. These, and others, are discussed in more detail in the April edition of *Transmitter*.

**Neuromodulation database, examination and new website**

At the last Board meeting, we had a presentation by Simon Thomson on progress in the development of a national neuromodulation database. This has been developed with David Cunningham who has been responsible for similar national registers for cardiac implants. The database has been piloted in four hospitals and feedback has been generally favourable. If rolled out nationally, the database would enable, for the first time, audit of outcome and complications after these procedures. The team are preparing an application to the Healthcare Quality Improvement Partnership (HQIP) for funding to develop the system further. The FPM Board agreed that we should continue to support this initiative, particularly with respect to governance and design.

Examination preparation proceeds at a pace and the final regulations have been approved by College Council. These are available on the website as well as much more information. Please make sure that your trainees are aware of this; by now, candidates should be deeply involved in reading and revision. I hope by the time you are reading this our new website will be operational. Pilots have shown that the new site is a vast improvement but the proof of the pudding will be in the browsing. Please have a look at it and tell us what you think.

**Chronic pain and the Department of Health**

There is further evidence that the work we are doing with partners in order to raise the profile of chronic pain within government is having an influence. Recently, in reply to a question in Parliament by Linda Riordan MP (Chair, All Party Chronic Pain Group), the Rt Hon Paul Burstow MP (Minister of State for Care Services, Department of Health) stated: ‘The Department recognises chronic pain as a long-term condition, either in its own right or as a component of other long-term conditions. Everyone who suffers persistent pain should have a timely assessment in order to determine the cause of the pain – if a cause can be determined – and to advise on options for treatment, including self-help.’ We think this is a very significant statement which gives further impetus to our work on ensuring effective and accessible pain services within the NHS, delivered by appropriately trained professionals.
Developing the systems to facilitate revalidation

The Faculty of Intensive Care Medicine (FICM) has gained the approval of the General Medical Council (GMC) for a training programme leading to a certificate of specialty training (CST) in ICM alone. Consequently, the Faculty must assume the role of assisting its fellowship to revalidate; a process hitherto supervised by parent colleges.

Where are we in this evolution? The GMC issued guidance in April 2011 concerned with developing a good medical practice framework (GMPF) for appraisal and revalidation,1 and with identifying supporting information for the same purposes.2 The GMPF comprises of domains covering: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; and maintaining trust. Each contains three attributes defining their scope and purpose, relating to practices and principles adapted from the GMC’s core ethical guidance Good Medical Practice to which all doctors should adhere. The FICM has adopted each document into a position paper which should be on its website in the Spring of 2012.

How will these generic (i.e. applicable to all practitioners) domains be assessed? This will occur through enhanced appraisal, which must include multi-source feedback (MSF) at least once in each five-year cycle. MSF tools developed to date have been designed principally to assess the performance of clinicians with continuing care responsibilities, who may have much greater patient contact than intensivists. However, the RCoA aims to address the lack of validated patient feedback questionnaires which are appropriate for use in short consultations, by providing guidance concerning the timing and mode of administration of such surveys in specific areas of practice, including critical care. Pending the completion of such work the FICM has adapted (with permission) existing RCoA material to produce interim guidance for MSF (patient and colleague) which we hope to place on the website in Spring 2012.

What of specialty specific revalidation? Guidance is now emerging through a piece of work managed jointly by several colleges. A consistency check to determine whether common guidance notes can be provided to practitioners from different specialties is underway. The Board is seeking to adapt this for Faculty use and aims to produce guidance on the core supporting information for doctors in ICM. Access to electronic systems will be needed to facilitate effective revalidation. The Faculty will support the initiative of parent colleges in investing in this technology. Moreover, as we move from developing revalidation to implementing it, the Faculty will collaborate with the Royal College of Anaesthetists and Faculty of Pain Medicine to share expertise and experience in a joint service designed to help our Fellows revalidate, and to assist those with responsibility for assessing their fitness to do so.

What should practising intensivists do? First, ensure you undertake effective appraisal annually with an appraiser trained in the relevant systems, with MSF at least once in every five-year cycle, selecting feedback from sources identified in the Faculty’s position paper. Relevant other material (e.g. surveys) can and should be included to inform the process. Second, ensure your CPD is up to date. Again, the Faculty will provide guidance in this respect. Third, ensure you and your colleagues collect information concerning the quality of your clinical practice and adherence to national guidance and standards of care relevant to the service you provide. Evidence of regular audit against such quality markers will be needed.

Remember, the GMC has indicated that it expects the majority of consultants to clear the hurdle of revalidation without difficulty.

References

Career Grade Committee – an update

Committee structure
After ten years’ service and representation Andy Lim steps down from his final term of office. It has been a tremendous privilege to work with Andy who is a like-minded and supportive colleague. His commitment to enhancing opportunities for SAS doctors has been determined and widely appreciated. Ramana Alladi has been elected unopposed to take his place on Council whom many of you will know from his work with the AAGBI.

The RCoA is primarily concerned with training and education. Reflecting this the CGC, has as its main tasks, helping SAS doctors back into training, providing guidance for CESR applications and encouraging SAS doctors in training roles.

Self-assessment document
With this in mind the CGC has released a new self-assessment document to help individuals determine how their personal levels of training and experience compare to the 2010 training curriculum. It is intended to be used as a reflective process so that you will have a better idea of where you stand, and may assist your discussion regarding career progression with your local mentor or advisor. Having completed this there is an opportunity for you to apply to see an advisor at the College.

CESR
Applying for a Certificate of Equivalence for Specialist Registration is an onerous (and expensive) task and not one to be undertaken lightly. Guidance is available via our website and, as well as the above document, do read the document on equivalent assessment guidance for GMP 1A.

Since the introduction of the new 2010 training curriculum, the requirements have become more structured and potentially more difficult for those whose original training was some time ago. Whilst GMP 1A may be the most challenging, it is essential for you to provide evidence to satisfy all four domains of good medical practice. A key point is that the assessors are looking for evidence that supports and corroborates that which is available in your CV. Summaries of logbook data (rather than reams of theatre lists) are especially valuable. The assessment process also includes the need to have undertaken an audit cycle and, increasingly, this is proving an area that applicants have failed to do.

SAS as trainers
We have a wealth of experience and can and, indeed, should be involved with training others. As well as anaesthetic trainees, training opportunities may also include non-medical staff and foundation doctors. All College Tutors have been appraised of the roles that SAS doctors can undertake and I encourage you to maximise your opportunities. Quality assurance of trainers is being examined by the GMC whose consultation exercise ‘recognising and approving trainers’ is due to report in June. Through the College we have advocated the need for the GMC to adopt an inclusive approach such that SAS doctors will be appropriately recognised for training roles. Until we know more about the criteria the GMC will adopt, we have unfortunately suspended further applications to the 'approved to teach register'.

Regional meetings
With the development of associate SAS deans and regional meetings, the committee has been pleased to provide a stand supported by some of our committee members. We welcome your comments and views and our regional representatives can always be contacted by email – details are available on our website.

Further reading
Introduction
Detrimental psychological effects of a prolonged stay in an intensive care unit (ICU) are well documented. It has been reported that on average, one in ten of patients who spend more than 48 hours in ICU will go on to develop post-traumatic stress disorder (PTSD) – a failure to fully process a traumatic event. Many others will experience symptoms of anxiety whilst a patient, flashbacks and possibly depression afterwards. A 2010 study looked at whether ICU Patient Diaries would reduce the numbers who go on to develop PTSD and concluded it would and would in fact aid psychological recovery generally.

In this article I want to explore the importance of ICU Patient Diaries and other permanent records of an ICU stay, drawing on my own experience and those of others about whom I have read.

Experiencing ICU as a patient
In 2010 I spent over 60 days ventilated as an ICU patient at University Hospital Lewisham where I was being treated for sepsis associated ARDS (acute respiratory distress syndrome). Like many other patients in ICU, I spent a considerable time sedated. I experienced the hallucinations and so-called ICU psychosis that I understand are associated with the infection, absence of sleep, drugs, lack of orientation and other stresses on the body in ICU. I cannot find words adequate to describe the feeling of waking in an unknown environment, unable to move or talk, feeling physically restrained, having no idea why you are there and in the middle of all sorts of interventions by people you do not know. I understand now that all these were necessary and feel incredibly fortunate to be here. All the same, I would recommend to all ICU professionals to listen to some of the experiences of patients regaining consciousness in ICU on the website Health Talk Online. The general feeling of confusion, frustration and agitation is well expressed. It is also interesting to read an article, written by the journalist David Aaronovitch in The Times, that vividly describes his own frightening ICU experience.

What is an ICU Patient Diary and why keep one?
As I began the long process of weaning from the ventilator and gradual physical recovery, I continued to feel confusion and incomprehension as to how I had gone from my usual everyday life to complete incapacity. As part of that I tried to make sense of the time whilst I was sedated that I had lost entirely. I was told I had said things, had received visitors and obviously had all sorts of medical procedures – but I had no recollection of it all, save the powerful dreams that were mixed with snippets of reality as my sedation was reduced at times. At some point the ICU staff suggested to my husband that he keep a diary of what happened each day, containing such things as who was on duty, what happened, who visited and any progress or setbacks. Patient Diaries for ICU patients were pioneered in Sweden and are seen as a tool to fill in memory gaps of sedated patients and to help them understand what has happened. The idea is that staff keep a simple diary in lay language of the daily events in ICU (with photographs) and that the diary is given to the patient when they leave ICU or to their family if the patient does not recover and dies. I understand that such Patient Diaries are only used in some units and, even then, the initiative has sometimes been an inevitable victim of funding cuts.

My husband’s diary proved to be a crucial tool in aiding me to reassemble the time I had lost whilst sedated, when so much had gone on. To start with, the value was in very basic things such as being able to understand...
what day it was in relation to the day before. The necessary bareness of a hygienic clinical environment does not offer any aids to working out what time of day, day of the week or even month it is. The diary also helped me remember who people were. To start with it was very odd to have so many people who knew me but I did not know them, and recalling names was very hard. As my stay in ICU went on, I found my painfully slow recovery very frustrating at times but somehow a written record of it validated any change, however small. The inevitable setbacks felt more in proportion if I could be reminded of staff who wrote it and that family writes it. Whilst it is just a factual record, somehow the idea of someone you know writing it makes it feel more personal, rather than simply a set of medical circumstances. Whilst the staff in Lewisham ICU did an amazing job in making the experience as dignified and personal as possible, ICU is inevitably a fairly dehumanising experience. Many of the usual everyday decisions we all take for granted – such as talking, eating, having a sense of smell, getting to see beyond one small room, even wearing anything that’s not a hospital gown – are taken away. A record of daily events added significance to the grind and annoyances of the day in ICU. It is easy to think of the experience as one horrendous episode but the diary has reminded me that it was not without its positives – the love and care of family and friends whom I was fortunate to have visit so much, remarkable staff, the joy of making some physical progress and, dare I say it, even humour.

Initially, I was quite surprised to read the suggestion that a photo of the patient whilst sedated be included in the Patient Diary. I can see how at some point it may make the patient see how really very ill they were and how they have recovered since then, but it would be very much a personal choice of the patient as to whether they wanted to see that photo or have it in the diary.

Who should write the Patient Diary and what should go in it?
During a significant time in ICU I was unable to write due to oedema and muscle weakness. The recommendations for Patient Diaries I have read suggest that it is a member of staff who writes it and that family can contribute. I would suggest where possible that a member of the patient’s family writes it. Whilst it is just a factual record, somehow the idea of someone you know writing it makes it feel more personal, rather than simply a set of medical circumstances. Whilst the staff in Lewisham ICU did an amazing job in making the experience as dignified and personal as possible, ICU is inevitably a fairly detailed picture in my mind of the nurses’ station that was just metres from me. When I eventually got to see it in my final few days in the unit, it was disappointingly not as exciting as I had imagined. Photos of the unit, elsewhere in the hospital (that I had never been in before) and even of some of the staff outside would have really helped me tether the inside of the unit to a real day in the real world outside.

Once I could hold a pen myself I would also make my own records – for example, I used to write a daily note to our young children. To begin with they were short and hardly legible but I felt a lot of satisfaction from being able to write more and even draw a few pictures. When I had visitors I’d gossip through writing in my notebook and I even started texting friends. I still have all these records that I looked at often during my recovery. They worked for me as tools to understand the process of my illness and to learn to get out into the real world again.

Other written or photographic records
To me the Patient Diary is just a start. Much of what helped me recover were the thoughtful letters and cards that I was sent, and my husband displayed them beautifully so I could see and read them on the wall from my bed. Again, I found that written words somehow made the experience more real and helped me comprehend a world beyond my bay. The same goes for photographs. I was very struck by David Aaronovitch’s article where he said that he had no idea of what was behind his bay. I also spent many hours also trying to imagine what went on behind my bed and had a

References
   intensive_care_Patients_experiences/Topic/1318/.
Shared decision making in elective abdominal aortic aneurysm (AAA) repair

Shared decision making is good medical practice that uses the ethical principles of autonomy, benevolence, non-malevolence, equity and justice to help patients decide the treatment they want. Its history is described in a book by Professor John Wennberg called ‘Tracking Medicine’. This also contains a good definition of shared decision making.¹

‘... a process in which the physician or other health care practitioner discusses high quality, up-to-date information about the condition, including risks and benefits of available options and, if appropriate, the limits of scientific knowledge about outcomes; values clarification to help patients sort out their values and preferences; and guidance or coaching in deliberation, designed to improve the patient's involvement in the decision making process.’

A key part of this definition is that patients’ values and preferences are central, with the healthcare practitioner facilitating informed choice. The King’s Fund has published a recent review on shared decision making.²

Benefits and risks of open AAA surgery

The purpose of elective surgery for abdominal aortic aneurysms (AAAs) is to extend survival. Randomised controlled trials (RCTs) provide the best evidence to support decision making. Two RCTs showed that open AAA repair, when less than 5.5 cm diameter, temporarily increased mortality 12 times without long-term benefit.³⁻⁴ The EVAR 2 study is the only RCT of surgery in larger AAAs and again showed no benefit.⁵ Some data favour surgery, for instance the observation that the rate of rupture increases with size of AAA, the rate of AAA growth and pain. On the other hand, a hostile abdomen, inflammatory aneurysms and the involvement of renal arteries make surgery more risky. There is even less information to support choice for women with AAAs.

Benefits and risks of EVAR

Endovascular AAA repair (EVAR) causes fewer deaths and less morbidity than open repair in the short term, accompanied by shorter lengths of stay, but without long-term benefit.⁶ It is a developing technology, with both technical and clinical experience increasing its use. The use of intravenous contrast during EVAR is an additional risk to patients with renal impairment. A straight aorta with a good ‘landing zone’ above and below the AAA is associated with fewer complications after EVAR. Patients who have had EVAR are more likely to be hospitalised for further aneurysmal surgery than after open repair and require long-term radiological followup.

Risk factors common to surgical and conservative choices

Mortality risk doubles for every seven years of age (Table 1), whilst population mortality falls 2% each year: for instance a 73-year-old man’s risk of dying this year is 98% the risk that a 73-year-old man would have died last year. There are many studies on survival that link aerobic fitness to improved survival. Aerobic capacity can be estimated by history or directly measured by a cardiopulmonary exercise test.⁷ A history of peripheral arterial disease, stroke, heart failure, myocardial infarction or renal disease (serum creatinine > 150 µmol/L) each independently increase the risk of dying by about times 1.5.⁸ A history of transient ischaemic attack or angina increases the risk of dying by 1.2. As a rough guide the risk of postoperative morbidity is double the risk of postoperative mortality.⁹
The purpose of elective surgery for abdominal aortic aneurysms (AAAs) is to extend survival.

Benefits and risks of observation or no surgical treatment

The benefit from AAA repair intended by surgeons and hoped for by patients is improved survival with an acceptable morbidity and quality of life. Both are trying to avoid death from rupture, as well as iatrogenic morbidity and a reduced quality of life. Survival after a ruptured AAA is low: about 10% if you include all ruptures and 40% for selected patients who go to the operating theatre. Postoperative morbidity is high. The risk of rupture is usually quoted as an annual risk of rupture (Table 2).\(^ {10}\) The certainty with which these data are sometimes quoted is often disproportionate to their evidence base. For instance the rupture rate of 6.8 cm AAAs in the EVAR 2 study (1 in 8) was less than suggested by the table. It is important to say that the corresponding chance of the aneurysm not rupturing was 7 in 8, important if median life expectancy is five years. As the AAA size increases, the confidence in the risk of rupture decreases. There is also a problem in the comparison of risk. Survival after surgery is usually 30-day or in-hospital mortality but survival without surgery is annual risk of rupture. There is a publication bias towards surgery in the disproportionate number of studies published on operation and outcome compared to the number of publications on no operation and outcome.

The patients’ perspectives

The role of the clinician is first to estimate the chances of benefit and harm. The confidence one has in these estimations varies with both specific aneurysmal features and general patient factors, such as age, co-morbidity and aerobic fitness. There may be more than one surgical option which may change over time. We need to be able to share these estimations and their uncertainties with patients and their families without frightening them. Fright prevents the calm consideration of choice. After all, aneurysms are just one of life’s many ‘ticking time bombs’:

their repair does not remove the other clocks and often makes them tick faster. The key for a more sanguine approach to discussions about AAAs is to unlock the patient’s perspective.

Start with explaining the problem in brief and then move on to finding out what the patient understands so far and what is their desired role in decision making. Be aware that a patient’s first response to what they want to know may change as the consultation progresses. Go through the pros and cons of the available options including uncertainty. Now focus on the patient’s values and preferences. Avoid the tendency to retreat to the comfort of pathology, physiology or interventional technique on which your training centred. Accept and share uncertainty rather than ignore it. You have to understand why or how a patient is making a decision to help coach or guide them to make the best choice for them. Often something in the patient’s past experience or their family or social history will determine their perspective. Your role is not to judge their decision, but to understand and ensure their decision is based on correct information and that they are not put under any undue pressure. Involving friends and family is useful. Sometimes decisions are reached quickly and sometimes they need deferring for more time or more information. Emphasise to patients that they can change their minds.

The future of shared decision making and AAA surgery

Barriers to clinicians sharing decisions include our preference to dominate, our failure to recognise a patient’s preference and our poor communication skills. We need to learn how to communicate by listening, how to use open questioning, how to support patients’ deliberations and guide without
directing. With the exception of general practice these are not taught to postgraduates. We need better information about benefit and harm, long-term survival, morbidity and patient-related outcomes for open surgery, EVAR and no surgery. This requires a database and the follow up of all diagnosed AAAs. Other barriers are the lack of time or the lack of reimbursement for the time required for these consultations. There can be perverse incentives to operate if the reimbursement for a surgical procedure is disproportionate to the consultation. There are potential benefits in improved patient satisfaction and less litigation. There may also be a better allocation of healthcare resources in terms of the money going on good outcome for both patients and the healthcare system. In other surgical specialties shared decision making usually reduces the number of operations.

Decision aids have been developed for other surgical procedures. They can be in paper, audio or video format and can be put on the internet. They provide information about treatment options, risks, benefits and uncertainty, with videos of patients who have had to make decisions on their treatment. A Cochrane review on the use of decision aids found increased and improved patient knowledge, improved concordance between patients’ values and choices, with less patient regret.11

A survival calculator to assist shared decision making is available through the website https://sites.google.com/site/informrisk/.

References
9 www.gad.gov.uk/Demography%20Data/Life%20Tables/.
National abdominal aortic aneurysm (AAA) quality improvement programme

Clinical outcomes and standards of care in aortic aneurysm surgery in the UK are under the national spotlight. Recent recognition amongst the vascular community that clinical outcomes fall short of those expected for a first world country has prompted the formation of a national strategy to drive up standards of care. Perhaps the most influential publication of recent times that added to this evidence was the 2008 European Society of Vascular Surgery Registry Report (VascuNet). This reported the UK crude mortality rate following open aortic aneurysm repair to be twice that of the registry average (7.9% versus 3.5%). Interestingly, outcomes for elective EVAR and emergency AAA repair in the UK were found to be similar to the registry average which has led some clinicians to question the validity of the open repair data. Previous National Vascular Database (NVD) reports, small trials and NCEPOD were in line with this ‘ball park’ figure of 7%.

