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From the Editor

September Council commences with a brief ceremony to admit the new President and Vice-Presidents and I congratulate J-P on his election for his third year and do not doubt that Liam Brennan and Peter Venn will provide excellent support. Of course such elections have a knock on-effect requiring changes in the College committee compositions, and it is difficult to appreciate how rapidly the last two years have gone as I write my last editor’s piece. I am delighted that my old friend and colleague from the East of England School of Anaesthesia, Simon Fletcher, has accepted the challenge to be the seventh editor of the Bulletin.

The President’s statement highlights two broad areas which have significant influence on our practice, namely service delivery and workforce and the implications of the Shape of Training review. There is little concrete to write about regarding ‘Shape’ as yet, but I suspect this will be a major topic for the Training Committee soon. Regarding workforce, I point you to two articles in this edition. Katie Nicholson was the trainee member on the RCoA Workforce Planning and Strategy Group and she outlines some of the current issues. We still await the Centre for Workforce Intelligence (CFWI) report on Anaesthesia and Intensive Care (although we have made the headline conclusions well known nationally) but training numbers may well be cut in some ‘Deaneries’.

Whatever the workforce composition in the future across specialties, doctors will not be the only ones providing direct healthcare. Physician Associates (or a host of other titles) will provide some of the workforce as alluded to in the President’s statement and indeed previous Bulletin articles. Physician Assistants (Anaesthesia) or PA(A) number approximately 125 in the UK, hardly a current solution to the workforce crisis rapidly approaching, and given some data from our recent curriculum review, already here. Philip Cawkwell’s article on the work PA(A)s contribute to needs careful consideration, for no other reason that if the CFWI headline figure of a requirement for around a 25% increase in the anaesthetic and ICM workforce appears in their report, given the finances of the NHS, this is hardly likely to come from similar rise in consultant numbers.

Elsewhere within these pages are our guest editorial on the important emerging area of ‘trainer feedback’ and contributions from the Society for Education in Anaesthesia on ‘reflection’ and the Society for Ethics and Law in Medicine on ‘negligence’. Interesting material here, and my sincere thanks to Teresa Dorman and Kate McCombe respectively for organising these series. Our RCoA Education Fellow, Aiden Devlin, is conducting sterling work on our curriculum review and has two articles which ought to help trainers and trainees alike. Council member Professor Monty Mythen’s article introduces a major RCoA development regarding perioperative medicine and the central role for anaesthesia here, and for the historians, reflections from Professor Brandstater on London anaesthesia in the 1950’s.

I hope during my editorship that ACSA has been brought to the attention of the entire anaesthetic community. (I have no intention of spelling out that acronym since it ought now to be part of the anaesthetic vocabulary). The first ACSA accreditation visit has taken place, and the second follows later this month, and nearly 50 departments have engaged to date in the process. By the time you read this the Homerton Hospital Anaesthetic Department will have received their plaque as the first successful accreditation and my congratulations go to Sade Otukubo on leading this project. Regarding ACSA, work is well underway on producing the standards for our subspecialties within anaesthesia.

I could have filled my final editor’s column with a list of people to thank, without whose help the Bulletin would have appeared rather thin and late. You know who you are but I must acknowledge the President and Deans of our Faculties for submitting their articles on time with a minimum of ‘chasing’, the editorial board for reviewing and wise advice, our regular contributors and in particular Irene Dalton for ensuring thoughtful timely articles from our Lay Committee, and finally the College Directors and CEO for guidance. I must also record my immense appreciation to Mandie Kelly and Anamika Trivedi for their exceptional support, and without whom the Bulletin would simply not appear.

Dr Nigel Penfold, Editor
solvent or in profit and 50% in deficit; however the magnitude of the latters’ deficits significantly outstrip the good performance of the former. A facet of current models of healthcare delivery is that they are often constrained in a ‘one size fits all’ model of delivery without regard for demographic, geographic, social or economic factors. It has been recognised that greater flexibility in the organisation of service delivery is required in order to meet future challenges, particularly if poor financial control impacts on the safe delivery of services. Over the past six months, Sir David Dalton has been looking at how successful organisations work to deliver good care whilst remaining financially prudent. During the consultation period a number of options for organisational change have been looked at:

- **Multi-site trust model** – stand-alone acute trust operating over one or more sites.
- **Federations of trusts** – organisations come together under an overarching entity, with some shared operations and governance, individually managed with corporate ideals.
- **Service-level chains** – individual services within an organisation delegated to an external organisation.
- **Joint ventures supported by individual trusts** – two or more organisations form new structure with shared equity and governance to provide services, e.g. Elective Orthopaedic Centres.
- **Operational franchises and management contracts** – responsibility for running part of or whole organisation delegated to another organisation. Governance arrangements depend on model, e.g. Circle.
- **Multi-service chains** – single entity owning and operating multiple standalone hospitals with single executive team, utilise standardised systems and processes, including clinical pathways and protocols, and then exercise a strong degree of clinical accountability for outcomes through peer review.
- **Integrated care organisations** – formal or virtual vertically integrated organisation from primary to acute service levels, often serving a defined population.

Given the variability in operational management of each of these models, it will be a challenge for the College and the profession to ensure that the standards of service provision, education and training within each of these different environments are maintained to acceptable levels without compromise of patient safety and staff wellbeing.

**Do the maths...**

One of the major reasons many trusts have found themselves in financial difficulties has been an increase in staffing costs – particularly for locum staff – associated with providing safe levels of staffing. Cuts in anaesthesia training numbers around the UK are leading to shortages of doctors to maintain compliant on-call rotas, and impacting on the balance of service and training delivery. Some trusts are maintaining staff levels with locums, whilst others have increased the out-
Shaping our future

It is over a year since the ‘Shape of Training’ report was published; following an initial flurry of activity there had been limited progression of the proposals. In the last two months, however, there has been some action in moving the agenda forward. Early autumn saw a series of meetings seeking to delineate pathways to deliver the recommendations. Each meeting was co-organised by one of the commissioning stakeholders and tasked with coalescing ideas on the delivery of the following:

- General Themes/CST: how will postgraduate training be delivered beyond Foundation to meet the future needs of the service? – Organiser: Scottish Government, NI Health Department and Academy of Medical Royal Colleges.
- Interaction with employers: matching the requirements to balance service and training needs – Organiser: (HEE), Department of Health England (DHE).
- Blurring the primary care/secondary care interface. Looking at where training is delivered, balancing primary, community and secondary care – Organiser: HEE/DHE.
- SAS Doctors. Looking at the support of non-consultant career-grade doctors – Organiser Welsh Government/COPMED.
- Academic Pathway – Organiser: Medical Schools Council.
- Credentialing: with a foreshortened, generalist-trained workforce, how might specialist training be delivered and accredited? – Organiser GMC/Academy of Medical Royal Colleges.

The College was fortunate to gain representation at each of these seminars, to help inform the debate and provide specialty specific views on the potential impact of proposed changes on services and training.

Rough justice

The College remains concerned about the direction of travel of a number of bills currently going through Parliament as outlined in previous President’s statements. Whilst sympathetic to the intentions of the proposed law of wilful neglect to improve patient safety, we feel that the creation of a criminal sanction to enforce this is likely to be counter productive and, we and others have written to the Secretary of State to express those concerns, particularly in relation to the following:

The impact on reasonable everyday decision-making needs to be limited. The offence could mean that normal, everyday clinical decisions or decisions about resource allocation could be open to criminal investigation.

There needs to be more clarity as to how the offence will apply to a doctor’s actions. The government is excessively reliant on prosecutorial discretion to stop reasonable clinical decisions being investigated. Doctors will be uncertain and fearful about how their actions could be later deemed criminal.

The offence should not interfere with the development of a culture of transparency and learning in healthcare. The offence may make doctors more fearful of the way their conduct may be later criticised, less open and willing to admit genuine errors to either patients or management, and therefore may make healthcare less responsive and accountable to patients. The offence should deal with the most serious incidents so as not to spread fear about criminal sanctions.

Double celebration

Congratulations to the Hong Kong College of Anaesthetists (HKCA) who celebrate their silver jubilee this month. The College, in conjunction with the BJA, and the College of Anaesthetists in Ireland, have joined with the HKCA and the Society of Anaesthetists of Hong Kong – celebrating their 60th anniversary – to co-host a congress to commemorate the event.

You will by now have received your ballot papers for the Council election. Make your vote count.
Trainee feedback for consultants: time to take our own medicine?

Why, and why now? ‘Residency programs aspire to improve the clinical teaching provided by clinician educators,’ wrote Baker in *Anesthesiology* in 2010, and an accompanying editorial made the point that, without some form of assessment, we should no more assume the capacity to teach in theatre than we would the clinical ability to provide anaesthesia. Since self-evaluation of teaching skills appears to be poor, if we wish to assess and improve our teaching skills, there is little option other than to ask for feedback from trainees.

As well as wishing to make clinical teaching as effective as possible, there are other reasons why the collection of this kind of information may be useful. In the UK, the GMC has requested that training programmes provide assurance of the quality of teaching and teachers. Enhanced appraisal aims to cover the whole of a doctor’s practice, and requests for evidence of educational effectiveness must surely become commonplace. For programme directors, such evidence can enable appropriate recognition of committed and effective teachers, and can contribute to decisions around the educational roles of their faculty. Lastly, there is a responsibility upon schools and Local Education and Training Boards (LETBs) to help faculty develop their teaching skills. Although various resources from ‘train the trainers’ type courses to online material are available (www.faculty.londondeanery.ac.uk), engagement with structured feedback which uses the key domains of effective clinical teaching as well as anchors and rubrics for trainees to use to gauge good and poor practice of their supervisors, may in itself be of educational value.

What’s been done already and does it work?

There has been a substantial amount of work done to identify the characteristics of effective clinical teachers, and we can be reassured on two fronts at least; firstly, there is fair agreement about what is most important, and secondly, it is not about knowing everything and ‘transmitting’ it. A comprehensive systematic review published in 2008 did identify clinical knowledge and skill teaching as important, but these were closely followed by a positive climate, communication skills, and enthusiasm.