However, in March 2012 the Vascular Society of Great Britain and Ireland (VSGBI) published a report relating to AAA surgery undertaken between October 2008 and September 2010 using data from the NVD. Each vascular unit in the UK was asked to verify their data on at least three occasions prior to publication. The report revealed an overall mortality of 2.4% (average mortality for open repair of 4.3%, average mortality for EVAR of 0.9%). The report also confirmed that there is a relationship between volume and outcome, which finds in favour of higher volume units. This is a very encouraging report and demonstrates the importance of accurate and full data submission.

In 2009 a working party at the VSGBI was convened to formulate a plan of action based upon the data that suggested the UK to be an outlier. This led to the development of a national quality improvement framework; the aim and content of this framework were agreed later that year. The overriding purpose is to set out standards of clinical practice and to streamline overall patient management. Working with our society and the British Society of Interventional Radiology (BSIR) a quality improvement grant was received from The Health Foundation. In 2010 a project team was assembled and the National Abdominal Aortic Aneurysm Quality Improvement Programme (AAAQIP) was launched. The targets of the programme are to reduce postoperative mortality by half (to 3.5%) by 2013, increase contribution to the NVD and to standardise management through regional AAA clinical pathways. The rest of this article highlights aspects of the AAAQIP that will have direct implications for UK anaesthetists as listed below:

2. Contribution to the NVD.
4. Anaesthetists should form part of the core MDT process.
5. Care to be delivered by those with expertise in vascular anaesthesia.

Centralisation of vascular surgery

The AAAQIP supports centralisation of vascular services based upon accumulating evidence of improved outcomes in ‘high volume’ units across Europe. These designated centres will be expected to offer the full range of in-patient arterial services including elective and emergency arterial intervention (open and endovascular) 24 hours a day, seven days a week. The expectation is that smaller units will form networks with large units. The major arterial cases would be undertaken on the central site and complex work will be carried out at even fewer centres per region. No doubt there will
be considerable regional variation in how this is implemented and which final model is used. There will need to be changes in working practices and job planning for consultants, and the impact upon training will be considerable. It was only a few years ago that the RCoA removed vascular training as a key unit at intermediate level. This was in response to reported difficulties in the delivery of adequate training due to the caseload being spread thinly across numerous hospitals. Centralization should improve access to larger numbers of cases for those trainees sent to the vascular centre, but will be challenging for our training programme directors in delivering higher level training. For ‘advanced training’, if the demand outstrips supply, then a competitive process is likely to be required and trainees may need to apply for fellowships outside their deanery. Overall, the benefits of centralisation for advanced training will be the delivery of a varied, multidisciplinary, high caseload experience with opportunities for research, service improvement and audit projects. Trainees who wish to take up consultant posts in vascular will be expected to have undergone advanced training modules in a ‘vascular centre’. It is incumbent on schools of anaesthesia to raise awareness of this before the commencement of higher training.

Clinical audit: National Vascular Database (NVD)
The NVD was set up in 1997 and is a voluntary, web-based database run by the VASGBI. Collecting complete data on outcomes is important because it demonstrates governance for vascular surgery and helps identify areas for focused practice improvement. The NVD covers all the main index vascular procedures including AAA repair (open and EVAR). Many surgeons also submit data to long established supra-regional databases such as Vascular Governance North West (England). The NVD provides surgeons with summarised risk adjusted data on morality, complication rates and lengths of stay both by unit and by individual surgeon. This allows for comparison with national figures and acts as a catalyst for local audit and governance initiatives. As well as annual written reports, online analysis with real time reporting of numbers can also be accessed by members. In line with the recommendations made by the NHS AAA Screening Programme Board, contribution to the NVD is mandatory for all vascular surgeons who wish to operate on patients referred from screening. Commissioning bodies may well use data from the NVD to inform strategic decisions and so the accuracy of the data collected is of great significance. Contribution by anaesthetists to the current ‘Anaesthesia Section’ of the NVD is poor. This may reflect the length of the previous data forms and also the lack of awareness amongst UK anaesthetists. This section has been recently revamped (and shortened!) by the VASGBI Audit Committee and we hope that contribution rates will increase year on year once it goes live. Our members have been informed of this in our recent VASGBI newsletter and information will be made available on the VASGBI website in the near future. The new dataset collects information on:

1. Preoperative assessment.
2. Analgesia and anaesthesia.
3. Intraoperative monitoring and fluid therapy.
4. Outcomes in the recovery room.

Recently the NVD has received support from the Department of Health to become a long-term national audit topic and it will be renamed the National Vascular Registry (NVR). The Health Quality Improvement Partnership (HQIP) has already started the procurement process. Once the result of the tendering process is announced, we hope to incorporate the new ‘Anaesthesia section’ and contribute to the overall design of the NVR. The likelihood is that, rather than integrate ‘anaesthesia’ into the new NVR, a separate ‘anaesthesia tab’ will remain. To send in your data you will need to register your details with the NVR. My hope is that anaesthetists will then be able to receive online analysis and annual reports from the NVR in the future. This will assist in annual appraisal, self-audit and revalidation. It should also allow comparison against national standards in areas of practice such as preoperative assessment, contribution to MDT and delivery of services in general. An annual ‘snap shot’ audit (e.g. over a one-month period) will be encouraged by the VASGBI and will allow us to focus in on specific areas of practice in detail, with publication and presentation of such reports at our annual scientific meeting for dissemination across the vascular anaesthesia community. The NVR is a fantastic opportunity for anaesthetists to involve themselves in driving up and setting new standards of care in vascular surgery. Please get involved and support the NVR as and when it gets up and running.

Preoperative assessment
The importance of a timely risk assessment and implementation of clinical pathways that allow for the correction and optimisation of co-morbidity is recognised. The framework recommends that preoperative assessment and intraoperative care be delivered by ‘vascular anaesthetists’. The definition of a vascular anaesthetist has been hotly debated at recent VASGBI
committee meetings; in keeping with any sub-specialty, we think it describes a consultant with a regular clinical commitment (at least one session every other week) to elective vascular surgery and who contributes to the NVR. In addition, it is someone with expertise in preoperative risk assessment and in the intraoperative management of the index arterial vascular procedures (aortic, carotid and peripheral vascular surgery). According to a recent VASGBI survey, many anaesthetists are already providing out-patient assessment clinics. Hopefully, the remainder can point to the framework document as a lever to secure funding and administrative support to achieve this standard.

The QIP has produced an ‘Elective AAA Safe for Intervention Checklist’ (see Appendix), a traffic light protocol taken from the EVAR 1 and 2 trials. It has been endorsed by our society and is intended to be a first check of fitness to guide vascular surgeons in making a referral for assessment by a vascular anaesthetist. The checklist is made available to the other members of the vascular team to develop robust lines of communication and optimisation interventions are required so long as a written outcome of assessments and optimisation interventions are made available to the other members of the vascular MDT in a timely manner. It is incumbent upon the whole vascular team to develop robust lines of communication and the adoption of a locally agreed MDT proforma is an essential component of this process, examples of which can be found on the AAAQIP website.

Sharing of information with patients should be supported by the adoption of patient information leaflets and web-based resources such as those produced by the RCoA.7 Patients should be offered a choice as to whether to proceed with intervention and a choice between open and EVAR where appropriate. Your involvement as anaesthetists in this final decision is highly valued by patients.

The challenges of delivering a fit for purpose, safe and accountable vascular service are in part dependent on vascular anaesthesia getting involved. We can make a positive impact on outcome by contributing to the NVR and by engaging with every component of the clinical pathway from the initial assessment to the MDT meeting and by provision of clear information to patients. Vascular anaesthesia has much to offer future trainees and consultants. When I step back and view the framework documents, I can’t help thinking that it simply highlights the important role that anaesthesia has played and will continue to play in the delivery of care to this population. I feel confident that the profile of vascular anaesthesia as a sub-specialty will in part be shaped by our engagement in this national initiative over the coming years.

References
7 www.rcoa.ac.uk/patientinfo.
Appendix
Elective AAA Safe for Intervention Checklist

**Elective Abdominal Aortic Aneurysm – Preoperative Safe for Intervention Checklist**

**Patient Details**

<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th><strong>Y</strong></th>
<th><strong>N</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has the patient had a myocardial infarct or unstable angina? Angina at rest in the last 3 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has the patient had new onset of angina in the last 3 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Does the patient have a history of poorly controlled heart failure? (Nocturnal dyspnoea or inability to climb one flight of stairs due to SOB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Does the patient have severe or symptomatic cardiac valve disease? (e.g. aortic stenosis with gradient &gt;60mmHg or requiring valve replacement, drop attacks)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does the patient have significant arrhythmia? (Symptomatic, ventricular, severe bradyarrhythmias or uncontrolled supraventricular tachycardia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <em>If applicable:</em> does the patient have any of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. FEV1 &lt; 1.0 L or &lt;80% of predicted value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. PO2 &lt; 8.0 kPa; 3. PCO2 &gt; 6.5 kPa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer to any of 1-6 is yes, the patient is coded **RED** and is at high risk for surgery.

**Questions**

<table>
<thead>
<tr>
<th><strong>Question</strong></th>
<th><strong>Y</strong></th>
<th><strong>N</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Does the patient get SOBOE climbing one flight of stairs? (short slope if lives on one floor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Does the patient have evidence of moderate renal impairment (creatinine &gt;180 micromol/l) or previous renal transplant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Has the patient had treatment for cancer in last 6 months, or has life threatening tumour?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Does the patient have poorly controlled diabetes mellitus? (HbA1c &gt;7.5%, blood sugar usually &gt;10 mmol/l)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Does the patient have uncontrolled hypertension (i.e. SBP &gt;160; DBP &gt;105)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Has the patient had a TIA or CVA within the last 6 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the answer to any of 7-12 is yes, the patient is coded **RED** and is at high risk for intervention.

**Other Risk Factors**

Other risk factors that increase the risk (●) or preclude (●) repair (circle): Yes / No (e.g. dementia, cancer, stoma, adhesions - specify if yes).

**Please Tick**

<table>
<thead>
<tr>
<th><strong>Patient is coded:</strong></th>
<th><strong>Proposed Action:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Not recommended for immediate intervention – Specialist review required if surgical treatment still to be considered.</td>
</tr>
<tr>
<td>Amber</td>
<td>Significant comorbidity requiring preoperative optimisation.</td>
</tr>
<tr>
<td>Green</td>
<td>Fit to proceed to further stage of formal assessment</td>
</tr>
</tbody>
</table>

N.B. It is recommended that all patients scoring red or amber should be reviewed by an Anaesthetist with experience in Vascular anaesthesia prior to listing for intervention.

Name: ______________________ Grade: ____________ Date: ____________
Research in vascular anaesthesia

Cardiovascular disease remains a major cause of morbidity and mortality in developed countries. As such it is the subject of a great deal of ongoing basic science and clinical research and is a field that sees rapid and frequent advances in clinical care. Many of these have direct implications for the perioperative care of vascular surgery patients. Amongst the topics that tax the vascular anaesthetist are: the perioperative management of patients on new drugs such as prasugrel; the best anaesthetic management for procedures such as endovascular repair of ruptured aortic aneurysm; the protection of the patient from reperfusion injury; and myocardial protection in aortic surgery. The Research Committee of the VASGBI is tasked with promoting and supporting research into the perioperative management of vascular surgery patients.

The Society awards an annual project grant of up to £10,000 to support research in vascular anaesthesia. The broad range of projects funded reflects the challenges that face the vascular anaesthetist. Recent grants include support for research into endothelia function during aortic aneurysm repair, studies of the effect of intravenous fluids on coagulation, and studies of quality of life outcomes following aortic aneurysm repair. In order to achieve the best outcomes for patients, surgeons, anaesthetists and radiologists must collaborate in both the clinical care of patients and in research. The close collaboration between the Vascular Anaesthesia Society and the Vascular Society is noted in other articles in this Bulletin. The range of research supported by the VASGBI carries the implicit recognition that the management of vascular surgery patients is a multidisciplinary endeavour. The funding of multidisciplinary projects, such as that examining quality of life outcomes following vascular surgery, reflects the multidisciplinary research ethos of the VASGBI. Indeed, a notable achievement of the Society was the work conducted by Phil Bayly and colleagues on outcome following open aortic surgery which found mortality rates after aortic surgery consistent with those reported in the European Society of Vascular Surgery Audit and reinforced concerns about the high mortality associated with this type of surgery in the United Kingdom. This is an issue for all clinicians who care for vascular surgery patients. Recent data support the impact of perioperative anaesthetic management on outcome following vascular surgery, with improved mortality in patients undergoing elective major vascular surgery when the patient was anaesthetised by a specialist vascular anaesthetist (Figure 1).

![Figure 1](image)

*Research collaboration with the NIAA*

The VASGBI recognises the need for a co-ordinated approach to anaesthetic research in the United Kingdom. The Society is affiliated with the National Institute of Academic Anaesthesia (NIAA) and is represented on the NIAA Research Council. This brings the VASGBI practical support in the administration of grants and allows the Society to support the broader research...
endeavour in anaesthesia. VASGBI grants are administered through the NIHR portfolio status for a clinical study carries with it the recognition that the work is of high quality clinical research and has the potential to allow researchers to access additional resources for service support costs. The NIHR also provides the opportunity for the joint funding of research projects across more than one society and the VASGBI is considering the possibility of awarding joint research grants in collaboration with other societies.

The National Anaesthesia Research Priority Setting Exercise conducted by the NIHR highlighted a number of broad research themes of direct relevance to the Vascular Anaesthesia Society, for example cardiovascular risk stratification in high risk patients. In common with other societies affiliated with the NIHR, the Vascular Anaesthesia Society is working to generate a list of research priorities specifically targeted towards the well-being of patients undergoing vascular surgery.

National and international vascular research

The Annual Meeting of the VASGBI provides a forum in which the members present current research in vascular anaesthesia. Each year sees an increase in the number of posters and verbal abstracts submitted. The volume and quality of the work described at the Annual Scientific Meeting give the lie to the view that clinical research in anaesthesia is withering on the vine. The 2011 meeting of the Society in Nottingham saw the presentation of research on diverse topics including: combining the results of echocardiography and CPX testing into a risk stratification tool; the role of contrast and n-acetylcysteine in renal injury in endovascular aneurysm repair; perioperative thermoregulation in aortic surgery; the epidemiology of the EVAR population; and patient views on exercise training – to list but a few of the presentations and posters. At this meeting, as at all the previous meetings, prizes were awarded for both posters and abstracts. The judges observed that they faced an almost impossible task with an embarrassment of riches from which to choose.

The VASGBI has also contributed recently to several national and international meetings including: a regular education seminar at the Association of Anaesthetists of Great Britain and Ireland (AAGBI) entitled 'Reducing Risks in Vascular Surgery'; an invited session at the 2012 Winter Scientific Meeting of the AAGBI; and an invitation to Hong Kong Anaesthesiology 2010 'Surviving Catastrophes' at which members of the committee presented several lectures and participated in workshops and discussions.

As with any specialty the future wellbeing of vascular anaesthesia rests in the hands of our current trainees. A great deal of the research presented at every scientific meeting is conducted by trainees and speaks volumes for the enthusiasm and dedication of those training in vascular anaesthesia as well as offering reassurance that, no matter what the challenges of the future, there will be extremely capable colleagues to carry the beacon forward.
Training in vascular anaesthesia – from the trainee’s perspective

Vascular anaesthesia is an exciting, challenging and expanding specialty. The centralisation of vascular services will include the requirement for specialist vascular anaesthetists to staff dedicated vascular units. In addition, departments will need to have the organisation to allow cross cover of elective vascular lists and the potential creation in some centres of dedicated on-call vascular rotas. All this will increase the need for vascular anaesthetists. It is possible (and certainly the VASGBI would support this) that, if and when vascular surgery becomes a separate surgical sub-specialty, advanced vascular anaesthetic training will need to be formalised and be mandatory, compared to the situation at present where it is voluntary. Until that happens, how does one go about getting enough experience in vascular anaesthesia to be able to apply for a vascular consultant anaesthetic position and cope when thrown in at the deep end?

The following article presents two routes to achieve such an aim – one from the UK and one from the USA.

Dr K Ramaswamy
Specialist Registrar, Oxford University Hospitals

Dr C Atkinson
Specialist Registrar, Oxford University Hospitals

Advanced training module in vascular anaesthesia/vascular anaesthetic fellowship at the John Radcliffe Hospital, Oxford

As ST6 trainees Dr Ramaswamy and I had the opportunity to undertake a six-month advanced training module in vascular anaesthesia at the Oxford University Hospitals NHS Trust (OUH). In Oxford currently, approximately 75 patients per year undergo elective aortic aneurysm repair, of which half are done open and half as endovascular repair (EVAR), plus a further 25 emergency ruptures are repaired. In addition, approximately 100 patients per year undergo carotid endarterectomy, almost all of which are performed under regional anaesthesia, and about the same number of distal limb revascularisation procedures are performed. These numbers will increase and may even double with the South Central centralisation of vascular services and screening programmes.

During our fellowships, we were able to participate in a number of projects including the AAA Quality Improvement Programme, the development of innovative pathways, setting up an electronic database for anaesthetic data collection, and undertaking a national online survey under the auspices of VASGBI for the first time, and we are writing a review of regional anaesthesia for vascular surgery.

We feel such opportunities make vascular anaesthesia an attractive sub-specialty.

Clinical skills

The aim of higher and advanced training undertaken in ST years 5, 6 and 7 is to prepare trainees for independent professional practice in their chosen career path. Training in vascular anaesthesia offers an excellent mixture of transferable clinical skills, dealing with an elderly population with multiple co-morbidities along with opportunities for research, publications, service improvement, teaching and management experience.

The drive to audit improvement of surgical outcomes (including such measures as the AAA Quality Improvement Programme, Dr Foster and the changes introduced by the GMC for revalidation) has reinforced the role of multidisciplinary team involvement in the management of the patient and there is increasing expectation of anaesthetists to be at the forefront of perioperative patient care. Vascular anaesthesia requires skill in delivering general anaesthesia and regional anaesthesia as well as in a variety of procedures. It is a challenging anaesthetic to provide, with massive fluid shifts in patients with significant co-morbidities.

The importance of high-quality communication with surgeons, radiologists and other team members cannot be over emphasised.

Technological advances in surgery, especially the development of endovascular techniques, have been a driver for change in anaesthetic provision. All three major vascular open procedures – aortic aneurysms, carotid endarterectomy and infrainguinal bypass grafts – are now
being performed radiologically (endovascularly). The effects of anaesthetic technique on quality of recovery, morbidity, cost and length of stay are being analysed. This has opened new avenues to deliver anaesthetic perioperative care in a safe and cost efficient way.

**Research/publication opportunities**

Centralisation and the increased vascular workload in the vascular centres give us the opportunity to gather high-quality anaesthetic data. Together with data from the National Vascular Database (NVD) this can provide us with a robust basis for research projects based on newer surgical techniques. Grants are available from the VASGBI to cover all or part of the costs of research projects in the field of vascular anaesthesia, up to a limit of £10,000. Grants are awarded in open competition across Great Britain and Ireland after high-quality peer review of the application.

**Management and service improvement opportunities**

A clinician led management structure and the centralisation of services give an opportunity for further rationalising service provision, decreasing hospital stay, and providing cost-efficient, high-quality care. Most centres are already using innovative protocols and aim to implement enhanced recovery pathways for vascular anaesthesia. Anaesthetic trainees are well placed to take the initiative and improve quality and service delivery. There is certainly room for developments in manpower planning, creation of innovative pathways, quality improvement and the efficiency of service delivery.

**Audits, surveys and CEPD**

In addition to national audit, there are opportunities for auditing standardised practice as most of the services are protocol-driven. We have used the VASGBI platform to do a national survey. This could be used to gather the opinions of practising members on key issues. VASGBI also conducts an Annual Scientific Meeting, which along with CPD-related and other lectures gives opportunities for trainees to present their work.

**Training and education**

There is great potential for training in vascular anaesthesia. Though there is currently no nationally prescribed syllabus for a fellowship or advanced training module in vascular anaesthesia, we certainly wonder whether this may be required in the future.

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**Dr G D’Souza**
Department of Anesthesiology, University of Michigan, Ann Arbor, USA

**Dr D Hovord**
Department of Anesthesiology, University of Michigan, Ann Arbor, USA

**Vascular out-of-programme experience (OOPE) – experience as a visiting rotator at the University of Michigan Medical Center, Ann Arbor, Michigan, USA**

Ann Arbor is a beautiful MidWest American town, featuring surprisingly often in Hollywood movies. Sitting 30 miles from Detroit, there is a lively cultural and sporting scene – the University of Michigan stadium (which holds ten American football matches per year) seats 110,000 people – but amazingly tickets can be hard to come by! Very hot in summer (35°C) and freezing (-20°C) in winter, the weather is even more unpredictable than in the UK. With a fantastic range of eateries and bars lining Main St, to outdoor pools in every park, it didn’t take long before Ann Arbor felt like home.

The University of Michigan health system (UMHS) in Ann Arbor is a tertiary care centre, known for providing a broad range of high-quality care. Its hospitals have 1,260 licensed beds and 179 intensive care unit (ICU) beds. It regularly features in various lists ranking hospitals in the USA.

**Clinical experience**

The vascular division of surgery at UMHS is an extremely busy unit with an incredible variety of interesting and complex cases. In a typical year, 414 major vascular cases are performed. These include approximately 120 carotid endarterectomies (80% general, 20% regional), 80 endovascular aortic aneurysm repairs (50% abdominal, 50% thoracic aorta – with lumbar drain placement) and 60 open aortic aneurysm repairs. As a Visiting Instructor, your role is to work with residents to provide anaesthetic care to the varied mix of patients who present for surgery. Vascular surgery takes place in the Cardiovascular Centre, a purpose built hospital, with operating rooms specialising in cardiac, thoracic and vascular anaesthesia. The benefits of this approach are quickly evident. The resources available are fantastic – ICU beds on demand, easy access to Level 1 infusion systems, infusion pumps-a-plenty! Transoesophageal ECHO is also readily available. The other benefit is the wealth of experience and expertise from senior members of faculty who are readily available to discuss cases and help out. The same rules apply when abroad – never start something beyond your competence, and always ask for help.
Challenging work

A challenge faced, not only when working in vascular theatres, is the unfamiliarity of running two rooms. As a Visiting Instructor, your role is to supervise residents in two separate rooms (normally situated close together). It is mandatory to be present for induction and emergence, as well as significant moments in between. It can be daunting initially when supervising two junior residents across two rooms. In practice, however, one is never asked to supervise two major vascular cases at the same time, and there is always help available should one room demand the majority of your attention.

Vascular anaesthesia is paired with other specialties and these provide an additional challenge. For Visiting Instructors vascular anaesthesia tends to be coupled with either thoracic (Godwin) or liver transplant (David) anaesthesia. This adds another dimension to the training received in the year, which is complementary to the experience gained in vascular anaesthesia.

Challenging co-morbidities

As is often the case with vascular anaesthesia, it is not so much the extent of the surgical procedures that causes the challenge (although this is significant!), but the co-morbidities with which the patients present. As a tertiary referral centre, the University of Michigan is referred patients on whom smaller hospitals are unwilling to operate, often due to their wide range of co-morbidities. Successful anaesthesia requires careful planning and precise execution, as well as a flexible approach to unforeseen intraoperative challenges. These factors sit at the heart of the challenge that is vascular anaesthesia.

A trend that we have noted whilst working here is the increasing number of patients presenting with left-ventricular assist devices (LVADs). With the active LVAD programme at the University of Michigan, these patients increasingly present for non-cardiac surgery, including dental clearance (prior to cardiac transplantation) and peripheral arterial thrombectomy (thrombus formation is a known complication of LVADs in general). It seems likely that as the patient population with these devices increases, we will increasingly see them present for complicated procedures. Invasive monitoring is important – and sometimes difficult to achieve if the system circulation is non-pulsatile. Precise control of preload and afterload to maintain cardiac output is a must. Communication between all team members in the operating room is vital. These patients often share a similar set of co-morbidities with vascular patients in general.

Beyond clinical

In addition to the clinical work, there is a massive academic output from the department. Visiting Instructors are encouraged to involve themselves in projects ongoing in the department. There is an active audit and education programme for the residents. Visiting Instructors are expected to contribute to the formal teaching programme as well as ‘in theatre’ training. Cycling in at 06.00 in -15°C to give a breakfast lecture surely ticks the box of ‘commitment to education!’

The strictures of the European Working Time Directive do not apply in the US, although reducing working hours to improve safety is important. Allowed working hours for residents are being reduced to around 80 hours per week. Anaesthesia residents at the University of Michigan typically work around 55 hours on average.

It is the combination of high expectations – ‘The Michigan Difference’ – a challenging patient population undergoing complicated vascular procedures, a massive resource of expertise and help to which to turn, as well as a commitment to excellence that underpins the experience we have gained while on OOPE here at the University of Michigan. We suspect that these are similar to the reasons that trainees at the University of Oxford also find their experience worthwhile. A training programme in vascular anaesthesia offers a fantastic opportunity to extend one’s ability to provide safe anaesthesia to some of the sickest patients who present for surgery. The skills we have acquired during this training opportunity are clearly widely transferable to other sub-specialties.

The authors know of other similar OOPE training in vascular anaesthesia in Toronto and Ottawa (Canada) – but there are plenty of other potential sites in North America, Australasia, South Africa and Europe.

References

3 www.vasgbi.com/research.php
All consultant anaesthetists have the skills to anaesthetise patients for bariatric surgery

MOTION PROPOSED BY DR MATT THOMAS

Firstly, it is important to acknowledge the enormous and ongoing contribution that anaesthetists with a regular bariatric surgery list have made in improving the care of patients with morbid obesity undergoing anaesthesia. However, in the modern world it is essential that all consultant anaesthetists are competent to manage obese patients presenting for surgery, whatever the nature of that surgery.

Is weight reduction surgery special?

Weight reduction surgery in the form of laparoscopic gastric banding and laparoscopic gastric bypass is an effective treatment for obesity and associated medical conditions. The incisions and pneumoperitoneum created are similar to other types of laparoscopic surgery in the upper abdomen such as anti-reflux surgery. It is not the surgery but the medical conditions of the patients that make these operations more complicated for anaesthetists.

A laparoscopic gastric band in a patient with a normal BMI would most likely be a short day case procedure.

All anaesthetists must be able to look after these patients because obesity is common.

The following facts are known. Every year 2.9 million general anaesthetics are administered in the UK.1 UK rates of obesity show that in the UK 25% of adults are obese with a BMI over 30 and 2% have morbid obesity with a BMI above 40.

If we assume that patients presenting for surgery are in keeping with the national average, as has been shown in our preoperative assessment clinic (Figure 1), 58,000 morbidly obese patients will present for emergency and elective surgery per year. This is compared with around 8,000 who present for weight reduction surgery, 30% of which occurs in non NHS hospitals.2

Obese patients, who present as emergencies, present several unique challenges. In order to undergo weight reduction surgery, patients will have shown a degree of motivation and will have been assessed not just by an anaesthetist and a surgeon but also by a dietician, and frequently will have undergone psychological counselling. Obese patients presenting as an emergency have usually had very little medical input and have major self-esteem issues and depression.3 This can lead to far greater difficulty in explaining the risks and even in providing anaesthesia. As we are all likely to encounter morbidly obese patients in our practice, it is reliant on us to ensure that we are capable and competent in managing these patients.

Increasing specialisation of anaesthesia for elective surgery means that our emergency patients, who are often the highest risk, suffer as a result.4 This is not unique to obesity but no-one has yet suggested to me that only cardiac anaesthetists can anaesthetise patients with heart disease, or only neuroanaesthetists should manage a patient with a previous stroke.

There is already too much sub-specialisation

According to the General Medical Council’s list of approved specialities and sub-specialities, the RCoA recommends doctors for a CCT in Anaesthesia and the Faculty of Intensive Care Medicine a CCT in Intensive Care Medicine.5 There is a single sub-specialty available: that
Obstetric Anaesthetists Association (OAA)
Paediatric Intensive Care Society (PICS)
Society for Anaesthetists in Radiology (SAR)
Society for Computing and Technology in Anaesthesia (SCATA)
Society for the Advancement of Anaesthesia in Dentistry (SAAD)
Society for Intravenous Anaesthesia (SIVA)
Society for Obesity and Bariatric Anaesthesia (SOBA)
The Neuromodulation Society of UK and Ireland (NSUKI)
The Preoperative Association (Pre-Op)

If we were all stopped from practising in areas for which we are not members of a specialist society, there might be some interesting conversations during job planning along the lines of: ‘No, sorry, no more management for me, community dental – no thanks – give it to a specialist, labour ward needs covering – well I’d love to but I’m not a member and I’ll be ditching my preoperative assessment clinic as well. Whilst we’re on the subject I’m not sure I’ll be confident to do any on-call now’.

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I am by no means denigrating specialist societies, several of which I am a member, but the aim of these is for the enthusiast who wishes to push these specialist areas forward and must not be exclusive. I have concerns about membership of a society proving you are a specialist in anything.

Concern about increased sub-specialisation is not a new problem. Over a hundred years ago a Dr Gee was elected president of the medical section of the Royal Society of Medicine and expressed concerns that the purity of medicine had been affected by, first, surgery and, subsequently, other ‘medical sects and societies too numerous to mention, which had committed such ravages on Medicine’s garment’.

Although anaesthesia is perhaps unique in limiting the number of sub-specialties it registers with the GMC, it has no shortage of specialist societies. The following are purely those associated with the AAGBI and several major societies are missing:

- Anaesthetists In Management (AIM)
- Association of Dental Anaesthetists (ADA)
- Association of Paediatric Anaesthetists (APA)
- Difficult Airway Society (DAS)
- Regional Anaesthesia – UK (RAUK)
- Going Overseas Network (GON)
- History of Anaesthesia Society (HAS)
- Neuroanaesthesia Society of Great Britain and Ireland (NASGBI).

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Concern about increased sub-specialisation is not a new problem. Over a hundred years ago a Dr Gee was elected president of the medical section of the Royal Society of Medicine and expressed concerns that the purity of medicine had been affected by, first, surgery and, subsequently, other ‘medical sects and societies too numerous to mention, which had committed such ravages on Medicine’s garment’.

Although anaesthesia is perhaps unique in limiting the number of sub-specialties it registers with the GMC, it has no shortage of specialist societies. The following are purely those associated with the AAGBI and several major societies are missing:

- Anaesthetists In Management (AIM)
- Association of Dental Anaesthetists (ADA)
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Today the phrase ‘I am an anaesthetist’ should tell the world something about your training and ability.

Anaesthetists with regular weight reduction surgery lists need to work closely with the schools of anaesthesia to ensure all trainees get an opportunity to see the management of these patients in a controlled environment, with training provided by experts, not specialists.

There are specific circumstances where knowledge of obesity is crucial

Two recent national reports have raised the issue of obesity as a risk factor in anaesthesia. The first of these was the CMACE report and subsequent report on Maternal Obesity in the UK. This states that:

Pregnant women with a booking BMI ≥40 should have an antenatal anaesthetic consultation with an obstetric anaesthetist, as recommended by the Joint CMACE/RCOG Guideline on the management of women with obesity in pregnancy. An anaesthetic consultation should allow potential difficulties with venous access, regional or general anaesthesia to be identified and anticipated.

This is a sensible and important recommendation, however, if you recall there is no definition of an obstetric anaesthetist. If we have specialists in obstetric anaesthesia and bariatric anaesthesia, do we need a specialist obstetric bariatric anaesthetist?

The second report is the National Audit Project (NAP4) report. This showed us that obesity was associated with airway catastrophes in anaesthesia and intensive care. 45% of patients in the report had obesity listed as one of the reasons for the complication. This reinforces how prevalent obesity is in our difficult cases and how important it is that each and every one of us are trained and prepared to deal with this.

At least one of the cases occurred in an obese parturient, so do we require an obstetric bariatric difficult airway anaesthetist and intensivist? My concern is we are heading into the realms of Dr Seuss (Box 2).

Box 2

Excerpted from The Fox in Socks, by Dr Seuss

Mr Knox, sir.
Let’s have a little talk about tweetle beetles....
What do you know about tweetle beetles?... well...
When tweetle beetles fight, it’s called a tweetle beetle battle.
And when they battle in a puddle, it’s a tweetle beetle puddle battle.
AND when tweetle beetles battle with paddles in a puddle, they call it a tweetle beetle puddle paddle battle.
AND...
When beetles battle beetles in a puddle paddle battle and the beetle battle puddle is a puddle in a bottle...
...they call this a tweetle beetle bottle puddle paddle battle muddle.
Morbid obesity is an important disease for anaesthetists. It is common and increasing and is associated with numerous anaesthetic catastrophes.

The only solution to this is for all anaesthetists to be trained and competent to deal with morbidly obese patients presenting for surgery, whatever the nature of that surgery. I therefore support the motion that all consultant anaesthetists have the skills to anaesthetise patients for bariatric surgery.

On the larger question of whether increasing specialisation is a blessing or a curse, I'll leave the reader to decide for themselves whilst I go back to specialising in anaesthetising ASA1 patients for surgeons with a track record of finishing on time!

References


All consultant anaesthetists have the skills to anaesthetise patients for bariatric surgery

MOTION OPPOSED BY DR CLAIRE NIGHTINGALE

Are all consultant anaesthetists capable of anaesthetising a patient for bariatric surgery? A consultant paediatric intensivist may be a fully qualified anaesthetist having completed UK specialist training, but are they competent to anaesthetise an 180 kg patient undergoing a laparoscopic duodenal switch? Even if they felt they could manage, would it be in the best interest of the patient for them to do so? While we are all expected to anaesthetise any emergency that comes through the door, for elective surgery it is preferable to have anaesthetists with specific training and expertise. As a profession we do not encourage occasional practice in sub-specialties. The main reason is that it takes an experienced clinician to recognise the subset of high risk patients that differ from the norm and to know how to provide appropriate care, which may include not operating at all or performing a less invasive procedure. Likewise, familiarity with the normal postoperative course will allow the timely recognition of complications. We know that, for oesophagectomies, the number required to achieve low mortality is 20 per year. This recognition that familiarity with a procedure results in improved outcome is established throughout medicine, and is in my opinion equally applicable to the skill of bariatric anaesthesia.

The problems of obesity

Are all consultant anaesthetists familiar with all the issues of the obese? All co-morbidities seen in the normal population are exacerbated in the obese. The metabolic syndrome is particularly common and comprises dyslipidaemia, insulin resistance, hypertension, hypercoagulability and a pro-inflammatory state. The importance of screening for obstructive sleep apnoea or obesity hypoventilation syndrome cannot be over-emphasised. Un wary anaesthesia with long-acting opioids, benzodiazepines and excessive depths of anaesthesia, combined with inadequate postoperative monitoring, can result in postoperative hypoventilation, hypercapnoea and subsequent respiratory arrest.

Jay Brodsky from Stanford stated: ‘When dealing with the obese patient, the experience and ability of the laryngoscopist is the most important variable in establishing a safe airway’. As we all should know, decreased functional residual capacity and increased oxygen demand in obese patients mean they become hypoxic with less than two minutes of apnoea, despite adequate pre-oxygenation. It is recognised that while mask ventilation is more likely to be difficult, the incidence of difficult tracheal intubation is only marginally higher in the obese (with an odds ratio of 1.03). Difficulty is more likely in older, heavier men. Airway assessment is therefore vital, and an inexperienced anaesthetist may opt for an inappropriate airway management strategy, placing the patient at unnecessary risk. The fact that this is a problem in the obese was highlighted by the recent national audit of adverse airway events (NAP4), where, despite consultants being involved, obese patients were over-represented.

Poor positioning of an obese patient can lead to nerve injury. Getting the patient to walk into the operating theatre and position themselves on the operating table avoids injury both to the patient and staff. A non-bariatric anaesthetist may be unaware of helpful devices such as a ramping pillow, arm supports, suitable strapping and a hover mattress.
An appreciation of pharmacological variation in obesity is mandatory. Excess fat and increased cardiac output affect the distribution and excretion of drugs and altered neurophysiology affects sensitivity. Knowing whether to dose according to total body weight, ideal, lean or a corrected body weight is important. For example, with increasing experience, most bariatric anaesthetists dose rocuronium according to ideal body weight. Dosing according to total body weight results in prolongation of neuromuscular block that may outlast the duration of surgery.

The choice of anaesthetic can be very important for a subset of obese patients. Using short acting agents guided by depth of anaesthesia monitoring and ensuring adequate reversal of neuromuscular block allow the patient to be awake with good respiration and protective airway reflexes at the time of tracheal extubation. Recognising the subset of patients who are exquisitely sensitive to opioids is vital. This is the group most at risk of hypoventilation, hypercapnoea and postoperative extubation. Recognising the subset of patients who are exquisitely sensitive to opioids is vital. This is the group most at risk of hypoventilation, hypercapnoea and postoperative extubation. Recognising the subset of patients who are exquisitely sensitive to opioids is vital. This is the group most at risk of hypoventilation, hypercapnoea and postoperative extubation. Recognising the subset of patients who are exquisitely sensitive to opioids is vital. This is the group most at risk of hypoventilation, hypercapnoea and postoperative extubation. Recognising the subset of patients who are exquisitely sensitive to opioids is vital. This is the group most at risk of hypoventilation, hypercapnoea and postoperative extubation. Recognising the subset of patients who are exquisitely sensitive to opioids is vital. This is the group most at risk of hypoventilation, hypercapnoea and postoperative extubation.

These examples, plus the NAP4 results in particular, indicate that not all anaesthetists have the competency and training to safely anaesthetise the obese.

Competency and training
Are all anaesthetists trained to be competent in bariatric anaesthesia? All current consultants will have completed their training in the pre-2010 curriculum that did not include bariatric anaesthesia at all. They are unlikely to have encountered bariatric surgery during their training, as it is a relatively new specialty with only 238 procedures performed by the NHS in the UK during 2000. For the more mature consultant, there was less opportunity even to acquire transferable skills from the general surgical population, as in the 1980s the average UK male had a body mass index (BMI) of a mere 24.7 kg/m².8

Our new, 2010 FRCA curriculum is well defined and includes many assessments of competence, both exam and work place based. It is designed to ensure that every newly accredited anaesthetist can manage an on-call shift in an average DGH. In England the morbidly obese outnumber the pregnant by 1.3:1, yet in the FRCA curriculum while there are 63 coded items for obstetric training there are only two for bariatric surgery and one for obesity. It is clear therefore that the College does not expect a newly qualified consultant to have obtained specific knowledge of obesity or bariatric anaesthesia, and by inference may be insufficiently trained to deal with these patients.

Regarding revalidation, what do we have in place to ensure the on-going competence of all consultant anaesthetists for bariatric anaesthesia? The RCoA CPD Matrix has a whole section on paediatrics but nothing about people at the opposite end of the size spectrum. The Society for Obesity and Bariatric Anaesthesia (SOBA) is attempting to redress this imbalance, and circumstantial evidence of full attendance at every SOBA-run educational event over the past three years would indicate a perceived need for anaesthetists to augment their training in this field.

Issues specific to bariatric surgery
Should bariatric anaesthesia be considered a sub-specialty? Choosing the correct weight-loss operation for the individual patient is of vital importance. This is a joint decision with the surgeon, dietician, patient and anaesthetist all playing an important role. Inexperience of the surgical procedures can lead to wrong operations and ultimately poor outcome.