A recent article in this *Bulletin* [McCahon, June 2014] on feeding back to trainees pointed out the need for the message to be as objective and specific as possible. In this way, the recipient has some chance of making appropriate changes. So what information should we as trainers request that is sufficiently detailed to be useful without being burdensome and overly prescriptive? Current research is dominated by two closely related models, the Stanford Faculty Development model (SFDP26) and the Systematic Evaluation of Teaching Quality (SETQ) which was developed from it and has since been used extensively in Europe, across a range of disciplines but piloted first in anaesthesia.

The main themes in SETQ are: learning climate, professional attitude to trainees, communication of goals, evaluation of trainees and provision of feedback. Each area has between three and seven specific questions. Work to validate these tools is ongoing and to some degree validity depends on the context. The approach appears to be capable of delivering improved clinical teaching as
Baker’s work from Massachusetts over five years and 19,000 evaluations demonstrates.¹

Recent work using the SETQ model suggested that several numeric assessments were needed to come to a reliable score for teaching effectiveness. However, as such assessments are cumulative and essentially formative, it may not be necessary to collect six or eight individual assessments on a trainer before feeding the information back. Instead, a plot over time or a running average may be more useful. In any case the narrative component of feedback which was identified by Baker¹ as the most influential, does not rely on multiple assessments and internal reliability measures. Baker also used the average score of all consultants as a benchmark, and this has also been used in many UK hospitals.

What has been happening in the UK?
Trainee feedback on individual consultant supervision has been discussed and presented at RCoA College Tutors meetings in both Liverpool and more recently in Glasgow. It is clear that many hospitals and some programmes, have had some form of feedback on clinical supervision for many years, but these efforts seem not to have spread outside their local area or even, in many cases, outside a single hospital, and there is little or no published evidence of their effectiveness. One concern with very local systems (for example at one site within a programme) is that if there are concerns the site involved can justifiably argue that other sites don’t have a system in place (or use a different system), and that comparisons are therefore invalid. These are strong drivers for using one version of a reasonably validated model across all sites in a programme.

Mechanics
The survey rubric should be brief, but should probably include comments on the purpose and benefits of the survey, data handling, and confidentiality. Inclusion here of advice regarding reporting of serious problems may be appropriate. Where trainees have concerns regarding compromise of patient safety or dignity, then current GMC guidance places all doctors under a duty to raise them under existing mechanisms and supervision surveys may generate feedback that needs addressing outside the educational framework.

Irrespective of the specific question set used, it is possible to make some general comments. A high level of confidentiality is critical to trainee engagement. Even if it is not apparent to trainers and consultants, trainees are often acutely conscious of hierarchy gradients, and may be extremely reluctant to be critical of consultants who are considered to have influence over their future prospects. Ideally, access to the raw data should not be available to any of the faculty directly engaged in programme delivery.

Unless conducting feedback in a small or isolated setting, then an online system is almost certainly the easiest approach. It allows access from multiple sites, from mobile devices or homes. Most such platforms will then facilitate data collection, collation, analysis and some degree of automation over sending out results. Some thought needs to go into compliance with data-protection legislation and security. With this in mind, using commercial platforms such as SurveyMonkey, may raise concerns over security and ownership of data, and their use is a decision to make in partnership probably with the LETB/Deanery. Ethics approval should not be required, since the exercise is essentially quality assurance.

Examples
The references provided below give examples of the kind of questions and scoring systems in use. On the Nottingham training programme, a variety of systems have been in use in the past, however, a version of SETQ has been in use for over a year across the North programme involving six sites. The SETQ question set was adapted slightly to conform more closely to UK practice and is hosted on our local virtual learning environment (www.vle.eastmidlandsdeanery.nhs.uk/). In summary, the questions were divided into two areas. One area collected statistical items such as trainee identification, stage of training, current training site, trainer’s details and number of observations on which the assessment was based. The second area explored six specific areas; learning environment, engagement in assessment, provision of feedback, technical skill teaching, clinical supervision and attitude towards trainees. In addition, we included an overall assessment and an assessment of the trainer as a role model to help with validation. A parallel questionnaire was also provided for consultants to self-assess.

The system has proved fairly robust and useable, and preliminary analysis of the results is encouraging, with good overall reports, some extremely insightful narrative comments and strong correlation between specific items and overall scores.

Engagement and support
Trainee engagement should not be taken for granted. We are all bombarded with requests for survey completion, and fatigue is a very real issue. In response, there are a number of steps to
consider. Is the survey truly necessary? Does the length and detail strike a balance between being detailed enough to prompt insightful answers and be useful, but not so long as to make completion tedious? Trainees are more likely to engage if it becomes clear that the information is valued, has some impact on those concerned, and is used to effect change for the better. As consultants we can make it clear that the response quality is important to us as individuals. For Training Programme Directors and other senior educators timely appropriate visible responses to feedback should be expected.

A straightforward voluntary system can be explored, but it may be difficult to generate results for all or even the vast majority of consultants. Some form of incentive (carrot) or process (stick), or both, is likely to be required. At both Nottingham and Moorfields, examples of high quality feedback were publicized as a means of encouragement. At school level, prizes or other recognition of engagement may be possible.

When the Nottingham online system was set up, we asked Unit of Training leads not to sign off units as complete until trainees had provided feedback on three consultants they had worked with. A ‘stick’ approach, such as using the Educational Supervision Structured Report, or making engagement an Annual Review of Competence Progression (ARCP) requirement is an option. Apart from concerns over adding to the ARCP or Structured Report burden, there is a danger of encouraging a tick box approach, with consequent reduction in quality and utility. Several schools also use a system of asking for feedback at a particular time, for example immediately before or after ARCP, and this ‘captive audience’ approach can deliver near complete datasets but lacks the benefits of feeding back while memories are fresh and may reduce quality of response.

Consultant colleagues should be informed that the data is being collected, how this will be done, for what purpose, and how the results will be fed back. Circulation of and posting on websites of FAQs and guides to the system is one approach. In the majority of cases consultants will manage their own feedback through a process of looking at the results, comparing this with self-rating (if this is included in the tool being used), as well as against departmental or school averages, and make adjustments to their behavior. Some colleagues will request or even require more specific feedback and support, and some thought needs to be given to who should do this. Similarly it would be useful to have pre-prepared resources available to access by consultants on receipt of their feedback. Consultants with strongly positive feedback deserve recognition, and a system that collates this across a site or programme allows their efforts to be recognized and could clearly be used as evidence of educational effectiveness when applying for college, school, LETB or other positions with educational responsibility.

Worst-case scenarios
Unfortunately, narrative feedback may include comments with significant concerns. A judgement will need to be made regarding making this information known to employers as appropriate. Since one likely use of the scheme is to inform the appraisal process, this provides a reasonable approach in all but most urgent examples. Similarly to the annual GMC survey, it can be very difficult to know how much credence to place on individual isolated responses. This is a strong argument for encouraging trainees to feedback regularly, so that most/all consultants have had multiple ‘assessments’ and provide a rounded picture.

Conclusion
In the next few years, programmes will be expected to have a system for collection of feedback on consultants from trainees in place. Although this might seem like a scary development, in fairness we should be prepared to ‘take our own medicine’. Occasional unpalatable feedback, is far outweighed by the positive responses from trainees who recognize the time and effort taken to help them. Lastly, we should be just as equally concerned about poor teaching performance as we are about our patients being nauseated or in pain.

There is an opportunity for anaesthesia to lead in this area in the UK, and if we were to take it we may escape the imposition of another, inevitably more generic, tool with little evidence of utility or acceptability in anaesthesia.

References
1 Baker K. Clinical teaching improves with resident evaluation and feedback. Anesthesiology 2010;113:693–703.
2 Schwartz AJ. Resident/Fellow Evaluation of Clinical Teaching: An Essential Ingredient of Effective Teacher Development and Educational Planning. Anesthesiology 2010;113:516–517. 10.1097/ALN.0b013e3181eaad1e.
The revalidation helpdesk and CPD and reflection ‘on the go’

Mr C Kennedy, CPD and Revalidation Coordinator

The College regularly receives enquiries about revalidation and CPD, and in last November’s issue of the Bulletin we described how a revalidation helpdesk is available at the College to support anaesthetists, their appraisers and responsible officers.

For questions requiring clinician input the College has established a team of senior anaesthetists to act as advisors. The advisors are located across the UK and between them they have a wide range of expertise covering anaesthesia, pain and critical care. This may be of particular value when the appraiser or responsible officer is not a doctor practising in the same specialty as their appraisee.

Last November’s Bulletin article featured the answers to some of the questions typically received by the helpdesk. Since then we have continued to receive a number of further enquiries, and we thought it would be useful to highlight some more of these.

‘I am an appraiser reviewing a doctor’s CPD. What guidance is available to me, and is there a definition of the difference between clinical and non-clinical activities?’

The College has developed guidance for appraisers on what they should be considering when reviewing a doctor’s supporting information. The ‘keeping up-to-date’ section of the guidance includes the following definition:

‘CPD refers to any learning outside of undergraduate education or postgraduate training which helps you maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of your professional practice. It includes both formal and informal learning activities. CPD may be Clinical – including any specialty, or subspecialty, specific requirements [and] Non-clinical – including training for educational supervision, training for management or academic training.’

‘Does a pain consultant need to do intervention lists in order to be revalidated in pain?’

Revalidation should reflect a doctor’s practice. If a pain medicine consultant does not do specific interventions their appraisal should explain this although they should ensure that a referral process exists so that patients who need interventions can be offered them.

‘I am a consultant anaesthetist wishing to move from a full-time to a part-time job. Please advise how this will affect my CPD requirements for revalidation.’