There are steps during a bariatric operation that are specific for the procedure. As an example, many surgeons require a gastric calibration bougie to be passed during laparoscopic adjustable gastric band insertion. An experienced anaesthetist can help assess the laxity of the lower oesophageal sphincter, which may result in the surgeon prophylactically suturing the oesophageal hiatus to reduce the complication of band slippage. The Medical Protection Society highlighted a case where a patient was anaesthetised for a bariatric operation by an anaesthetist who was not familiar with bariatric surgery. There was difficulty in passing the bougie and postoperatively the patient developed mediastinitis due to an unrecognised oesophageal perforation. There were several learning points, one of which was: ‘The GMC is clear that doctors should not act beyond their professional competence. Thus, when faced with a new procedure, the individual should seek suitable training and/or supervision before attempting such procedures’.9

Postoperatively, an experienced bariatric anaesthetist will be familiar with the usual course of events and will be able to recognise when things are not right. They will know that a tachycardia is something not to be ignored as it is a leak until proved otherwise, they will be on the lookout for rhabdomyolysis so that early intervention can prevent the need for intensive care and renal support, and they will understand the value of multi-modal analgesia and the recommendation to use liquid oral medication.
Some of the more compelling evidence in favour of specialism comes from the data on postoperative venous thromboembolism (VTE). In 2007, 30% of the postoperative mortality was due to VTE.10 With routine extended chemical prophylaxis this has been reduced to near zero in some centres.11 Bariatric anaesthetists were early instigators of what has subsequently been coined enhanced recovery. It is routine practice to encourage early mobilisation and avoid tethering patients with unnecessary epidural, urinary, nasogastric and intravenous catheters, to favour multimodal analgesia and antiemetics plus the early re-establishment of enteral diet.

The perioperative management of diabetes in these patients is unique, due to the profound and immediate effects on glycaemic control engendered by the bariatric procedure. The anaesthetist must be aware of these changes and be able to manage the patient’s diabetic care during this transition. It is therefore clear that bariatric anaesthesia is not simply about anaesthetising a big patient. Experience, knowledge of the surgery and its effects on the patient, and the regular auditing of practice all lead to improvement in safety.

Evidence from specialist centres

Does the ‘see one, do one’ mantra hold for bariatric anesthesia? There is clear evidence from the USA that specialist bariatric centres have a lower mortality and complication rate than non-specialist centres. Flum and colleagues looked at Medicare patients and found that the odds of death at 90 days were 1.6 times higher (95% confidence interval, 1.3–2.0) for patients of surgeons with less than the median surgical volume of bariatric procedures.12 Liu and colleagues reported that hospitals in which 0–50 or 50–99 gastric bypasses were performed annually were more likely to have complications (odds ratios, 2.72 and 2.70, respectively) than those in which more than 200 such operations were performed.13

The Surgical Review Corporation, an internationally recognised surgical body, has identified centres of excellence for bariatric surgery. Two of the criteria for recognition as a centre of excellence are bariatric trained staff and caseload. We have two accredited centres in the UK at present. They specify that a dedicated multidisciplinary team is required to deliver the best care for obese patients. The International Federation of Surgery for Obesity (IFSO) is looking to set up a specific accreditation process for anaesthesia. Clearly, the implication is that not all anaesthetists have the necessary skill, knowledge and experience to be able to safely undertake bariatric anaesthesia.

Conclusion

So in conclusion, I have outlined some deficiencies in training and revalidation and I have highlighted some of the pitfalls of perioperative management. It is my opinion that bariatric anaesthesia should be regarded as a sub-specialty analogous to vascular and paediatrics, and as such requires to be undertaken by those who have had specific training in the specialty and who have sufficient experience in the field to attain good outcomes.

I therefore oppose the motion that all consultant anaesthetists have the skills to anaesthetise for bariatric surgery.

References

Supporting critical care teaching outside the ICU

Anaesthetists and intensivists have historically had a close working relationship based on the shared goal of delivering the optimal care for patients requiring surgical procedures, or with life threatening trauma and surgical conditions.

In ‘craft’ specialties like anaesthesia and surgery, the emphasis may be perceived to be on technical skills training, particularly with the European Working Time Directive impacting on time spent in the workplace. However, even excellent anaesthetic management and an expertly performed operation may lead to a poor outcome for the patient if they are not appropriately cared for perioperatively and, while this responsibility is shared across the multidisciplinary team, out of hours it falls mainly on surgical trainees as first and second medical responders to initiate treatment and escalate assistance appropriately.

Managing high risk patients

The recent publication of the report on the state of emergency surgical care in the UK, “The Higher Risk General Surgical Patient”, which had expert opinion from anaesthetic and intensive care medicine working party members, has highlighted the variability in outcomes and in the provision of emergency services nationwide.

One of the issues raised in the report was the importance of responding promptly and accurately to the variety of ‘track and trigger’ early warning scoring systems that are now in routine use in most hospitals. In particular, the problem of dealing with patients with sepsis in the surgical patient group was highlighted. Anaesthetists and intensivists are integral in training the doctors who care for these patients. However, many trainees no longer have rotations that include attachments in critical care and their ability to obtain training in the necessary skills is often ‘squeezed’ by the competing demands of training in their base specialty. Surgical trainees need critical care skills but aren’t required to spend their time training to get them on a critical care unit, so presently the only comprehensive way of squaring the circle nationally is to provide short, goal focused courses highlighting the skills needed.

Qualitative feedback from these critical care courses run with anaesthetic/intensive care medicine faculty suggests that trainees find the input invaluable.

‘[I feel] very satisfied to have acquired a system to approach a critically ill patient; in fact, it helped me greatly the next day at work when I was on-call.’

‘I found the communication workshops very good, as they highlighted to me some of my shortcomings in communicating to people, from the feedback I received.’

‘Communicating to the anaesthetist on-call during the moulages was made to be quite daunting, I found, which I feel is realistic.’

Targeted training

The Royal College of Surgeons of England has therefore designed three courses that cover all levels of surgical practice and which focus on these issues. The Systematic Training in Acute Illness Recognition and Treatment for Surgery (START Surgery) course is aimed at foundation year trainees (described as first responders in the report), the Care of the Critically Ill Surgical Patient (CCrISP®) course is aimed at first responders (described as second responders in the report), and the CCrISP® Instructor Course is aimed at higher specialist trainees.

A modified version of this article appeared in The Royal College of Surgeons of England Bulletin, January 2012.
and new consultants in surgery, anaesthesia and critical care who are the faculty of the CCrISP® course. The two provider courses are much more than ‘ABC’ courses as they emphasise the importance of understanding the implications of physiological abnormalities and the role and responsibilities of the individual junior doctor being called to see potentially sick surgical patients as first or second responder. The courses also allow the doctor opportunity to reflect on the effectiveness of their referrals and work with anaesthetic and intensive care colleagues in a non-clinical environment and whose assistance they may be seeking, or with whom they may work as part of their training in level 2 and level 3 environments in the hospital. ‘It was also good to have so many senior anaesthetists to give their specialist input.’ ‘…Anaesthetists are clearly more informative and knowledgeable in these topics [cardiovascular, respiratory and renal physiology].’

**START Surgery**

START Surgery is aimed primarily at doctors in the first foundation year, but final year medical students just about to start Foundation jobs have also found it valuable. It has been developed into a fully interactive one day course model. Any individual who is interested in providing this course in their hospital or local area, or who wishes to observe the course with a view to joining the faculty, are asked to contact the current critical care tutors at the RCS for further information.

**CCrISP® course**

Since its launch in September 2010, the 3rd edition of CCrISP® has been rolled out nationally in 36 centres. The 3rd edition CCrISP® course was developed through the generosity of Mr and Mrs Grant who continue to support the critical care portfolio at the RCS.

The basic format of the course involves lectures, workshops and role play with actors – with the content and some teaching methods extensively updated. The feedback from candidates continues to be good: in particular, data from the online feedback system have shown that a median of 96% of candidates across all the courses felt satisfied that the delivery of the learning aims of the course had been achieved and that these learning aims were delivered well by faculty. A median of 90% of candidates responded that they were satisfied with the teaching methods used on the course and quality of delivery. Similarly, for the acquisition of knowledge and skills pertaining to the management of critically ill surgical patients, median satisfaction levels were 94% and 90% respectively. ‘Feel I have taken away a wealth of knowledge that I can put into practice tomorrow!’

These data support the use of the CCrISP® course for core surgical trainees as a means to address some of the issues highlighted in the Higher Risk Surgical Patient report.

The CCrISP® course is faculty intensive – requiring a total of ten surgeons and anaesthetists or intensivists to deliver it to a total of 16 candidates. Acting as a faculty member several times a year is becoming increasingly difficult in the current NHS climate and, as such, existing faculty need to be supported as best as is possible along with providing an opportunity for senior anaesthetic and intensive care trainees to become involved in delivering the teaching. A faculty update day, with associated CPD points, is planned for late 2012 and role descriptors for faculty members and course directors are being developed to help support individual job planning, continuing professional development and portfolio management. We are keen to engage in dialogue with existing faculty to determine if there are any other ways in which their involvement can be maintained, as well as to involve anaesthetists and intensivists not currently teaching on the course to become involved either locally or at the RCS if they feel they may wish to do so.

CCrISP® courses run at the RCS in London are now being run as ‘flagship courses’ aiming to develop new faculty and allow experienced faculty to network and direct CCrISP® courses if they have not done so previously. Faculty for College courses is therefore made up of experienced regional faculty with some faculty places being filled by more junior members who can then be supported in an appropriate manner. Any existing experienced faculty of whatever background who wish to act as a course director or teach on one of the College courses are encouraged to contact the critical care tutors.

**Training the trainers**

The CCrISP® Instructor course combines the discussion of educational theory with its practical application using material from the CCrISP® 3rd edition. The generic educational content of this course is being...
enhanced to support faculty teaching on this course and in their more general teaching or educator roles in the workplace. In particular, the role of feedback and assessment of candidates on the provider course is being emphasised by means of small group working and practice giving feedback. Attendance on the two-day course is accredited for ten Educational CPD points. We are keen to encourage trainees at ST5 level or above to attend if they have an interest in teaching and would like to become CCrISP® faculty members. Additionally, existing more experienced teachers are welcome to attend the course as it should provide opportunities for networking and updating with other educators, and it is hoped they will benefit from the generic educational issues discussed.

We are working towards a future goal of the course being recognised as a suitable course to demonstrate competence to be a clinical or educational supervisor.

Sustaining a multidisciplinary faculty

All of the above courses were developed and designed to run with a multidisciplinary faculty, 50% of whom are not surgeons. START Surgery will be rolled out nationally in 2012 and the CCrISP® course continues to be popular both with the surgical core trainees who attend and the faculty who teach it. Many of the non-surgical faculty have been involved with CCrISP® ever since its inception over ten years ago, and there is a need to engage a new generation of trainers who may not be aware of these teaching opportunities both locally and nationally. Moreover, START Surgery will allow individuals to commit only one day of time to teaching which may be preferable for some people who find they are currently unable to commit to a three-day CCrISP® course. Many find involvement with the courses highly enjoyable: ‘It was clear that the trainers took a lot of pleasure in providing a thorough and stimulating course’.

We would therefore strongly encourage anyone interested in participating, or wishing to become involved as faculty for these courses to contact the authors at education@rcseng.ac.uk.
In 2006 the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the University of San Francisco California Global Partnerships in Anaesthesia and Surgery (GPAS) set up the Uganda Anaesthesia Fellowship programme. At this time there were only two physician trainees in post in Uganda. The aim of the programme was to increase the number of medical anaesthetists in the country which has been shown elsewhere to be a key step in the development of the specialty raising its profile and influence amongst professional colleagues and managers in hospitals and externally with health ministers and other politicians. The establishment of a critical mass of medical anaesthetists also makes available the necessary expertise to train future medical anaesthetists and their non-physician anaesthetic officer colleagues. In 2011 the Royal College of Anaesthetists joined with the other partners to fund three additional Fellowships for the next three years.

Postgraduate training in anaesthesia in Uganda

At present in Uganda there are two three-year M Med programmes in anaesthesia, one at Mulago Hospital in Kampala and the other at the Mbarara University Hospital. Postgraduate trainees in Uganda are required to pay university fees, and most do not receive a salary whilst training. The AAGBI/GPAS Fellowship programme provides trainees with an income to pay their university fees and provides moderate support for living costs when the trainee does not receive a salary from the employing hospital. The Fellowship funds trainees to a maximum of £3,000 per annum for each year of training.

The trainees are appointed to the programme after their internship year and they have regular assessments and annual written and oral examinations, and are required to complete a research project in their final year with a dissertation. They all have an annual appraisal and, when accepting a Fellowship, trainees sign an agreement to continue to work after qualification in sub-Saharan Africa for a period equal to that for which they received funding from AAGBI/GPAS.

**Fellowship programme progress so far**

There are currently 20 trainees funded by the scheme, 17 in Mulago and three in Mbarara. There are three trainees in the third year, six trainees in the second year and 11 trainees in the first year, which includes one trainee in each year in Mbarara. As mentioned above, all these trainees have been selected for interview by the local trainers and have signed the sponsorship agreement to work after qualification in sub-Saharan Africa for at least three years after qualification. There are six consultant trainers in Mulago. Dr Joseph Tindinwebwa is the Academic Head of Department, Dr Cephas Mijumbi is the lead for the training programme, and Dr Andrew Kintu is the senior scholar. There are three consultant trainers in post in Mbarara, Dr Stephen Ttendo is the Academic Head of
The trainees have a structured teaching programme to which they are all expected to contribute; the Mulago trainees have a day of academic training every Thursday during term time, and the Mbarara trainees have an academic afternoon once per week, including lectures by Skype from the Massachusetts General Hospital (MGH). There have been seven UK trainees supported by the AAGBI who have undertaken three-month OOPEs in Uganda since 2010; some of these have also been involved in the clinical training programme in Mbarara.

In September 2011 the new first year trainees, three of whom were sponsored by the RCoA all attended a three-week induction programme led by Professor Brian Warriner from Vancouver, assisted by Dr Gerald Dubowitz from UCSF. The internet can still be slow and unreliable and extensive experience has shown the value of providing appropriate and up-to-date books to support training in anaesthesia. In 2011 all trainees in post on the Fellowship programme received a copy of the 2011 ‘Oxford Handbook of Anaesthesia’, ’Safe Obstetric Anaesthesia’, ‘Understanding Paediatric Anaesthesia’, and the ’Basic Science edition of ’Update in Anaesthesia’ as part of the AAGBI book donation programme.

Exams and assessments
Oral clinical examinations were held in Mulago in November 2011 with members of the local faculty examining, as well as an external examiner. These were very successful, all the Mulago trainees passed them and one trainee in the first year and one trainee in the second year are required to retake the written examination for one course unit. Another trainee is repeating the second year and will delay graduation by one year but he is making satisfactory progress.

All third year trainees have to complete a research project and are currently in the process of finalising their dissertations.

Arrangements for funding the Uganda Fellowship
The trainees receive funding from a variety of sources. The AAGBI Fellowship scheme is the major source of funding for the training programme in Uganda via the Overseas Anaesthesia Fund (OAF). Other partners include the Difficult Airway Society (DAS), the Obstetric Anaesthetists Association (OAA), World Anaesthesia Society (WAS) and, since September, the RCoA.

GPAS currently funds one senior scholar post and supports faculty to deliver hands-on training in Mulago. The Belgian government is funding another two trainees and a mission hospital, St Mary’s Hospital, Lacor, is also funding one trainee for three years.

None of the current first year trainees is employed by the Ministry of Health yet, but all have applied for funding to support their university fees and for Medical Officer posts.

Second year trainees
Lameck Ssemongere, Mary Nabukenya and Peter Agaba

Notable achievements of graduates/trainees to date
A total of nine trainees have graduated from the Uganda Fellowship training programme and eight are employed including one in further training in Kenya.

Dr Arthur Kwizera
Graduated 2009

Dr Kwizera has had a paper on use of magnesium to treat halothane-induced arrhythmias published in ‘Update in Anaesthesia’ 2009. He presented a poster on delays to caesarean section at the AAGBI Annual Congress 2010 and delivered a lunchtime seminar. He also presented a poster on use of perioperative steroids during cardiac surgery in Mulago at the South African Society of Anaesthesia Congress Cape Town 2012, and has had a paper on recommendations for sepsis management in resource-poor settings accepted for publication in Intensive Care Medicine Jan 2012. He has also written an article for Anaesthesia News and established the Intensive Care Society in Uganda (www.intensivecareuganda.com).

Dr Daniel Obua
Graduated 2012

Dr Obua presented a poster that was presented at the Association of Paediatric Anaesthetists (APA) meeting in May 2009 (for which a special prize was awarded) and had a paper on provision of paediatric services in Uganda published in the WHO Bulletin 2010. He is currently employed at the Kampala International University Hospital.
Dr Andrew Kintu

Graduated 2012

Dr Kintu was sponsored by OAA to attend the OAA meeting in London 2012 and has had a poster on low dose syntocinon accepted for the World Congress 2012 (which he will attend after being awarded a Baxter Scholarship). He was appointed as GPAS senior scholar 2011.

Dr Joseph Kiwanuka

Will graduate 2013

Dr Kiwanuka has three posters accepted for World Congress 2012 being awarded a scholarship to attend by AAGBI: the barriers to improving maternal mortality in Mbarara, the introduction of monitoring and the WHO checklist to the obstetric unit in Mbarara, and the development of a Lay MEWS score in Mbarara.

Additional specialist training

As a result of other initiatives the Ugandan Fellowship trainees have been able to benefit from a number of specialist training courses.

i DAS airway workshop, June 2011

Trainees attended a one-week hands-on airway workshop organised by DAS at CoRSU Hospital in Uganda in June 2011.

ii ‘SAFE obstetric anaesthesia’ course, June 2011

Trainees Emma Ayebale, Lameck Ssemongere, Joseph Kiwanuka, Andrew Kintu, Mary Nabukenya, Sharon Mpumwire and Peter Agaba with Isabeau Walker and Stephen Ttendo at the SAFE obstetric anaesthesia training course in Mbarara 2011.

Twelve trainees attended the AAGBI ‘SAFE obstetric anaesthesia’ course in June 2011 and completed the Train the Trainers course. These trainees will be invited to take part as faculty in further SAFE courses in Uganda in 2012 as the programme rolls out across the country.

iii Cardiac anaesthesia training, July 2011

Emma Ayebale, Mary Nabukenya and Cephas Mijumbi in cardiac theatre, Mulago July 2011.

Trainees received hands-on clinical training during clinical visits to Mulago in July 2011 and February 2012 and also attended a hands-on workshop organised by Dr Paul Firth (Massachusetts General Hospital) in Mbarara in November 2011.

iv Outreach training

There is an active programme of training organised by visiting faculty from UCSF, and GPAS is organising outreach training for anaesthetic officers in Soroti District to support Millennium Development Goals (MDG) 4 and 5, with anaesthesia trainees from Mulago playing an active part in the training programme.

Future of the Uganda Fellowship programme

The plans are well in place to continue funding for this Anaesthesia Fellowship programme for trainees, in line with the wishes of the anaesthetists in Uganda to expand physician training in Uganda. Now it is successfully underway it is hoped to further encourage development of more Medical Officer posts in anaesthesia as the specialty grows nationally. With the growth of a critical mass of anaesthesia expertise countrywide, the patients will receive improved standards of care and the training of non-physician anaesthetic officers will be able to progress.

One of objects for which the Royal College of Anaesthetists was incorporated is to ‘further instruction and training in anaesthesia both in the United Kingdom and overseas’. The recent support of this particular Uganda Anaesthesia Fellowship programme, which has already established a track record of success, further promotes this. The government’s own UK global health policy “Health is Global” says that to keep the UK population healthy we must help keep the whole world healthy, and again this helps support that aim.

Acknowledgement

We are grateful to all those who have given their time and effort to develop the Uganda Fellowship programme and contributed to its ongoing success.