Doctors working less than full-time (LTFT) will be expected to revalidate in the same way as full-time doctors, including participating in annual appraisal and collecting supporting information in relation to their practice. All doctors should be participating in CPD activities that cover their professional practice, and the appraiser must be satisfied that their portfolio demonstrates this. The College recommended amount of at least 50 CPD credits per year, including a minimum of 20 per year in each of external and internal activities, also applies to LTFT doctors because they have the same equal obligation to provide high quality patient care as do those working full-time, and thus should maintain the same commitment to their CPD. This position is stated in the College guidance on CPD.

‘Can you explain how the deferral process works, because I am thinking of taking a career break.’

A request for the doctor’s revalidation date to be deferred is one of the recommendations which can be made to the GMC by a responsible officer. The GMC defines this type of recommendation as follows:

‘Deferral requests apply to doctors who are engaged in the systems and processes that support revalidation, but about whom there is incomplete information on which to base a positive recommendation (this will be where a doctor has not been able to gather all of the required supporting information by the time the revalidation submission date falls due)... Deferral requests are appropriate only where a doctor has engaged with the systems and processes that support revalidation.’

Where doctors take a career break within their revalidation cycle, appraisals should be managed around that break as far as possible. Some of the supporting information is required over the five-year cycle, not annually, so it may be possible to manage this around the career break. An approach
should be agreed with the doctor’s appraiser and responsible officer and a ‘return to work’ appraisal may be required. It is advisable for doctors to try and keep their CPD in their clinical areas up to date, even when they are not actively practising.

The responses provided to many of the helpdesk enquiries are used to update the Revalidation and CPD sections of the website, which are regularly reviewed, and to include new FAQs with latest guidance.

**Record and reflect upon your CPD at a time which suits you**

We receive many enquiries about recording and reflecting upon CPD activities. Our recently launched web app has been assisting with this and it is available free of charge to all subscribing members. Fully compatible with iPads and iPhones, Android devices and Windows Phones, the web app mirrors the key functions from the full (desktop) version of the CPD Online Diary, and it allows doctors to add their CPD activity details and reflection ‘on the go’ (e.g. on the train journey home immediately after an event).

This can be done when the doctor’s device is offline (when there is no signal/internet connection), and when connectivity is restored the information which they have added will be synchronised into the full version of their CPD Online Diary.

The web app is also fully linked to the College list of approved CPD events, and it can be used to generate a certificate of the doctor’s completed CPD activities and their reflective comments. This can then be taken to the doctor’s appraisal meeting, emailed to their appraiser or uploaded into an electronic revalidation management system to demonstrate that they have met the supporting information requirement for CPD.

With the emphasis being on documenting reflective comments as soon as possible after completing a CPD activity or attending an event, the opportunity to do this ‘on the go’ with the web app has proved to be very popular in supporting members through revalidation.

**Further information**

The Revalidation Helpdesk can be contacted at revalidation@rcoa.ac.uk or by telephoning 020 7092 1729, although all enquiries requiring clinician input must be made by letter or email. For further information about the web app including how to access it, please visit www.rcoa.ac.uk/cpd or contact cpd@rcoa.ac.uk.

**References**

Bullying

Mrs I Dalton, Chairman, The Lay Committee

Bullying has become a ‘fashionable’ issue to explore in all aspects of public life. Following a discussion on the GMC survey of this at a recent Trainees’ meeting, I have reflected on it from the point of view of a former headteacher with considerable experience of dealing with bullying by adults and teenagers. Believe me, if any head says that there is no bullying in their school, they are lying, and I suspect the same is true for any senior clinician or manager in the NHS. What matters is facing up to it and dealing with it effectively, and there are neither silver bullets nor off-the-peg solutions available.

Dealing with bullying is important but prior clarification of what the word means is critical; it is also important to recognise that something may be wrong but is not bullying. So let us start with a definition:

- Bully (noun): a person who is habitually cruel or overbearing, especially to smaller or weaker people;
- Bully (verb): to treat in an overbearing or intimidating manner; to force one’s way aggressively or by intimidation.

Implicit in these definitions, is that the behaviour is habitual, an abuse of power and makes the victim of bullying feel helpless and inferior. The effects of bullying can be very disabling, eroding confidence, lowering self-esteem and inculcating a desire to keep one’s head down at all costs. Being bullied can cause suppressed anger, which may result in passing the bullying down the line to others even less powerful. As ‘greater fleas have lesser fleas upon their backs to bite them’, lesser bullies will follow the lead of a ‘big’ bully, picking on one who already feels inferior and isolated – this is the dreaded ‘bullying culture’ if it goes unchecked. And no number of policies or rules and regulations will of themselves change such a culture.

Behaving badly

We can all behave badly under stress, although some people are better at controlling their bad behaviour than others. If an adult or child thumps someone once, that is not bullying; it is assault. If, when someone lower in the hierarchy does something silly on a single occasion, causing potential harm, and you swear at them, that is not bullying; it is verbal abuse and unprofessional conduct. If someone is not doing their job and you tell them so, that is most certainly not bullying; it is the proper carrying out of your professional responsibilities.