References

Clinical outcome data, comparative performance reports and revalidation
A department initiative

The revalidation process aims to ensure doctors focus on their professional development, keep up-to-date with current practice and maintain and improve their performance levels. The RCoA revalidation group, as part of the Academy of Medical Royal Colleges, is in the process of developing a framework of the core information that clinicians will be expected to present as part of their annual appraisal to prove that they are achieving these goals.¹

Quality outcomes in anaesthesia
One domain set out in this provisional framework is the ‘Review of practice: Evaluating the quality of your professional practice’. This includes evidence of audit, quality improvement and clinical outcomes data and, at an institutional level, ties nicely with the government’s goals set out in the ‘Transparency in Outcomes’ consultation. However, as alluded to in a recent RCoA Bulletin article,² there are a paucity of quality indicators in anaesthesia and a lack of consensus on how we should describe quality in our practice in order to provide outcome data. What is clear is that whatever clinical indicators are used they should be appropriately piloted, validated and be clearly benchmarked to allow comparison.

Proposed quality outcome measures
In an attempt to address the difficulty in measuring clinical performance in anaesthesia, we have developed a Post-Anaesthesia Care Unit (PACU) database which records defined quality outcome measures following anaesthesia. Parameters recorded include: worst pain score in recovery (0–10), lowest temperature, incidence of nausea, incidence of vomiting, the need for rescue anti-emetics and unexpected admission (to the ward if day surgery or to a critical care area if an in-patient). All theatre cases requiring an anaesthetist are entered into the database. The only current exceptions are: cataract surgery under regional block, cardioversions, paediatric cases and obstetric deliveries under regional block. Of approximately 1,000 cases per month in our trust, around 66% meet the criteria for inclusion.

A method for collecting and presenting outcome data
Outcome data are entered by PACU staff into a bespoke PACU module within our electronic theatre management system,³ collating it with patients’ theatre data including the operation type, names of surgeons and anaesthetists, key theatre time points, type of anaesthetic and pre-assessment or CPX data if performed. The quality outcome data are easily exported from the theatre management system to produce customised spreadsheets for analysis. Quality outcome reports are then produced for individual anaesthetists with departmental results for comparison. The departmental results included are the means and ranges for the whole department and also results for the individual’s appropriate peer group (e.g. trainee, staff grade, consultant). The reports are confidential, with no individual results identifiable to the department. An example of a report produced is shown in Figure 1. These reports allow the anaesthetist to evaluate the quality of their professional practice and, over time, to demonstrate improving or continuing performance levels; a key domain of the revalidation process.
Figure 1
Example of an individual’s quality outcomes in recovery report

Quality Indicators for Recovery

Report: Dr Average
Period: February to July 2011 (inclusive)

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Consultant: Dr Average</th>
<th>All Department</th>
<th>Consultants’ range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases (with recovery record)</td>
<td>145</td>
<td>Approx 3,800</td>
<td>119–244</td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>36.4</td>
<td>36.5</td>
<td>36.3–36.5</td>
</tr>
<tr>
<td>Range</td>
<td>35.3–37.6</td>
<td>34.6–37.6</td>
<td>34.6–37.6</td>
</tr>
<tr>
<td>% &lt;36°C</td>
<td>4.0</td>
<td>2.4</td>
<td>0.0–5.9</td>
</tr>
<tr>
<td>Pain (0–10)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.21</td>
<td>1.16</td>
<td>0.8–1.54</td>
</tr>
<tr>
<td>% score &gt;3</td>
<td>17.1</td>
<td>16.8</td>
<td>13.0–23.8</td>
</tr>
<tr>
<td>% score &gt;5</td>
<td>10.5</td>
<td>10.2</td>
<td>6.9–15.9</td>
</tr>
<tr>
<td>Nausea (%)</td>
<td>5.6</td>
<td>4.02</td>
<td>1.48–6.95</td>
</tr>
<tr>
<td>Vomiting (%)</td>
<td>0.6</td>
<td>0.97</td>
<td>0.0–2.76</td>
</tr>
<tr>
<td>Rescue antiemetic (%)</td>
<td>5.6</td>
<td>3.66</td>
<td>1.49–5.65</td>
</tr>
<tr>
<td>Unexpected admissions (%)</td>
<td>0.81</td>
<td>1.87</td>
<td>0.5–4.86</td>
</tr>
</tbody>
</table>

Figure 2
Change in departmental mean scores over time

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cases with recovery record</td>
<td>2,404</td>
<td>3,646</td>
<td>3,800</td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>36.4</td>
<td>36.5</td>
<td>36.5</td>
</tr>
<tr>
<td>% &lt;36°C</td>
<td>4.6</td>
<td>3.0*</td>
<td>2.4</td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.25</td>
<td>1.21</td>
<td>1.16</td>
</tr>
<tr>
<td>% score &gt;3</td>
<td>20.5</td>
<td>16.7*</td>
<td>16.8</td>
</tr>
<tr>
<td>% score &gt;5</td>
<td>14.3</td>
<td>10.64*</td>
<td>10.2</td>
</tr>
<tr>
<td>Nausea (%)</td>
<td>4.85</td>
<td>4.51</td>
<td>4.02</td>
</tr>
<tr>
<td>Vomiting (%)</td>
<td>1.3</td>
<td>0.88</td>
<td>0.97</td>
</tr>
<tr>
<td>Rescue antiemetic (%)</td>
<td>3.97</td>
<td>4.37</td>
<td>3.66</td>
</tr>
<tr>
<td>Unexpected admissions (%)</td>
<td>5.1</td>
<td>1.8*</td>
<td>1.87</td>
</tr>
</tbody>
</table>

Figures in bold represent an improvement in departmental mean.
*Represents statistical significance (p<0.05) compared to previous collection period.

Interesting preliminary results
Following a one-month pilot, data collection commenced in April 2010. The first individual outcome reports were distributed to all members of the department, containing data from April–July 2010. The process has since been repeated for the periods August 2010–January 2011 and February–July 2011 with close to 10,000 cases having now been analysed.

A finding of great interest has been the change in the outcome scores of the whole department over time (Figure 2). For a number of outcomes, comparative statistics have demonstrated a significant improvement in scores between collection periods. We must stress of course that this process was developed as a quality improvement exercise, enabling individual anaesthetists to evaluate and compare the quality of their performance, and not to statistically analyse the effects of distributing these data. Also, the improvement in departmental outcomes may be the combined effect of a number of other processes occurring simultaneously, for example ‘The Productive Operating Theatre’ programme. However, whatever the cause for the improving departmental performance, the net result has been improved patient outcomes and safety. There is also a clear cost saving for the trust resulting from a reduction in postoperative complications and, therefore, length of stay and a reduced number of unexpected admissions. This fits well with the current national drive on patient safety and cost savings, especially as the improvements in patients’ care have come at no additional cost, other than the authors’ time to produce the reports.
Potential difficulties and solutions

The idea of individual PACU outcome reports initially raised significant concerns within the consultant body. Individual anaesthetists were worried that their particular case mix would automatically result in poorer performance scores compared to a department average. Obvious examples included a higher incidence of PONV with more gynaecology cases. However, due to our department size and flexible working, close examination of consultant case mixes demonstrated a similar spread over a six-month period. For larger departments, it would of course be possible to generate outcome data by surgical specialty for greater detail and to overcome this problem. Additionally, for the purpose of revalidation, it is the individual’s performance over time that needs to be demonstrated, not relative performance within a department.

Whilst not presented here, it is possible to analyse our PACU outcome data in many other ways. For example, operations resulting in consistently high PACU pain scores can be identified allowing targeted education and training in an attempt to improve the service. We have used our data in this way to improve outcomes following day-case laparoscopic cholecystectomy.

Future work

In summary, the revalidation process will require anaesthetists to reflect on their professional practice, demonstrating improvement in performance based on defined clinical outcomes. We have described a simple method for distributing individual clinical performance reports using our existing electronic theatre management system, providing anaesthetists within our department the data with which to do this. Whether the production of individual comparative performance reports results in global improvement in patient care, as a result of reflective practice, remains to be proven. We are currently looking at potential trial designs in an attempt to answer this question.

References

3 Bluespier Theatre Manager (http://www.bluespier.com).

AN ANNOUNCEMENT

For more than ten years, the Mersey School of Anaesthesia has functioned as a charity by reason of its capital being held in a restricted Charitable Trust Fund by the Liverpool Heart and Chest Hospital (LHCH) NHS Foundation Trust. During this time, we have enjoyed an excellent relationship with the Trust and have always appreciated the help and guidance we have received from the Charitable Trust Fund Committee.

Also during this time, the MSA has been able to donate more than £450K in support of Research and Education most of which support has been of an anaesthetic texture.

For various reasons, partly to do with reorganisation of the Finance Department at the LHCH Trust and partly to do with reorganisation within the Mersey School, the best advice we have had is that the MSA should become a Charitable Company responsible directly to the Charity Commission and thus independent of the necessary constraints of the Trust.

Thus I am pleased to announce that the MSA Charity comes into existence on 1 April 2012.

Among other effects of the change will be that it will broaden our options as regards the dispensing of charitable donations. For instance, over the last six months we have become aware of the importance of the Lifebox Charity which, bound by the registered objectives of the LHCH Charitable Trust funds, we have been unable to support. It is expected that, as an independent charity with broader objectives, we will be able to contribute to such worthy causes.

Finally, I have no hesitation in broadcasting the fact that none of the many, consultants, staff grades and trainees, many from beyond the Mersey Deanery, who actively contribute to the Mersey School and its courses derives any personal financial income in return for their time, effort and commitment. That has been the case from the start and will certainly remain the case in the future. Further, in accord with the Charity Commission’s protocols and procedures, the audited accounts of the MSA Charity will be published annually such that any interested parties will be able to learn the details of our work.

I trust that the more than 5,000 alumni of the Mersey School who have passed our way in pursuit of success in the examinations appreciate what has been achieved by reason of their subscription to the school and its courses.

David Gray, MSA Director
Audit Recipe Book (3rd edition 2012)

Quality improvement in anaesthesia: making effective change

The Audit Recipe Book has provided a popular manual of audit topics for anaesthetists since the 1st edition in 2000. The strapline for the past two editions has read ‘a compendium for continuous quality improvement in anaesthesia’. The emphasis has been on the provision of audits focused mainly on measurement against defined process standards. Since the publication of the last Recipe Book, clinical audit, nationally, has demonstrated some very impressive achievements, such as the NAP3 and 4 audits,¹⁻² and the improvements in patient care driven by the data provided in the national hip fracture database and hip fracture perioperative network.³⁻⁴ However, at a local level, enthusiastic clinicians can be frustrated by audit when they realise that identifying less than optimal system performance may create the momentum for change, but may not be enough to alter the workings of a complex system, nor sustain initial improvements that may have been made. This new edition of the Recipe Book seeks to bridge the gap between audit and improvement, by providing anaesthetists with an introduction to the science of improvement⁵ and demonstrating some basic tools which can be used to drive positive patient-centred change. A number of anaesthetists and intensivists throughout the UK have now learned improvement methodology, often from participation in one of the national or regional patient safety programmes.⁶⁻⁸ We have therefore included a number of examples from practising clinicians illustrating how they have identified problems using audit methodology, and then applied simple improvement techniques to achieve change.

Anaesthesia has a long tradition of improving clinical safety and outcome by continuous critical examination of our practice. However, changing the increasingly complex clinical systems in which we work, and making those changes last, is a very difficult task. We need to combine our professional knowledge of what is the best evidence in practice with knowledge of how to improve, in order to deliver consistent care for the patients we treat in our hospitals. Improvement science takes into account that context is key in delivering best care; what works best for one patient population in one hospital, may not be relevant in another.⁹ Knowing what is the best care is not enough: we must ensure that delivery is effective.⁶⁻⁹ The NCEPOD reports¹⁰ provide ample evidence that delivery of evidenced-based care is at best inconsistent and at worst woefully inadequate.

Audit is recognised as the cornerstone of clinical governance, strengthened by acceptance of the value of systematic critical and objective examination of practice by clinicians and management alike. The quality of delivery of healthcare can be divided into three domains:¹¹

➤ Structure, e.g. how many emergency operating theatres are available 24 hours per day?
➤ Process, e.g. what percentage of the components of the ventilator bundle are delivered reliably
➤ Outcome, e.g. what is your hospital’s 30-day mortality for ruptured aortic aneurysm?

Much audit has been process based; many of the audits in the 2006 edition assess adherence to process measures. Although we still have this emphasis, we would urge anaesthetists undertaking a process-based audit always to consider the question: how will this improve care for my patients? The NHS White Paper ‘Equity and Excellence: Liberating the NHS’¹² demands a ‘relentless focus on clinical outcomes’. It states that ‘success will be measured, not through bureaucratic process targets, but against..."
results that really matter to patients.... such as survival rates’. Darzi’s NHS plan ‘High Quality Care for All’ describes the NHS as ‘safe, effective and personal’, and therefore audit should evaluate care against one of these three domains. These principles are also the central focus of the key Scottish Health Policy ‘The Quality Strategy’ which is currently being implemented by three Ambition Delivery Groups for Safe, Effective and Person-Centred Care. The Compendium is now in two sections. The first section is an updated version of the Audit Recipe Book. The second section includes some simple guides to basic improvement techniques, based mainly on the PDSA cycle developed by Associates in Improvement and taught by the Institute for Healthcare Improvement. Most of the UK safety and quality programmes such as the Safer Patients Initiative, the Lead in Patient Safety programme, the Scottish, Welsh and Southern safety programmes use this methodology, and therefore that is the one we have chosen to demonstrate. We do acknowledge that other techniques such as Lean and Six Sigma may be in use in some centres and familiar to some colleagues, but while we have referenced them there is not scope in the Recipe Book to provide an extensive discussion of different approaches. We have chosen to illustrate a few common topics with improvement projects undertaken by anaesthetists and illustrated with run charts and multiple PDSA cycles. Where appropriate, we have linked these examples with audits in the Recipe section. We chose not to change the whole format of this successful book, but to introduce the topic of improvement more gradually; maybe by the next edition audit and quality improvement will be so inexorably linked that both sections will seamlessly merge!

**What is clinical audit?**

Clinical audit has been variously defined over the years. This appears to be a well-accepted and relevant definition endorsed by the National Institute for Clinical Excellence (NICE) and others:

‘Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, process and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery’ (Figure 1).

---

**Figure 1**

The clinical audit cycle (from National Institute for Clinical Excellence; Principles for best practice in clinical audit; March 2002 (www.nice.org.uk/page.aspx?o=29058) (accessed 29 February 2012))

**Figure 2**

The NICE publication ‘Best Practice in Clinical Audit’\textsuperscript{18} clearly sets out the challenge to universally implement good quality audit and is worthwhile reading for those involved in audit on all levels. Essentially this involves an increased emphasis in the value of clinical audit, recognising that it is a key tool to changing practice and that it requires a supportive environment and use of appropriate methods. As we noted earlier, clinical audit, particularly, has had some marked successes in recent years. The NAP\textsuperscript{3} and \textit{4} audits\textsuperscript{1–2} have examined important areas of our clinical practice and highlighted areas for improvement. In surgery, following the Bristol Enquiry,\textsuperscript{19} the Society of Cardiothoracic Surgeons\textsuperscript{20} has relentlessly driven up standards by the publication of outcome results by hospital and individual surgeon, and identification and investigation of mortality that is higher than expected. This methodology has been applied to all operations undertaken since 2006 and has been associated with a more than 50\% improvement in risk-adjusted mortality. The improvement in outcomes has not only saved lives but reduced costs, and engendered a cultural change putting patients at the centre of care delivery. Creating a multidisciplinary link between surgery and anaesthesia, the interest in outcomes in emergency surgery has driven contribution to the emergency laparotomy network,\textsuperscript{21} publication of emergency laparotomy data from multiple centres and the funding of the first anaesthesia driven Healthcare Quality Improvement Partnership (HQIP) audit for emergency laparotomy.

\textbf{What is quality improvement and how does it differ from clinical audit?}

Quality improvement is a formal approach to the analysis of performance, and then the use of systematic efforts to improve it. Improvement comes from the application of knowledge and a thorough understanding of the system you are trying to improve. The Model for Improvement\textsuperscript{15–16} has five key points (Figure 2).

\begin{itemize}
  \item Knowing why or what you need to improve (audit will have provided this information).
  \item Having a feedback mechanism to identify if improvement has happened (closing the audit loop).
  \item Developing a change that will lead to improvement.
  \item Testing a change before implementation; this may lead to multiple cycles of further change.
  \item Knowing when you have an effective change that will lead to an improvement.
\end{itemize}

Doctors have not traditionally been taught how to achieve change; and techniques widely used in industry, based on the work of Deming from which the Model for Improvement and most other improvement techniques derive, have only recently been introduced into healthcare.\textsuperscript{22} The quality improvement section provides some examples of the successful use of this technique to drive change. It is important to remember, however, that improvement can result from learning from failure and so testing what works and learning what does not, are central to this methodology.

\textbf{Revalidation and quality improvement}

Revalidation will require evidence from all doctors about their quality improvement activity, which should be ‘robust, systematic and relevant to your work’. Quality improvement activity should contain an element of evaluation and action, and, where possible, demonstrate an outcome or change. The GMC\textsuperscript{23} suggests that quality improvement activity is wider than clinical audit and includes other measures such as review of clinical outcomes, case review or discussion, audit and monitoring of the effectiveness of teaching programmes and evaluation of the impact and effectiveness of a piece of health policy or management practice. We would hope that this new book will provide a tool for all of us undertaking revalidation to be able to link audit to improvement.

\textbf{Patient and relative participation}

Patient experience and patient-centred care\textsuperscript{51} should be cornerstones of the modern NHS and as such we would encourage the use of, and further development of, patient and family experience audits. The limitations and pitfalls associated with collection and interpretation of patient satisfaction data are increasingly recognised.\textsuperscript{25} Conversely, the high value of specific information relating to patient experience is also recognised and we would encourage the use of such data including PROMs (patient reported outcomes) in any service evaluation.\textsuperscript{25} We are grateful to representatives of the RCoA Patient Liaison Group who provide discussion of these aspects documented in this book. We would expect this to be of use in the execution of many of the included topics and in the future design of new audits.

\textbf{The future, and how far we have come!}

In the last introduction we stated: ‘the editors of the first edition had a vision that providing standard structured audits may facilitate regional or national audit initiatives... this has not yet happened at a national level to any great extent...’. Of course, since then Anaesthetic Audit has been very successful, providing excellent outcome data (NAP\textsuperscript{3}) and driving change such as the need for capnography in all areas where
patients are intubated (NAP4), and the urgent need for improved care for patients undergoing emergency surgery through the hip fracture database and emergency laparotomy network. Anaesthetists have also always been a major force in critical incident reporting and we would very much encourage continued reporting as part of audit and risk management. Whenever possible this should be done locally (to ensure learning within your own organisation) as well as to the national bodies supported by the Royal College of Anaesthetists. Developments in IT and electronic data management should be utilised to assist audit, especially outcome based audit. We would encourage all anaesthetists to use the methods in this book and the basic template to create their own topics or adapt topics to their own particular needs. If these are of general applicability we would also encourage you to submit them to us (auditrecipes@rcoa.ac.uk) for consideration in our next update, and will publish them on the website. The hip fracture database and emergency laparotomy network have demonstrated the power of audit and the use by large numbers of us of standardised data collection. We can now learn from comparisons of practice on a grand scale. We would encourage readers to consider other audits, which may be found in this book and which could be used on a large scale to create the same momentum for change in important areas of patient care, if enough data are collected. As a specialty with a proven track record in audit and patient safety our next major step will be to improve patient care by reducing variation in outcome.

We hope the 3rd edition of this Audit and Quality improvement Compendium will continue to be a useful reference source to specialist and trainee anaesthetists across the breadth of our specialty.

References
9. Woolf SH, Johnson RE. The break-even point. When medical advances are less important than improving the fidelity with which they are delivered. Ann Fam Med 2005;3:545–552.
As We Were

The constitution and laws of England are the glory and boast of the nation; they are considered perfect; yet each annual revolution ought to convince us of the fallacy of our preconceived notions. There are some points in our legal code which must be changed; there are stains on the statute book which must be washed out as repugnant to reason, to common sense, and at variance with the truths of physiology.

Have we not lately witnessed an example which proves the truth of the foregoing remarks? In the middle of the nineteenth century a case exists in which judgement is bound down by the shackles of gross ignorance, and the misguidance of superstition. When a woman is capitally convicted of a crime the penalty of which is ‘blood for blood,’ she is allowed to put her plea of pregnancy as a bar to execution. The spirit of the law which gives her the privilege of procrastinating her execution when she asserts pregnancy is full of humanity, since two lives are concerned, one of which is innocent; but unfortunately the mode of proving the truth of her plea is neither rational or just.

The recent trial of Mary Ann Hunt for murder at the central criminal court, before Mr. Baron Platt, points out the ignorance and injustice on this vital question which now exists on the statute book. The wretched woman, epileptic, and almost in a fainting state, was placed at the bar to receive sentence. In reply to the judge, she said, ‘I believe I am in a family way.’ The judge then remarked, ‘Let a jury of matrons be empanelled, to try whether the prisoner be quick with child or not.’

To play this farce, 12 matrons were selected and introduced to the learned judge, and in order to give the affair seemingly a more tragical character they were solemnly told that their duty was ‘to ascertain whether the prisoner standing at the bar was big with a quick child or not.’ To give this matron chance more importance they were duly sworn; the privilege was also given to them of having the assistance of a surgeon if they thought such aid necessary; they did not, however, avail themselves of it, having no doubt the fullest confidence in their own minds that such a step was quite useless, and that they were adequate to solve the question. Their verdict was that she was not. In order that no mistake might occur, the following remark was made by the judge, ‘You say that she is not quick with child – that she has not a living child within her? Their answer was that, ‘we are all of that opinion.’ The judge then says, ‘Let the prisoner be removed – the law must take its course.’

THE LAW MUST TAKE ITS COURSE! AWFUL DECISION! To hazard the life of an innocent helpless human being on the testimony of twelve ignorant women!

To ascertain the existence of pregnancy the greatest address and practical skill is required. Every obstetrician knows the greatest difficulty experienced in these enquiries; errors in diagnosis are frequently made by men of experience. The decision of such a question by a jury of matrons is too absurd to require any serious argument. Our legislators ought to expunge from the statute book that portion of the law ...

**********

PS The powerful efforts first made by the medical press, Lancet, and London Medical Gazette, especially the former, supported by an influential leading article in the Times newspaper, has had the effect of drawing the attention of the home secretary to the case of Mary Ann Hunt. He humanely exercised his executive power, and directed that her case be examined by three medical men, who pronounced her to be pregnant. The execution is therefore stayed. It is sincerely hoped that this case may be the last in which a jury of matrons will be empanelled.

(The sentence was commuted to transportation for life, but the law remained unchanged for another 40 years.)

Extracted from:

David Zuck
History of Anaesthesia Society

Congratulations to Dr David Zuck who was awarded the President’s Commendation on 14 March 2012 in recognition of his contribution to the Bulletin since 2002.

Dr Zuck has been a Fellow of the College since 1953.
Safe Anaesthesia Liaison Group

PATIENT SAFETY UPDATE

Including the summary of reported incidents relating to anaesthesia

1 OCTOBER 2011 TO 31 DECEMBER 2011

THIS DOCUMENT AIMS TO ACHIEVE THE FOLLOWING:

➤ Outline the data received, the severity of reported patient harm and the timing and source of reports.
➤ Provide feedback to reporters and encourage further reports.
➤ Provide vignettes for clinicians to use to support learning in their own Trusts.
➤ Provide expert comments on reported issues.
➤ Encourage staff to contact SALG in order to share their own learning on any of the incidents mentioned below.

MORBIDITY AND MORTALITY MEETINGS

The SALG Patient Safety Updates contain important learning from incidents reported to the National Reporting and Learning System (NRLS). The Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) would like to bring these Safety Updates to the attention of as many anaesthetists and their teams as possible. We would like to encourage you to add this Update to the agenda of your next morbidity and mortality (M&M) meeting and we would also like to hear your feedback on learning points.

Feedback from M&M meetings on how the Patient Safety Update has informed action can be sent to the SALG administrator at salg@rcoa.ac.uk.

SUMMARY

A total of 3,336 anaesthesia related incidents were reported during the specified time period. 58 incidents were reported using the anaesthetic eForm. 40% of these cases were reported as near miss (harm was prevented from reaching the patient). 53% of incidents reported via the eForm were reported to the National Patient Safety Agency (NPSA) within one day of occurrence (Figure 1).

3,278 incidents were reported using Local Risk Management Systems (LRMS). 18% of these cases were reported as near miss. 50% of incidents were reported via LRMS to the NPSA within 30 days of occurrence (Figure 1).

All incidents graded as death or severe were reviewed by the National Patient Safety Agency and, if identified as having potential cause for concern, were reviewed in turn by consultant anaesthetists from the RCoA or AAGBI. This review was carried out in accordance with the NPSA’s data sharing protocol (no information about the Trust is disclosed; only information about the incident). Most incidents were reported by consultant anaesthetists, but the eForm is available to all members of the perioperative team.

As with any voluntary reporting system, interpretation of data should be undertaken with caution as the data are subject to bias. Many incidents are not reported, and those that are reported may be incomplete having been reported immediately and before the patient outcome is known. Clarity of ‘degree of harm’ to patients who experience a patient safety incident is an important aspect of data quality.
ANAESTHETIC eFORM

The anaesthetic eForm was formally launched in England and Wales on 30 November 2009 and can be found at: https://www.eforms.npsa.nhs.uk/asbreport. There have been 913 completed reports submitted up to 31 December 2011. SALG has produced some top tips for use of the eForm which can be viewed on page 60 of this issue.

The NPSA will be closing in 2012 as a result of the Arm’s Length Bodies review in 2010. Responsibility for the NRLS will move to the NHS Commissioning Board. SALG would like to encourage you to continue to use the eForm (or your local reporting systems), and would like to reinforce the importance of continuing to report patient safety incidents during the transition period so that trends and incidents can be acted upon and learning maximised. The eForm is particularly useful as it was designed to allow specific clinical information relating to anaesthetic incidents to be reported by anaesthetists and other members of the anaesthetic team. It provides a mechanism by which high quality information can be rapidly reported and disseminated nationally.

TIMELINESS OF REPORTING

Figure 1 shows the time taken to report incidents via the anaesthetic eForm (directly received into the NRLS) and via LRMS (uploaded to the NRLS periodically via local systems) during the period 1 October 2011 to 31 December 2011.

Figure 1
Reporting timeliness of anaesthetic incidents

![Graph showing reporting timeliness of anaesthetic incidents](image)

DEGREE OF HARM (ACTUAL INCIDENTS)

Figure 2 shows the degree of harm incurred by patients within the anaesthetic specialty during the period 1 October 2011 to 31 December 2011. Twelve deaths were reported though LRMS and three via the anaesthetic eForm.

Figure 2
Reported degree of harm

![Graph showing degree of harm](image)
Figure 3 shows the type of incidents that occurred within the anaesthetic specialty that were reported using LRMS or the anaesthetic eForm for the period 1 October 2011 to 31 December 2011. The categories were determined at local level.

Figure 3
Type of incident reported

SUMMARISED EXAMPLES OF REPORTED INCIDENTS FROM ALL CATEGORIES

Cemented joints
- 85-year-old lady with fractured neck of femur having hemiarthroplasty. Seven minutes after the cement went in she suffered a cardiovascular collapse (resuscitation unsuccessful). I did not know it was a cemented joint. No discussion about patient risk factors preoperatively... (Orthopaedic) consultant not present at the time out.
- Patient (ASA 3–4) undergoing revision of knee replacement for periprosthetic fracture. Cardiac arrest during cementing of femoral component.
- 95-year-old patient undergoing emergency right hip hemiarthroplasty under general anaesthesia... sudden cardiopulmonary collapse about 2 minutes after applying cement (resuscitation unsuccessful). Management of case appropriate... third such case we have had recently.
- 90-year-old lady (ASA 3) undergoing emergency hip hemiarthroplasty under GA and nerve blocks had a cardiac arrest 2–3 minutes after cementing. Very hypotensive, bradycardic and cyanosed. IV glycopyrrolate given, ventilated with 100% oxygen... remained bradycardic, atropine given... CPR started but stopped after 20 minutes.

Cardiovascular collapse during surgery for hip arthroplasty is well-recognised, possibly due to venous embolism of fat or marrow contents during instrumentation of the femoral canal or cement insertion. Bone Cement Implantation Syndrome (BCIS) has been reviewed in the British Journal of Anaesthesia [http://bja.oxfordjournals.org/content/102/1/12.full.pdf+html]. Risk factors for severe reaction include older age, significant co-morbidities, impaired cardiopulmonary function, bony metastases, osteoporosis or pathological or intertrochanteric hip fracture and hypotension prior to insertion of bone cement.
The NPSA issued a Rapid Response Report (RRR) (www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59867&p=2) in March 2009 which provided advice on how to mitigate the risk of BCIS. Surgeons and anaesthetists are advised to identify patients who are at risk preoperatively and choose the appropriate technique; anaesthetists should maintain normovolaemia throughout and maintain vigilance during instrumentation; surgeons should conduct pressurised lavage of the femoral canal, consider a suction catheter to reduce the pressure in the intramedullary canal, use a cement gun and communicate with the anaesthetist when cement is to be inserted.

Recent NICE guidance on the management of hip fracture in adults (www.nice.org.uk/nicemedia/live/13489/54918/54918.pdf) suggests that cemented rather than uncemented implants should be used in patients undergoing arthroplasty. There was no clinical evidence of benefit from uncemented arthroplasty and no randomised controlled trials evidence that raised concerns about safety in the use of cement.


Clinicians are asked to continue to report every incidence of perioperative harm or patient death after total hip replacement and hemiarthroplasty to the NPSA and Medicines and Healthcare Products Regulatory Agency (MHRA), stating use of cemented or uncemented prosthesis, to review local guidelines against best practice, and to submit data to the National Hip Fracture Database (www.nhfd.co.uk/).

**It’s how you do the checks that matters**

- Wrong patient details entered on emergency list booking form; correct patient was in adjacent bed. Problem identified at anaesthetic pre-op assessment so correct patient was seen without additional delay.
- Wrong patient brought to anaesthetic room and, despite check-in procedure, patient anaesthetised. Patient kept asleep and transferred to appropriate theatre for correct surgery by the correct surgeon...
- 2-year-old dental patient… looked distressed and was making loud obstructive noises… recovered satisfactorily for transport to the ward. Child suddenly in marked respiratory distress with severe sternal recession, tracheal tug and started to retch. A green theatre swab was in his mouth and was occluding the airway. This was extracted by the staff nurse immediately...
- Patient undergoing oral surgery had throat pack. Incorrect procedure used, resulting in failure to remove throat pack before extubation… (no harm).

Human error will always occur and a culture of routine checks by anaesthetists contributes greatly to safe patient care. The WHO checklist was mandated by the NPSA in 2009, and the NPSA issued a Safer Practice Notice (www.nrls.npsa.nhs.uk/resources/?entryid45=59853&q=0%C2) in April 2009 that recommended throat packs be included as part of the swab count and the ‘sign out’ of the WHO checklist.

Surgical checklists have been shown to reduce mortality and morbidity (www.ncbi.nlm.nih.gov/pubmed/22123159) in many different settings. The benefit of checklists depends crucially on checklist compliance, but, clearly, effective checks are not always carried out.

These incidents should prompt us to consider the safety culture in our own theatres and how this contributes to compliance with mandatory safety checks. The Manchester Patient Safety Framework (MaPSaF) (www.nrls.npsa.nhs.uk/resources/patient-safety-topics/human-factors-patient-safety-culture/?entryid45=59796&p=1) is a useful tool to help teams to assess their safety culture and has been developed by the NPSA in association with the University of Manchester.
Equipment problems
➤ A box of Sprotte Surety needles (non-Luer lock) had been incorrectly distributed to... obstetric theatre. One of these needles was used to perform a spinal anaesthetic for elective caesarean section. It was only when CSF was obtained that the non-Luer connector was identified... the procedure had to be repeated as there were no syringes available that would connect to the non-Luer connector.
➤ Braun epidural catheter markings different from Portex epidural catheter markings leading to confusion and risk of inadvertently leaving too much or too little of catheter length in epidural space...
➤ Obese patient... intubation unexpectedly difficult... McCoy laryngoscope requested. The blade was single use, did not fit the handle in the box, or any other available handle. An LMA was inserted... (anaesthesia uneventful).
➤ Patient vomited on induction, turned on side, attempted to put bed head down but the bed wouldn’t work, not charged and wouldn’t work until it was plugged in... delayed treatment.

The introduction of new equipment into clinical practice to improve patient safety (or reduce cost) may have unintended consequences. The NPSA issued an RRR to alert clinicians to the risk of mismatching spinal, epidural and regional devices (www.nrls.npsa.nhs.uk/resources/?entryid45=132897). Manufacturers have been alerted and requested to improve packaging design, but clinicians are advised to specifically check that they have compatible needles and syringes when performing spinal anaesthesia.

The AAGBI has published a safety guideline ‘Safe Management of Anaesthetic Equipment’ (www.aagbi.org/sites/default/files/safe_management_2009_0.pdf). More than half the adverse incidents reported to the MHRA do not result from an identifiable equipment fault but are due to ‘user error’. Each department should have an equipment officer who works in close liaison with the procurement officer, particularly when new equipment is purchased. All anaesthetists must be trained and understand the complexities of the equipment that they use.

Anaphylaxis – unusual reactions, unusual presentations, timing of antibiotics
➤ Skin cleaned with 2% chlorhexidine (for CVC insertion). Uncomplicated first pass of CVC with ultrasound guidance. Subsequent sudden desaturation and severe hypotension (no loss of pulse). Wheeze and rash noted. Responded to IV adrenaline. Likely anaphylaxis to chlorhexidine.
➤Shortly after routine induction of anaesthesia using propofol, remifentanil and atracurium developed rash, hypotension and hypoxia. Suspected anaphylaxis to atracurium. Responded well to IM adrenaline, fluids, steroids and antihistamines. Surgery abandoned.
➤ IV access established for elective caesarean section. Patient was given co-amoxiclav for surgical prophylaxis... developed acute hypotension, rash and difficulty with respiration. Resuscitation of the mother hampered by a term pregnancy... neonate possible severe impairment.

Anaphylactic reactions are uncommon and are most frequently due to neuromuscular blocking agents. Reactions to chlorhexidine are being reported more often in recent years, and the MHRA has published a Drug Safety Update (www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON140701) highlighting this.

The AAGBI published a safety guideline ‘Suspected anaphylactic reactions associated with anaesthesia’ (www.aagbi.org/sites/default/files/anaphylaxis_2009.pdf), which recommends that all departments should identify a lead anaesthetist for anaesthetic anaphylaxis, with agreed referral pathways for investigation in a specialist centre (see here: www.aagbi.org/safety/allergies-and-anaphylaxis for a list of allergy centres).

Reactions should be reported to the MHRA via the Yellow Card System (www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Reportingsuspectedadversedrugreactions/index.htm). The timing of antibiotic prophylaxis in caesarean section is controversial.
Always read the label
➤ Category 1 caesarean section (22.00)... anaesthesia by ‘topping up’ the epidural. I asked the anaesthetic nurse to prepare sodium thiopental and suxamethonium should there be an urgent need to convert. ...the epidural was working well... picked up a syringe of sodium thiopental 500 mg I mistakenly believed to be 1.2 g of co-amoxiclav... confirmed that the patient had no known drug allergies and administered 500 mg of sodium thiopental... patient unconscious... anaesthetic nurse asked me where the sodium thiopental was and I realised I had administered it to the patient. I announced to everyone in theatre that I had mistakenly administered a general anaesthetic... cricoid pressure, 100% oxygen, suxamethonium, patient intubated. Rest of the operation was uneventful (baby admitted to NICU).
➤ Wrong order for the administration of anaesthetic resulted in the patient being conscious at the beginning of intubation prior to appendectomy... risk of significant psychological impact...
➤ Patient came to theatre for an LSCS because of failure to progress (01.00)... had an epidural catheter in situ which was used to anaesthetise. Doctor... began giving the patient some oxygen... shouting for a tube... Doctor had administered thiopentone instead of antibiotic.

Drug errors are amongst the patient safety errors most frequently reported to the NPSA and remain a serious cause of harm to patients. There are numerous reasons why drug errors occur in anaesthesia, particularly when the anaesthetist is tired, stressed or distracted.

The NPSA, RCoA and AAGBI have undertaken a feasibility study of confirming drugs administered during anaesthesia (www.nrls.npsa.nhs.uk/resources/clinical-specialty/anaesthesia/?entryid45=59845&p=2), either by double-checking or by new technology involving bar-coding. Both methods are effective but have advantages and disadvantages. Anaesthetists should give serious consideration to implementing methods of confirming the drugs administered during anaesthesia.

Open and honest communication is at the heart of healthcare. Once a drug error has occurred it is essential that the team work together to mitigate the harm to the patient – the first report gives an excellent account of such teamwork.

Discussing errors with patients and their families can be very challenging, but research has shown that being open when things go wrong can help patients and staff cope better with the after-effects of a patient safety incident. The NPSA has published a best practice guide ‘Being open: communicating patient safety incidents with patients, their families and carers’ (www.nrls.npsa.nhs.uk/resources/?entryid45=65077).

Using drugs requiring low temperature storage
The issue of refrigerated drugs has been raised via the SALG safety network. A patient safety incident occurred after rocuronium was given and failed to take effect. A patient coughed during intubation but was unharmed. It was not known for how long the rocuronium had been at room temperature prior to being drawn up. This serves as a reminder that drugs requiring storage at low temperatures may not work as expected if they are not stored appropriately. Do not use these drugs if you are in any doubt as to how long they have been unrefrigerated, and be aware of the manufacturer’s instructions for storage and your local drug refrigeration policy.

Patient Safety Conference 2012, Glasgow
The SALG Patient Safety Conference 2012 will be held on Tuesday, 23 October 2012 in Glasgow at the Royal College of Physicians and Surgeons. Please save the date and look out for the programme.
The anaesthetic eForm is a tool for reporting patient safety incidents and near misses that occur in the anaesthetic pathway. It provides an enhanced dataset for anaesthesia and a rapid mechanism for learning via the Safe Anaesthesia Liaison Group (SALG). All reports received by SALG are completely anonymised. The eForm is available for use in England and Wales.

1 CLICK THIS LINK FROM ANY COMPUTER
You can access the eForm from any computer or Smartphone from https://www.eforms.npsa.nhs.uk/asbreport/. You don't need any software, just click and go.

2 DON'T FORGET TO SAVE A LOCAL COPY
You can either print or save a copy of your submission by following the instructions given when you've completed the form. This gives you the opportunity to use the data for local learning.

3 MAKE FRIENDS WITH YOUR RISK MANAGER
Let your risk manager know that you will be using the eForm. Your eForm submissions will be viewable in their usual NPSA portal by clicking the eForm tab.

4 BE CONFIDENT THAT YOUR REPORT WILL BE WITH YOUR RISK MANAGER INSTANTLY
Reports submitted via the eForm reach your risk manager in real time. As soon as you submit, the report reaches both the Trust’s local portal and the national database (NRLS).

5 LET IT ALL OUT
The eForm has been designed to capture the anaesthesia specific details that other forms will not. There is plenty of space for free text so you don’t need to hold anything back. If you are in doubt as to whether any aspect of your incident is important, please include it. A detailed understanding of the incident will ensure optimum learning locally and nationally.

6 FAMILIARISE YOURSELF WITH GRADES OF HARM
If you are unsure about the grading of harm that applies to your incident you will find the help box next to the grading field on the eForm helpful. It gives definitions from page 100 of the publication ‘Seven Steps to Patient Safety’ (http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787) and some examples.

7 LOOK OUT FOR YOUR REPORT IN THE PATIENT SAFETY UPDATE
All reports submitted to the eForm are anonymised. They are then read by a consultant anaesthetist and accounted for in the quarterly Patient Safety Update (www.rcoa.ac.uk/node/2992). Deaths and severe incidents submitted using this tool are read by clinical reviewers and shared, where appropriate, with a consultant anaesthetist on a weekly basis. Look out for the Update and see where your report fits in to the national picture.