Equally, there are some people who ‘run to mummy’ at a single cross word. Accusations of bullying are very serious and there is a need to distinguish being properly told-off or treated once with impatience by a stressed colleague from true bullying. They almost always need some training in assertiveness, and even in understanding their conditions of service – it always amazes me that employees at all levels know their contracts to the minute, but have never read the conditions of service underpinning them.

Getting it in the open

Of course, systems are needed to discover where bullying occurs – a proper chain of command built on a good and confident relationship with the immediate superior is the ideal and a sensible (not just shoulder-to-cry on) ‘buddy’ arrangement can help for junior staff. This is not simple though; if the superior officer knows that bullying is going on, they have an obligation to do something about it, inevitably bringing it into the formal arena. A ‘buddy’ needs to be skilled in negotiating with the confiding colleague over how to pass this on to the right person and get it stopped.

When I say ‘stopped’ I do not mean just a ticking off or even disciplinary action, though these have their place. Fundamental to addressing this issue is bringing the parties together and developing an understanding of the feelings involved. Those who apply Chinese burns or give ‘dead legs’ know perfectly well what they are doing. It is more difficult to recognise that your own confident and assertive (arrogant?) behaviour may be eroding someone else’s self-esteem.

Bullying in action

I tend to assess the quality of a colleague by whether or not I would...
wish to work for them, and when I think of these for whom I would not work, they are usually bullies. I have met a few in the NHS. Putting people down in public on a regular basis when they do not have the power to respond; belittling their ideas; airing their own learning to intimidate not inform; breathing down necks when colleagues are working; name-dropping to assert superiority by association; ordering rather than asking; failing to listen to suggestions (however naive, they do not have your experience!); inviting others to collude in mockery; insisting on doing things exactly your way and stifling initiative through fear are obvious examples. Bullies make people shrink, not grow, in a professional setting. And when they shrink, they do not thrive or become effective members of a team. This could be critical in a situation where, assisting at a procedure, they spot something, going wrong. If you are afraid of your ‘leader’ how can you point this out with any confidence? Behaving like James Robinson Justice, trailing his sycophantic coterie of junior doctors, tittering at his every jest and making fools of the patients, would be difficult to imagine in 2014, but there are subtler ways these days to make yourself feel important if you are a bully. And bullies always want to feel important.

What, me?
Bullies have to be brought to acknowledge their behaviour. It is very difficult to change a mature (?) personality but behaviour, if recognised, can be modified. The essential thing is to lead such a person to an understanding of what they have done, are doing, to the human being on the receiving end. This can not be done in a ‘Come on, old girl, we both know that Mr X is a bit sensitive but can’t you lay off a little.’ atmosphere, for that in itself is collusion and won’t work long term. The person who feels bullied also needs to be very clear about what has caused them to feel diminished or professionally damaged, and whether this is a one off which can quickly be put right, or systematic undermining, which is different.

Shared understanding
They then need to be brought together on neutral and safe ground to talk things through. I believe that senior professional colleagues, if and only if they possess courage, empathy, talent and probably have had training, are probably better at doing this than human resources experts because they are thinking within the professional, not the managerial and ‘concern about litigation’, context. This will be an unpopular view within most institutions, and I mean no disparagement of the excellent job human resources specialists do, but dealing with bullying requires an intimate and experienced understanding of professional standards and practice.

Finally
Bullying occurs at all levels, from husbands and wives putting each other down in front of dinner guests (run for your coat!) to government bullying involving one-size-fits-all targets and all levels in between. It is always negative in effect, causes serious damage to both bullies and the bullied, and must be tackled. It isn’t easy: bullies are scary and they can do it upwards as well as downwards but as Kant said, the only way you can ever be sure that something is right is that you really, really don’t want to do it!
Currently writing a grant proposal? Planning on applying for funding for anaesthesia or perioperative medicine-based research? Then we can help!

Patient and Public Involvement (PPI) is the creation of a partnership between patients and the public, and researchers, to try to make the research process more effective. INVOLVE (the national advisory group, funded by the National Institute for Health Research (NIHR), that promotes active public involvement in NHS, public health and social care research) defines patient and public involvement in research, as research carried out ‘with’ or ‘by’ members of the public rather than ‘to’, ‘about’ or ‘for’ them. This includes, for example, working with research funders to prioritise research, offering advice as members of a project steering group, commenting on and developing research materials and undertaking interviews with research participants.

‘No matter how complicated the research, or how brilliant the researcher, patients and the public always offer unique, invaluable insights. Their advice when designing, implementing and evaluating research invariably makes studies more effective, more credible and often more cost efficient as well.’

Professor Dame Sally Davies, Chief Medical Officer.

For some time it has been considered good practice to involve patients and the public in research. This involvement can lead to the development of more relevant research questions, and many funding bodies, in particular the NIHR, now require detailed information on patient and public involvement as part of the research funding process. Funders need to see how researchers have collaborated with patients and the public and how patient needs and expectations have been incorporated into research plans. The National Research Ethics Service also asks for information about plans for public involvement during the application process for research ethics approval. This is important, not only to improve the experience of participants in the research, but also to ensure the research has real potential to deliver meaningful benefit for patients.