8 REMEMBER TO REPORT
Reporting critical incidents and near misses is imperative to the advance of patient safety in our specialty. Please remember to report.
The College launches new online services

The College is currently piloting a webcasting platform to supplement our growing online educational resources. This new technology, provided by market leader, Mediasite, will enable users to access a broader range of the College’s excellent educational programme by providing open and free access to selected educational meetings, events and lectures online. It is hoped that these taster sessions will also ease time and financial constraints that may restrict doctors’ ability to attend events in person. The initiative will additionally present users with the opportunity to gain critical CPD credits and help support revalidation.

Secure area access
For confidential material, there is a secure area that can be accessed by authorised members belonging to such groups as the Clinical Directors, College Tutors, Regional Advisers and Examiners. If you are a member of any of these groups, you will be emailed login details directly. All webcasts are available via the College’s website.

User-friendly system
The user-friendly system offers an intuitive interface with simple navigational tools, as well as flexible viewing options, which allow you to switch the size and position of the slides and presenter on screen (Figure 1). It is compatible with both Macs and PCs (and shortly, smart phones), though you will be prompted to download a simple and free piece of software from Microsoft called Silverlight. An alternative, standard viewing option is currently provided if you are unable to download this software.

Internet connection
It is also worth noting that the webcasts are being streamed, requiring a sound internet connection, so if you intend to access material at work, you should contact your local IT administrator, as it is likely that some hospitals will block the site. The College will work with hospital IT Departments to help alleviate this problem.

Material available now
A number of presentations from ‘A Career in Anaesthesia’ and ‘Current Concepts Symposium’ are now freely available to be viewed by visiting the College’s website. The Clinical Directors and Regional Advisers Meetings are also available in the confidential area.

Future plans
Clearly, we are at the start of this initiative, but the technology will also support greater functionality, such as interactive and live streaming. For example, users may be able to log into a live presentation from the comfort of their own home or workplace, as well as be able to submit questions to the presenter and share a presentation with others, by sending a link from a particular point of interest or the whole presentation.

If you have any comments or feedback on the webcasts, we would like to hear from you, please email webcast@rcoa.ac.uk.
Small Grants and Awards

RCOA SMALL GRANTS
The National Institute of Academic Anaesthesia has several small grants funded by the Royal College of Anaesthetists for the purpose of supporting research, education or travel connected with the study of anaesthesia. Priority will be given to educational projects, the presentation of original work or the provision of education to developing countries.

Applications are invited for the following funds:

Ernest Leech Research Fund
This fund was established in June 2011 to be utilised for the purposes of research.
Value up to £2,500

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

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

Eligibility
All Fellows in good standing and registered trainees are eligible to apply for the above grants. We regret that applications for funding towards registration for higher degrees or College course fees will not be considered.

To apply
Please visit https://rayzume.com/NIAA/article.php?newsid=89 to view the assessment criteria and download a copy of the application form. The deadline for applications is Friday, 3 August 2012.

Payne Stafford Tan Award
An Award for Clinical Excellence
This award was originally established through the generosity of an American friend of the College, Mr Norman Knight. The aim of the prize is to mark excellence in clinical practice, teaching or research in anaesthesia, critical care or pain management.
The award is open to any Fellow or Member of the College, and comprises a grant (to a maximum of £1,000) to be used for educational purposes such as attendance at a major conference or the purchase of educational materials. The recipient will be expected to provide a short report outlining how the funds have been used.

To apply
Nominations are now invited for the 2012 award, and must be made by a Fellow or Member of the College on behalf of another. The nomination should be in the form of a letter outlining the particular merits of the individual nominated, and should be accompanied by a full curriculum vitae for that individual. Nominations should be sent to the NIAA Administrator at the address below by Friday, 3 August 2012.

Macintosh Professorships
The College has established a number of initiatives to foster research in anaesthesia, critical care and pain management. The aim is to encourage researchers to expand their horizons beyond normal clinical activities.

Important among these are the Macintosh Professorships. The purpose of these Macintosh Professorships is to encourage the presentation and dissemination of high quality research in clinical topics or basic science subjects allied to anaesthesia, critical care and pain management.
The Macintosh Professorships are awarded for one year (normally the College academic year). The Professors are required, within that time or soon after, to give a lecture on the subject of their research, either at the College, or at another suitable venue, in the presence of an audience including College officers and Council members. Such a lecture can be given at a major College meeting or as part of the proceedings of another relevant organisation or specialist society. The lecture is commemorated by the presentation of an illuminated certificate.

Applications for Macintosh Professorships are open to Fellows and Members of the Royal College of Anaesthetists, together with clinicians and clinical scientists involved in anaesthesia, critical care and pain management within the United Kingdom. Applications will be considered by a panel nominated by Council, and including members of Council and expert external advisers.
The award of a Macintosh Professorship does not carry with it any financial grant towards the cost of the research and this funding has to be obtained from external sources.

To apply
Please submit a synopsis of your proposed lecture, along with a CV and covering letter by email and post to the NIAA Administrator at the address below by Friday, 3 August 2012.

Maurice P Hudson Prize
Dr Maurice Hudson was a consultant anaesthetist in London, took the DA
in 1936, was awarded the FFARCS in 1948 and had a particular interest in dental anaesthesia. The Hudson Harness was one of his innovations. The late Dr Maurice Hudson’s daughter generously donated money to the College in memory of her father for an annual prize for the best paper on his favourite subject: resuscitation. The criteria for this prize have now been extended and the prize will be awarded to the anaesthetic or intensive care trainee who is the principal author of the best paper relating to the management of acutely ill patients published, or accepted for publication, in a peer reviewed journal.

To apply
If you are such a trainee, would like to apply for the prize and have published such an article since 1 August 2011, please submit your article with a copy of your CV and a covering letter to the NIAA Administrator at the address below by Friday, 3 August 2012. A prize of £500 is available this year.

Full details can be found on the NIAA website at: www.niaa.org.uk/article.php?newsid=131 and the deadline for applications is Friday, 3 August 2012.

Applications for all of the above grants, awards and prizes should be sent to:

Miss Clare Bunnell
NIAA Administrator
The Royal College of Anaesthetists
35 Red Lion Square
London WC1R 4SG
cbunnell@rcoa.ac.uk

The Faculty of Intensive Care Medicine

Election to Faculty of Intensive Care Medicine Board 2012

Details of elections to the Board of the Faculty of Intensive Care Medicine are now available on the FICM website. Fellows eligible to stand for election will be sent via the post a letter and Form of Notice of Intention to stand and Form of Nomination on 20 April 2012. All papers will be sent to the address our Fellows have registered with the Faculty. Completed forms must be received by the FICM Secretariat no later than 5.00 pm on 17 May 2012. Any forms received after this date will not be accepted. The names of the candidates and whom they have been nominated by will be published on the FICM website on 21 May 2012. Ballot papers will be sent by post by 28 May 2012 to the address registered with the Faculty. Ballot papers must be returned to the Faculty by 5.00 pm on 21 June 2012 and the election results will be declared as soon as possible after the election on 29 June 2012 via the Faculty website and will be published in Critical Eye in due course.

www.ficm.ac.uk

CORRECTION
Page 24, Bulletin 72, March 2012
Mr Andrew Lansley was the Health Secretary who issued the White Paper, not Mr Andy Burnham.
Report of Council

At a meeting of Council on Wednesday, 8 February 2012, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

Regional Advisers

North Thames West
To note that Dr M Hayes, Chelsea Westminster Hospital will act as Regional Adviser until a successor is found for Dr P Brodrick

West Midlands South
*Dr J James, Birmingham Heartlands Hospital

Deputy Regional Advisers

North Thames West
Dr S Jaggar, Royal Brompton Hospital (in succession to Dr M Hayes)
*Dr R Bacon, St Mary’s Hospital

College Tutors

Oxford
Dr M W Speirs, Oxford Radcliffe Hospitals NHS Trust (in succession to Dr C Grange)

West Yorkshire
*Dr J Burns, Airedale Hospital

North Thames West
Dr A Prabhu, Central Middlesex Hospital (in succession to Dr A Wijetunig)

Mersey
Dr N Zafar, Macclesfield Hospital (in succession to Dr D Banks)

Kent, Surrey, Sussex
Dr N C Forder, Eastbourne District General Hospital (in succession to Dr S Walton)

Head of School
Dr Peter Brodrick, Head of London Academy (in succession to Dr R Ginsburg)

Dr S-A Phillips, Head of School for Northern Ireland (in succession to Dr Clive Stanley)

Council noted the following 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.

South East
Dr Nelun Wijayasinghe
Dr Barry Mark Featherstone
Dr Jonathan Adrian Short
Dr Samuel George Hillyard
Dr Rajib Dutta

North Central
Dr Simon Dun Shin Liu
Dr Suresh Babu Loganathan
Dr Simeon Jon West

Barts and The London
Dr Stephen Robert James

Leicester
Dr Daniel Huw Rhys O’Neil *

Nottingham
Dr Mark Barley

Mersey
Dr Alison Margaret Hall *
Dr Sandra Kay Lawrence

North West
Dr Catherine Heidi Doherty

Northern
Dr Sian Helen Davies
Dr David James Pritchard
Dr Alistair William Cain
Dr Patrick Shiuin Jye Chiam

Oxford
Dr Anwar Kandarumadathil Rashid
Dr Justin Craigie Mandeville *
Dr Christopher James George Green

Severn/Bristol
Dr Edward Ewart Bick
Dr Tobias Christohper Everett

South West Peninsula
Dr Fiona Hilary Martin
Dr Shahed Kaleem Kim Chishti

Stoke
Dr Michael William Greenway
Dr Martyn Peter Traves
Dr Lloyd Robert Craker
Dr Gaurav Kakkar
Dr Abir Doger
Dr James Fulton Neil

South East Scotland
Dr Tarkeshwari Mane
Dr Emma Lynette Anderson

North Scotland
Dr Michelle Lamont

West Scotland
Dr Malcolm Archibald Broom

East Scotland
Dr Stephanie Marie Sim

West Yorkshire (Leeds/Bradford)
Dr Vanida Kathryn Na Ranong
Dr Neil James Allan *
Dr Matthew Philip Simpson
Dr Stephen John Hill

East Yorkshire (Hull/York)
Dr Sayed Tarique Kazi *

*Joint CCTs in Anaesthesia and ICM

At a meeting of Council on Tuesday, 13 March 2012, Dr J A Langton, Dr J R Colvin and Dr N W Penfold were admitted as Consultant Members of Council following the recent election. Dr V R Alladi was admitted as a Staff and Associate Specialist Member of Council and Dr S Gulati was admitted as a Trainee Member of Council following the recent election. Dr R Bill (Belfast), Dr A Brodbeck (Norfolk), Dr M Chugh (Derry), Dr O S Kehinde (Liverpool), Dr G Kunst (London), Dr J Russell (Belfast) and Dr D Watson (Warwickshire) were all admitted to the Fellowship ad eundem.
New members of Council (from left to right)
Dr S Gulati, Dr N W Penfold, Dr J A Langton,
President, Professor D J Rowbotham,
Dr V R Alladi and Dr J R Colvin.

Fellows ad eundem (from left to right)
Dr D Watson, Dr M Chugh, Dr A Brodbeck,
President, Dr J Russell, Dr K Bill, Dr O S Kehinde
and Dr G Kunst.

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

Regional Advisers

**North West**
Dr I Geraghty, Salford Royal NHS
Foundation Trust

**Deputy Regional Advisers**

**Northern Ireland**
*Dr S-A Phillips, Royal Group of
Hospitals (in succession to Dr D Lowery)

**North West**
*Dr I Brocklehurst, Royal Oldham
Hospital

**West of Scotland**
*Dr M Smith, Royal Alexandra
Hospital

**College Tutors**

**North Thames Central**
Dr J W Holding, University College
Hospital (in succession to Dr M V
Chapman)
Dr J H Smith, Great Ormond Street
Hospital (in succession to Dr D G
Williams)
Dr M S Sodhi, Chase Farm Hospital (in
succession to Dr N J Hogg)

Dr O W Boomers, Lister Hospital (in
succession to Dr S J Eckersall)

**Mersey**
*Dr K E Brodbelt, Wirral Hospitals

**West of Scotland**
Dr M L Haetzman, Wishaw General
Hospital (in succession to Dr A M
Simpson)

**Leicester and South Trent**
Dr S Panjwani, Pilgrim Hospital (in
succession to Dr M W Butt)

**West Midlands North**
Dr S B Gummaraju, Robert Jones and
Agnes Hunt Orthopaedic Hospital (in
succession to Dr J C John)

**Head of School**
Dr P Davies, Head of School for South
West Peninsula (in succession to Dr J
Saddler)

Council noted the following
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.

**South East**
Dr Vivek Kakar *

**North Central**
Dr Davina Jane Ross-Anderson

**Imperial**
Dr Atika Sabharwal
Dr Alexander Sell

**St George’s**
Dr Kanchan Patil
Dr Thomas Rawlings
Dr Joanthan Mayer
Dr Ashok Raj *

**Kent, Surrey, Sussex**
Dr David Bacon

**North West**
Dr Alison Hool
Dr Ravnita Sharma

**Northern**
Dr Sarah Platt *

**Northern Ireland**
Dr David Hendron *
Dr John Hinds *
Dr Gail Browne *

**Oxford**
Dr Laurence Hullat
Dr Manish Bhardwaj
Dr Karunakaran Rameswamy
Dr Vivek Vishwanath Sharma

**Wales**
Dr Anna Jolly
Dr Elizabeth Boucher
Dr Rebecca Jones

**North Scotland**
Dr Neil Iain Stewart *

**West Scotland**
Dr Alistair Meikle *
Dr James Maybin
Dr Lee Michael Riddell

**West Yorkshire (Leeds/Bradford)**
Dr Elizabeth Marshall
Dr Mark Mifsud
Dr Kathryn Howie
Dr Josephine Sarah Stewart

**South Yorkshire (Sheffield)**
Dr Anu Sara Philips

*Joint CCTs in Anaesthesia and ICM
Deaths

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

Dr Kenneth J Covell, Taunton
Dr Paul E F Leyden, County Antrim

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.

Apptointment of Fellows to consultant posts

The College congratulates the following Fellows on their consultant appointments:

Dr A D Ashworth, Wythenshawe Hospital, Manchester
Dr M R Baruch, Royal Victoria Infirmary, Newcastle
Dr L R Craker, University Hospital of North Staffordshire, Stoke-on-Trent
Dr L Edger, North West London NHS Trust
Dr B Featherstone, William Harvey Hospital, Kent
Dr S K Fisher, St Helens and Knowsley NHS Trust
Dr A Ghazi, Barts Health NHS Trust
Dr A S Jeffrey, St John’s Hospital, West Lothian
Dr A M Knights, Ysbyty Gwynedd (Gwynedd Hospital), Bangor
Dr A Kotecha, Chelsea and Westminster Hospital, London
Dr V Kumar, Scunthorpe General Hospital
Dr N Ladak, Sheffield Children’s Hospital

Apptointment of Members, Associate Members and Associate Fellows

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

Associate Fellows
February 2012
Dr Arif Hussain Ghazi
Dr Shiv Kumar Gurung
Dr Malarvizhi Mani
Dr Peter Merjavy

Members
February 2012
Dr Radha Venkatesan
Dr Mohammad Taskinur Rehman Hazarika

Associate Members
February 2012
Dr Fadil Saab Wabil Bilal
Dr Kiran Bangalore Srinvasan

Affiliate – Veterinary Practice
February 2012
Ms Ambra Panti

BULLETIN ADVERTISING

The RCoA 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. 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
CPD study days: general topics
**22–23 May 2012 (code: B54)**
RCoA, London
Registration fee: £395 (£295 for RCoA registered trainees and affiliates)

Introduction to leadership and management for anaesthetists: the essentials
**24–25 May 2012 (code: B56)**
RCoA, London
Registration fee: £395

Ethics and the law
Joint meeting with The Society of Ethics and Law in Medicine
**11 June 2012 (code: D19)**
RCoA, London
Registration fee: £205 (£155 for RCoA registered trainees and affiliates)

College Tutors’ meeting
**13–14 June 2012**
St George’s, Bristol
By invitation only

Joint intensive care symposium
Joint meeting with the Intensive Care Society and the Faculty of Intensive Care Medicine
**14–15 June 2012 (code: C55)**
RCoA, London
Registration fee: £425 (£320 for RCoA registered trainees and affiliates)

Recent advances in anaesthesia, critical care and pain management
**19–21 June 2012 (code: A32)**
Surgeons’ Hall, RCS of Edinburgh
Registration fee: £470

Airway workshop
**20 June 2012 (code: C81)**
RCoA, London
Registration fee: £250 (£190 for RCoA registered trainees and affiliates)

Anaesthetists as educators: an introduction
**20 June 2012 (code: C18)**
RCoA, London
Registration fee: £210 (£160 for RCoA registered trainees and affiliates)

Research methodology workshop
**20 June 2012 (code: C85)**
Aberdeen Exhibition and Conference Centre, Scotland
Registration fee: £140

Returning to work: how to succeed
**21 June 2012 (code: D08)**
RCoA, London
Registration fee: £150 (£125 for RCoA registered trainees and affiliates)

Final FRCA course
**2–6 July 2012 (code: A79)**
RCoA, London
Registration fee: £360

Becoming a consultant
Joint meeting with the AAGBI
**20 July 2012 (code: B14)**
RCoA, London
Registration fee: £210 (£160 for RCoA registered trainees and affiliates)

Leadership and management for anaesthetists: personal effectiveness
**2 October 2012**
RCoA, London
Registration fee: £215

CPD study day
**3 October 2012 (code: C97)**
Waterfront Hall, Belfast
Registration fee: £195 (£150 for RCoA registered trainees and affiliates)

Current concepts symposium
**1–2 November 2012 (code: B05)**
RCoA, London
Registration fee: £435 (£325 for RCoA registered trainees and affiliates)

Continuing professional development day (formerly known as CME day)
**3 November 2012 (code: A76)**
RCoA, London
Registration fee: £235 (£175 for RCoA registered trainees and affiliates)

Current concepts symposium 2012/continuing professional development day 2012
A reduced rate of £570 (£430 for RCoA registered trainees and affiliates) has been introduced for those attending both the current concepts symposium and the continuing professional development day meeting. Places for the events will be offered on a first come, first served basis.
RETURNING TO WORK – HOW TO SUCCED

Date and venue:
21 June 2012 (code: Do8), RCoA, London

Registration fee:
£150 (£125 for registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr C Evans

This event is supported by the London Academy of Anaesthetists

- 9.00 am
  Registration and refreshments

- Welcome and Introduction
  Dr J-P van Besouw, Vice-President, RCoA

- AoMRC Report 2012 ‘Return to Practice – Guidance’
  Dr C Evans, Member of AoMRC Working Group

- The HR View
  Mr D Grantham, HR Directo, Kingston Hospital

- Impact of Revalidation
  Dr U Lane, Director for Continued Practice and Revalidation, GMC

- Lessons from NCAS ‘Back on Track’ and returning to work
  Mrs C McLaughlan, Senior Adviser, NCAS

- ‘The elephant in the room’ – mental health and returning to practice
  Dr N Brown, Consultant Psychiatrist, NCAS

- Financial Implications including pensions
  Ms J Brook, Independent Financial Advisor

- Return to work – a personal view:
  Injury and disability (Dr H Walmsley, Eastbourne)
  OOPE in management (Dr D McPherson, Scotland)
  Maternity leave and Injury (Dr L Jobling, West Yorkshire)

- Return to work after maternity leave – the Wessex experience
  Dr D Hopkins and Dr I Smith, Wessex School of Anaesthesia

- The role of simulation – giving anaesthesia safely again (GAS again)
  Dr A Hunningher, GAS Again Faculty Anaesthesia

- AAGBI return to work days
  Dr Y Horswill, organiser AAGBI RTW days

BECOMING A CONSULTANT

Date and venue:
20 July 2012 (code: B14)
RCoA, London

Registration fee:
£210 (£160 for registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr R Moonesinghe

- 8.50 am to 9.20 am
  Registration and refreshments

- Welcome and Introduction
  Dr R Moonesinghe, London

- Challenges for the anaesthetist over the next ten years
  Dr J-P van Besouw, Vice President, RCoA

- Revalidation
  Dr L Brennan, Cambridge

- What the Clinical Director wants
  Dr Mike Nevin, Bristol

- Dealing with difficulty
  Dr S Chieveley-Williams, London

- Medico-legal pitfalls for the anaesthetist
  Dr H Hartley, Medical Protection Society (MPS)

- Independent practice
  Dr J Down, London

- The anaesthetic as an educator
  Dr A Goodwin, Bath

- Becoming a consultant in 2012
  Dr I Wilson, President, AAGBI

- Question and answer session

- 5.20 pm
  Close of the meeting and Drinks reception
RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Date and venue:
19–21 June 2012 (code: A32)
Surgeons’ Hall, Royal College of Surgeons of Edinburgh

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

Event organisers:
Dr J Wilson and Dr C Young

<table>
<thead>
<tr>
<th>TUESDAY, 19 JUNE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30–10:15 am Registration and refreshments</td>
<td></td>
</tr>
<tr>
<td>Introduction and Welcome</td>
<td>Dr C Young, Edinburgh</td>
</tr>
<tr>
<td>Accessing the airway in 2012</td>
<td>Dr A McNarry, Edinburgh 2A01, 3A01</td>
</tr>
<tr>
<td>Anaesthesia and disorders of sleep</td>
<td>Dr T MacKay, Edinburgh 1A01</td>
</tr>
<tr>
<td>Abdominal wall blocks: too good to be true!</td>
<td>Dr B Nicholls, Taunton</td>
</tr>
<tr>
<td>Pain in medical patients: what’s the problem?</td>
<td>Dr M Rockett, Plymouth 3E00, 2B02</td>
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<tr>
<td>You think you are sceptical – are you sceptical enough?</td>
<td>Dr A Moore, Oxford</td>
</tr>
<tr>
<td>Feminisation of the workforce</td>
<td>Dr J Montgomery, Borders 3J02</td>
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<tr>
<td>Financial pressures: the challenge and opportunities of decreased resources</td>
<td>Dr H Robb, Forth Valley 3J02</td>
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</tbody>
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<table>
<thead>
<tr>
<th>WEDNESDAY, 20 JUNE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk pregnancy clinics</td>
<td>Dr R Burns, Edinburgh 2B05</td>
</tr>
<tr>
<td>Stemming the red river: update in obstetric haemorrhage</td>
<td>Dr V Clark, Edinburgh 3B00</td>
</tr>
<tr>
<td>Vascular anaesthesia: an update</td>
<td>Dr A Nimmo, Edinburgh 3A05</td>
</tr>
<tr>
<td>Peri-operative anaemia and blood transfusion: is the paradigm shift complete?</td>
<td>Professor T Walsh, Edinburgh 2A05</td>
</tr>
<tr>
<td>Upper GI bleeding: how can we improve outcome further?</td>
<td>Dr J Plevris, Edinburgh 2A12</td>
</tr>
<tr>
<td>Acute liver failure: are we doing any better?</td>
<td>Dr A Lee, Edinburgh 2A12, 3A04</td>
</tr>
<tr>
<td>Imaging pain and consciousness</td>
<td>Professor I Tracey, Oxford 3E00</td>
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<tr>
<td>Using opioids in children</td>
<td>Dr S Walker, London 2D03, 3D00</td>
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</tbody>
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<table>
<thead>
<tr>
<th>THURSDAY, 21 JUNE</th>
<th></th>
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<tbody>
<tr>
<td>Acute pain update</td>
<td>Professor R Langford, London 2E01, 3E00</td>
</tr>
<tr>
<td>Persistent post-operative pain: risk factors and prediction</td>
<td>Dr E Aasvang, Denmark 3E00</td>
</tr>
<tr>
<td>Problems with the diagnosis of ventilator associated pneumonia</td>
<td>Professor J Simpson, Newcastle 2C02</td>
</tr>
<tr>
<td>Ventilatory management of severe hypoxaemia</td>
<td>Dr M Gillies, Edinburgh 3C00</td>
</tr>
<tr>
<td>ECMO: standard of care or the last resort?</td>
<td>Mr G Peek, Leicester 3C00</td>
</tr>
<tr>
<td>Long-term ventilation: from the old curiosity shop to great expectations?</td>
<td>Dr A Bateman, Edinburgh 2C02, 3C00</td>
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<tr>
<td>Closing remarks</td>
<td>Dr E Wilson, Edinburgh</td>
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<td>3.00 pm Close of meeting</td>
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PROGRAMME SUBJECT TO CHANGE
JOINT INTENSIVE CARE SYMPOSIUM

Date and venue:
14–15 June 2012 (code: C55)
RCoA, London

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

Event organisers:
Dr J Goodall and Dr T Evans

Day 1
- 8.45 am to 9.20 am
  Registration and Refreshments
- Welcome and Introduction
  Dr T Clutton-Brock, Birmingham

SESSION 1
CARDIOLOGY UPDATE
- Grown up congenital heart disease: what next?
  Dr A T Lovell, Bristol
- Do we fail the failing heart?
  Professor T McDonagh, London
- Dysrhythmias: dispelling the myths

SESSION 2
CHANGING TIMES – CHANGING ICM
The implications for ICU of:
- An ageing population
- Fast track surgery
- Anorexia, obesity and ICM: problems with extremes of body habitus

SESSION 3
HOW I ...
- Manage resistant infections in the ICU
- Manage the injured spinal cord
- Investigate brain injury on the ICU

SESSION 4
BURNOUT IN ICU
- Burnout – what burnout?
  Dr J Goodall, Manchester
- Sources of occupational stress in ICM
  Dr P Alexander, Manchester
- A suitable job for a woman?
  Dr R Haslett, Salford

Day 2
SESSION 5
A CAREER IN ICM
- Faculty update
  Dr S Baudouin, Brompton
- Career advice: are we any good?
  Dr J Goodall, Manchester
- Results of trainees survey
  Dr C Booth, Manchester

SESSION 6
DO WE STILL NEED TO WORRY ABOUT
- Tight glucose control
  Dr J Cordingley, Brompton
- Low tidal volume ventilation
  Dr T Clutton-Brock, Birmingham
- The surviving sepsis campaign
  Dr R Beale, London

SESSION 7
THE YEAR IN REVIEW
- What’s new in renal ICU
  Dr M Osterman, London
- What’s new in paediatric ICU
- What’s new in imaging for intensivists

SESSION 8
LAW AND ETHICS
- Reliability of the expert witness
- An acute legal service for ICM
- 4.50 pm
  Close of meeting
ETHICS AND THE LAW

Date and venue:
11 June 2012 (code: D19)
RCoA, London

Registration fee:
£205 (£155 for registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr R Iqbal

8.45 am
Registrations and refreshments

Introduction to medical ethics
Dr R Iqbal, Consultant Anesthetist, St George’s Hospital, London 1F05

Medical law – the essentials and what’s new
Dr L Field, Medical Protection Society, London 1F05

MCA and deprivation of liberty safeguards
Ms A Weeraratne, Barrister, Doughty Street Chambers, London 1F01, 1F02

The complaints procedure
Mr P Swain, Acting Assistant Director of Investigation in Fitness to Practise, General Medical Council, London 1L04

End of life issues and organ donation
Dr T Clutton-Brock, Consultant Anaesthetist, Queen Elizabeth Hospital, Birmingham 1F05, 2C06

Workshops (see below)

| Workshop 1 | Consent in obstetrics and legal rights of the fetus |
| Dr Elizabeth Combeer | 1F01, 1F05 |

| Workshop 2 | Resource management and personal responsibility |
| Dr Carwyn Hooper and Dr Philip Newman | 1F01, 1L02 |

| Workshop 3 | Consent in paediatrics |
| Dr Andrew McLeod | 1F01, 1F05 |

Data protection and confidentiality
Mr T Lloyd, Medical Protection Society, London 1F01, 1F03

4.15 pm
Close of meeting
Dr R Iqbal, Consultant Anaesthetist, St George’s Hospital, London

AIRWAY WORKSHOP

Date and location:
20 June 2012 (code: C81)
RCoA, London

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

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.
LEADERSHIP AND MANAGEMENT FOR ANAESTHETISTS

Are you irritated by management jargon?
Are you baffled by NHS policy change?
Are you uncertain about what being a leader as a consultant actually means?
Do you want to understand personal development better?
Are you thinking about a leadership role in your department or trust?

If you answered yes to any of the above, our Leadership and Management workshops may be right for you.

The RCoA has introduced a series of interactive workshops covering a spectrum of topics designed specifically for anaesthetists (both senior trainees and consultants). They have been designed to help you answer these questions and give an insight into personal strengths, development needs and the skills necessary to have a real impact as a leader in today’s NHS.

Leadership and management: personal effectiveness
2 October 2012       Fee: £215
Leadership and management: working well in teams and making an impact!
13 December 2012       Fee: £215
Leadership and management: leading and managing change; success with service development
5 March 2013           Fee: £215
Introduction to leadership and management for anaesthetists: the essentials
21–22 May 2013        Fee to be advised

The workshops are facilitated by Dr Charles Ralston, a Consultant Anaesthetist, with 20 years experience as a Clinical Lead, Clinical Director and Medical Director.

The workshops are a balance of plenary sessions, group work and exercises with the emphasis on real life issues, open discussion, up to date information and specific time for one to one discussions where requested.

Attendance at all four workshops will provide you with:

- a sound knowledge of past and current NHS policy
- a good insight into personal development needs and the opportunity to construct a personal development plan
- an introduction to negotiation and influencing tools and skills
- an understanding of how to effect change
- and more.

The workshops are designed to allow participation in any or all, although we recommend the two-day Introduction to Leadership and management: the essentials as an excellent pointer to which of the three one-day workshops would suit you best.

The choice, however, is yours! The overall content is geared to requirements of the Academy of Medical Royal Colleges Leadership and Management Competency Framework. Visit www.rcoa.ac.uk/events for further information.
CURRENT CONCEPTS SYMPOSIUM 2012: Anaesthesia and Critical Care

Date and venue: 1–2 November 2012 (code: B05)
RCoA, London

Registration fee: £435 (£325 for RCoA registered trainees and affiliates)
Event organiser: Dr S Patel

Day 1
SESSION 1
FLYING PREMIUM ECONOMY... PERI-OPE RATIVE UPDATES
■ Before
■ During
■ After

SESSION 2
MYTHS AND LEGENDS
■ Recent advances in evidence-based Anaesthesia
■ Magic or misconduct... the truth behind anaesthetic research
■ NIHR the future of anaesthetic research

SESSION 3
MEDICAL UPDATES FOR THE ANAESTHETIST: PART 1
■ Chronic heart failure... a perioperative challenge
■ Spontaneous vs mechanical ventilation

SESSION 4
INTENSIVE CARE MEDICINE
■ Recent advances in intensive care medicine
■ What happened to surviving sepsis
■ ECMO ... here to stay

MACINTOSH LECTURE
■ Interactions of volatile anaesthetics and the hypoxic ventilatory response at cellular-molecular level: advances by ‘reverse translation’

Day 2
SESSION 5
SPECIALIST UPDATES
■ Cold is cool
■ Paediatric anaesthesia
■ Obstetric anaesthesia

SESSION 6
REGIONAL ANAESTHESIA AND PAIN MEDICINE
■ Hot off the press in regional anaesthesia
■ Regional anaesthesia ... a time and a place
■ Recent advances in pain medicine

SESSION 7
MEDICAL UPDATES FOR THE ANAESTHETIST: PART 2
■ Novel antiplatelet
■ Transfuse or not to transfuse ... that is the question
■ Rocuronium vs suxemethonium

SESSION 8
PATIENTS COME FIRST
■ Morbidity in anaesthesia and peri-operative care
■ Minimising adverse reaction
■ Incident reporting systems ... friend or foe
■ Anaesthesia and the law

RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Date and venue: 21–23 November 2012 (code: C11)
Bath

Registration fee: £480
Event organisers: Dr J Nolan, Dr T Cook and Dr A Goodwin

■ Pre-operative risk stratification
■ Which cardiac output monitor to use peri-operatively?
■ Prehospital emergency medicine – an update
■ Early management of severe head injuries: state of the art
■ High risk surgical patients: a quality improvement approach
■ Stabilising the critically ill child
■ Communicating bad news
■ Communication and teamwork in a crisis ...
■ Beta Blockers, statins and stents in peri-operative care: what to do in 2012?
■ Perioperative arrhythmias and cardiac arrest
■ Anaphylaxis
■ Ultrasound-directed nerve block
■ And more ...

Current concepts symposium 2012/continuing professional development day 2012
A reduced rate of £570 (£430 for RCoA registered trainees and affiliates) has been introduced for those attending both the Current concepts symposium and the Continuing professional development day meeting. Places for the events will be offered on a first come, first served basis.

Continuing professional development day 2012
Programme coming soon!
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: D D M M Y Y 
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: 
Expire date: 
Issue number: 
Security code: 

Terms and conditions

■ 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.

Please complete this form in BLOCK CAPITALS

and return to the Finance Department at the
RCoA or via fax (020 7092 1733).
The Faculty of Intensive Care Medicine

FFICM Examinerships

The Faculty of Intensive Care Medicine invites applications for vacancies to the Board of Examiners of the Faculty’s Fellowship Examination. Applicants shall be assessed against the following person specification:

**Essential**

1. Shall normally be a Fellow (FFICM) or Associate Fellow (AFICM) in good standing with the Faculty.
2. Applicants must be able to demonstrate that they have the competence, confidence and credibility to assess the next generation of consultants.
3. Shall currently be active in clinical practice in the NHS or a comparable post.
4. On 1 August 2012 shall have the expectation of completing at least ten years as an examiner whilst filling a Consultant appointment in the NHS, or comparable post.
5. Can demonstrate active involvement in the training and assessment of trainees.
6. Good written and verbal communication skills.
7. Ability to work as part of a team.
8. Documentary evidence of satisfactory completion of Equal Opportunities training in the last five years.
9. Able to commit to long-term and active involvement to examiner duties including the ability to devote a minimum of ten days per academic year to the role (the majority of which should be developmental and not require travel to London). This includes both the delivery and development of the examinations.
10. Must have observed an examination of either Intensive Care Medicine or one of the Faculty’s parent College specialties.

**Desirable**

1. Shall demonstrate a special interest(s) directly relevant to the balance of expertise required in the Board of Examiners.

Application forms and information for applicants can be downloaded from the FICM website or obtained from the FICM secretariat via the contact details below.

The closing date for receipt of completed applications is **Friday, 15 June 2012**.

020 7092 1653 or 020 7092 1727
ficm@rcoa.ac.uk

www.ficm.ac.uk
XXVIth EDINBURGH ANAESTHESIA FESTIVAL
22–24 August 2012

The Edinburgh Anaesthesia Festival is organised by the University Department of Anaesthesia and Pain Medicine at the Royal Infirmary of Edinburgh to coincide with the 2012 Edinburgh International Festival of the Arts. The three-day programme will consist of lectures and discussion on current topics in anaesthesia. The lecturers are from all parts of the United Kingdom and represent leading opinions in their field.

Please contact Mrs M Pepper for further details:
University Department of Anaesthesia and Pain Medicine,
Royal Infirmary, Edinburgh EH16 4SA

tel 0131 242 3136 fax 0131 242 3138
maxine.pepper@ed.ac.uk www.eafonline.co.uk

The RCoA has become a Corporate Partner of the Academy of Medical Educators, the professional organisation for all those involved in medical education – the education and training of students and practitioners in medicine, dentistry and veterinary science.

Corporate membership provides our Fellows and Members with a 33% discount off membership. The benefits of membership include: access to a network of medical educators; a monthly newsletter; discounted access to workshops and events; plus the opportunity to comment on the future of the profession.

There are three membership grades available depending on your involvement and level of career development in medical education.

Please see:
www.medicaleducators.org/ for further details
The Intensive Care Society

State of the Art Meeting 2012

Monday 10 to Wednesday 12 December 2012

The ICC, East ExCeL, London

Critical Care - with a focus on what really works! Best practice, personal experience & insight from acknowledged experts in the field

Join us for 3 days in December 2012:

• An International Faculty - presenting on Evidence - based Haematology, What’s new in Fluid Therapy, Drug Therapy Updates, Acute Kidney Injury, Severe Sepsis & ARDS, Infection Controversies, Nutritional Support, Airway Management, Acute Heart Failure, & Resuscitation Update
• Research Presentations
• Industry Symposiums
• Poster Presentations
• Nurse, AHP and Pharmacists Forums
• Intensive Care Foundation Updates

Book your study leave now and ensure you don’t miss the UK’s largest meeting for Intensive Care professionals

CPD Accreditation: 15 Points Pending

Further details are available by emailing events@ics.ac.uk

www.ics.ac.uk  @ICSMeetings

15th Anaesthesia Critical Care & Pain Forum

1-4 October 2012

The Algarve
Da Balaia

lectures
workshops
Guest speakers

www.doctorsupdates.com
THE MERSEY SAQ WRITERS CLUB

The Writers Club has seen more than 250 trainees through the SAQ and E&SAQ Papers with a first-time Pass Rate of between 80 and 90 percent. But many trainees apply far too close to the examination to derive anything like the full benefit from Membership. That Full Benefit includes Free Admission to the SAQ Weekend Courses, the Acquisition of a large and useful Collection of Answer Sheets and the valuable Discipline of Revision.

Candidates are urged to JOIN NOW for Autumn 2012 and Spring 2013 Examinations

Enquiries to: writers.club@aintree.nhs.uk

<table>
<thead>
<tr>
<th>Event</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY MCQ Week</td>
<td>2.00 pm Saturday, 19 May – 4.00 pm Friday, 25 May</td>
</tr>
<tr>
<td>FINAL Viva Weekend</td>
<td>2.00 pm Friday, 15 June – 4.00 pm Sunday, 17 June</td>
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<tr>
<td>FINAL MCQ Week</td>
<td>2.00 pm Saturday, 21 July – 4.00 pm Friday, 27 July</td>
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<td></td>
<td>LIMITED TO 48 PLACES</td>
</tr>
<tr>
<td>FINAL SAQ Weekend</td>
<td>11.00 am Friday, 17 August – 1.00 pm Sunday, 19 August</td>
</tr>
<tr>
<td>PRIMARY OSCE Weekend</td>
<td>2.00 pm Friday, 7 September – 4.00 pm Sunday, 9 September</td>
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<tr>
<td>PRIMARY OSCE/Orals Week</td>
<td>2.00 pm Friday, 28 September – 4.00 pm Friday, 5 October</td>
</tr>
<tr>
<td>PRIMARY Viva Weekend</td>
<td>2.00 pm Friday, 14 September – 4.00 pm Sunday, 16 September</td>
</tr>
<tr>
<td>FINAL Viva Revision Week</td>
<td>2.00 pm Saturday, 26 May – 4.00 pm Thursday, 31 May</td>
</tr>
<tr>
<td>PRIMARY MCQ Week</td>
<td>2.00 pm Saturday, 14 July – 4.00 pm Friday, 20 July</td>
</tr>
<tr>
<td>FINAL (Private Writers Club) SAQ Weekend</td>
<td>2.00 pm Friday, 27 July – 4.00 pm Sunday, 29 July</td>
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<td>MEMBERS ONLY</td>
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<tr>
<td>FINAL (BOOKER) Revision</td>
<td>2.00 pm Sunday, 19 August – 4.00 pm Friday, 24 August</td>
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<td>LIMITED TO 90 PLACES</td>
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<tr>
<td>FINAL Viva Revision Week</td>
<td>2.00 pm Saturday, 10 November – 4.00 pm Thursday, 15 November</td>
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</tbody>
</table>

For details and application procedure, please see: www.msoa.org.uk
Contact information

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Director of Education    Sharon Drake          020 7092 1613
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