Whilst strong PPI has been an important feature of research in chronic disease management for some years, there has been less activity in research in more acute fields of medicine, where it can be difficult for clinical researchers to develop the kind of relationships with their patients that allow them to identify and invite suitable patients to take part. To help address the specific challenges of PPI in anaesthesia and perioperative medicine research, the NIAA Health Services Research Centre established a PPI Working Group in July 2013.

Who we are
The HSRC PPI Working Group consists of members selected from the RCoA’s Lay Committee who have an interest in clinical research, and is chaired by Professor Rupert Pearse, Consultant in Intensive Care Medicine, Barts and The London School of Medicine and Dentistry. The Group has received bespoke PPI training from an independent adviser and has had input from researchers from different fields, to better understand the research process and determine how we can be most effective with our support. We are very fortunate to have such a well-informed and enthusiastic group.
of volunteers willing to help with this initiative.

**What we can offer**

We have developed a section with information and resources on PPI on the HSRC website. Researchers can use our online application tool to submit requests for PPI support here: www.niaa-hsrc.org.uk/PPIRegister#pt

Each request for PPI support is reviewed independently by members of the Group, then, where possible, a group consensus is sought before delivering the final feedback to researchers. We provide feedback and additional commentary on our understanding of the patient experience in the proposed study. Research proposals are reviewed under the following headings. We would encourage anyone intending to submit a research proposal for funding to consider these points when drafting the protocol:

- **Lay summary** – Is the explanation of the study in simple enough terms for the general public to understand? Effective communication increases the likelihood that patients will be more receptive to the research and participate in the study.

- **Impressions of the research**
  - The importance of the topic to patients and its value to future patient care. If the research topic is deemed important to patients, this is then a very strong statement to be able to include in a research application.

- **Consent** – When is the most appropriate time to talk to patients regarding this? We understand that consent is not always obtainable due to the nature of emergency procedures.

- **Communication** – Are there clear inclusion/exclusion criteria? Have the researchers consulted with their target group for input, and what are the plans for dissemination of the results to both the research community and patients recruited into the study?

- **Patients** – Number required, age, distribution (is it a local or national study)? Is this achievable/realistic? Is there any evidence of prior discussions with any local PPI organisation or their target group of patients regarding the research?

- **Confidentiality** – Will Patient Identifiable Data be collected and if so, what will happen to this data?

- **Limitations** – Is what the research asking of patients reasonable? Would you agree to participate in the study? If not, why not?

- **Finances** – Is the research cost-effective/value for money? Is there any money allocated for PPI in the budget? No patient or member of the public should be out of pocket from participating in a research project.

We endeavour to provide PPI feedback in good time for applicants to make any necessary modifications to their proposals before the deadline of the identified funding organisation. The sooner you are able to submit your draft proposals to us the better. Two weeks’ notice is the minimum we require to conduct a preliminary PPI review and provide basic feedback. The amount of PPI support we can offer to any one project is determined on a case-by-case basis and on the resources available to us at the time.

Although still in its infancy, the Group has already reviewed several applications for NIHR funding, providing initial feedback and comments with a provisional commitment to provide support tailored to the individual needs of the project (e.g. join a project steering group, be named as a co-applicant on proposals etc.) We hope our PPI support will have a significant impact on the ability of UK anaesthesia and perioperative medicine researchers to develop proposals of the highest quality. Our aim is to help ensure that this area of research is focused on the public’s interests and meets the needs and priorities of patients.

**Further information**

- www.invo.org.uk
- http://piiaf.org.uk/
- www.niaa-hsrc.org.uk/PPI

**References**

Over the past months, we have seized several opportunities for liaison. We met with Professor Mark Baker of the National Institute for Health and Care Excellence (NICE). The Faculty has for a small number of years been negotiating a NICE Quality Standard for pain. This meeting gave us the reassurance that this is going to happen and that every effort will be made for it to be timely.

In June, we met with the editor of the British Medical Journal, Dr Fiona Godlee, and members of her team. Again in June, we met with Dr Maureen Baker, Chair of the Royal College of General Practitioners. The RCGP are fully engaged on a number of topics, including commissioning and standards for the practice and delivery of pain management.

In September, we met with Dr Judith Hulf of the General Medical Council to discuss pain management training and learning at undergraduate level.

The Professional Standards Committee (PSC) are producing Core Standards covering the provision of pain services which reach across professional boundaries of those involved in pain, to include physiotherapy, psychology, nursing, occupational therapy and general practice.

The PSC has now completed the first batch of FPM patient information leaflets, which cover drugs used in pain medicine and they are moving on to produce the same for pain medicine interventions.

The Training and Assessment Committee are shortly to launch the trainee survey and to publish the Regional Advisor in Pain Medicine report.

The examinations team has produced advice for FFPMRCA examinees, drawn up the examination prize and appointed two new examiners and two new question-writers.

The world of commissioning is something foremost in the minds of all those working in pain medicine. The Faculty makes clear statements about the place of specialised (‘secondary’ in ‘old money’) and specialist (‘tertiary’) pain medicine in the new world of patient referral, our mantra ‘Right patient, right professional, right time’ makes clear that a proportion of those with persistent pain do not get their problems resolved in primary care and in the community, and these patients have a right to be referred into specialised care and specialist care if necessary. The UK Pain Consortium (the British Pain Society, the Chronic Pain Policy Coalition, the Clinical Reference Group for Specialised Commissioning, the Royal College of General Practitioners and ourselves) holds regular meetings bringing together what are the key bodies in pain medicine/management at this critical time, attending to issues of commissioning and protection of the speciality of pain medicine.

Our Essential Pain Management (EPM) project, exporting the course of the Australian and New Zealand College of Anaesthetists to parts of Africa, is now in its stride. A further course has taken place in Uganda, and courses are set to run in Malawi and Ethiopia.

The EPM course has been adapted to a version known as ‘EPM lite’ for delivery as a half-day course to undergraduates. This project is well established in New Zealand and India. The Faculty is pioneering its introduction to UK medical schools; it was piloted in Bristol in September and, we hope, is set to roll out to further UK medical schools. If you are involved in undergraduate pain education, we are very keen to hear of what you are doing. We are also keen to introduce ‘EPM lite’ to other medical schools. Please contact us on fpm@rcoa.ac.uk.

The Faculty has been delighted to present its evidence base for pain, created by Stephen Ward and presented by Dawn Evans; this is now available on the FPM website.

The Faculty’s activity is out of necessity diverse, and we trust it is meeting the demands and needs created in a world of changing healthcare. If you would like to discuss areas to which you feel the Faculty should turn its attention, or areas of work in which you would like to become involved, than please email me at fpm@rcoa.ac.uk.
Following the Cheshire West and Chester ruling, the Intensive Care Society (ICS) and the Faculty held a colloquium covering the potential issues for critical care relating to Deprivation of Liberty Safeguarding. The acid test, is the patient under constant supervision and are they free to leave, would apparently include most intensive care patients! This colloquium was held in July at the Royal College of Physicians in London, and was expertly put together by Dr Chris Danbury. The day was well attended by a number of clinicians from within intensive care, and the speakers included two excellent legal experts in Mr Alastair Pitblado and Mr Alex Ruck Keene. The conclusions of this event are about to be published in the Journal of the Intensive Care Society. Meanwhile if anybody needs some guidance in a clinical situation involving the Mental Capacity Act you may find these apps useful:


The Joint Standards Committee (JSC) of the FICM and the ICS have made some excellent progress in the development of a general provision document for the specialty. Titled Guidelines for the Provision of Intensive Care Services (GPICS) and modelled in part on Guidelines for the Provision of Anaesthetic Services (GPAS) the document has been brought together thanks to the hard work of a number of talented authors under the watchful eyes of JSC Co-Chairs, Dr Simon Baudouin and Dr Gary Masterson. The first drafts of virtually all chapters have now been submitted. The JSC has made excellent progress with its audit recipe book, ably led by Dr Adrian Wong. The JSC is currently looking into a method of improving incident reporting for the intensive care community by continuing negotiations with the Medicines and Healthcare products Regulatory Agency.

From the Training and Assessment Committee, the FICM already has links with the Association of Cardiothoracic Anaesthetists (ACTA), which has a strong critical care group. The publication of the Core Standards for ICUs has led to much helpful dialogue with the Neuroanaesthesia Society of Great Britain and Ireland (NASGBI). The requirements of the Core Standards present unique challenges to specialist centres, and although the need to implement such developments as splitting rotas is accepted, the timescale for this may not be short and the transition may not be without issue. The FICM will ensure it builds a secure and lasting relationship with ACTA, NASGBI and all specialist areas of the specialty in order to understand the concerns and to facilitate training of the specialist intensivists of the future.

Following concerns about airway management outside of the operating theatres, as described in NAP4, the FICM is collaborating with the ICS, the Difficult Airway Society (DAS) and the RCoA on producing a fit for purpose guideline. The group has met once in August, and hopefully by 2015 guidance will be available.

The FICM held the second conference for Advanced Critical Care Practitioners (ACCP) in June this year, with a programme produced by Ms Carole Boulanger and Dr Graham Nimmo. The Royal College of Physicians of Edinburgh kindly provided rooms for the various lectures and workshops. The very first meeting of the FICM’s ACCP Advisory Group will be held in September which will take forward a number of work streams, including the publication and distribution of the ACCP curriculum.

Finally, the FICM is hosting a two-day meeting on 14–15 May 2015, called ‘Critical Works’. The meeting will embrace a number of areas, including CPD updates, recent research outcomes, and national initiatives, along with areas of wider political interest for the specialty.
Reflection

Dr J Barrie, Consultant Anaesthetist, Pennine Acute NHS Trust, Council Member, SEA UK
Mr J Barrie, Consultant Orthopaedic Surgeon, East Lancashire NHS Trust

Introduction
Reflection is seen as a key part of personal development both as a clinician and an educator. It is an important component of the process of learning, as outlined in the first article in this series.¹ The GMC requires evidence of reflective practice for clinical revalidation² and it will be important for recognition as a trainer.³ In this article we will assume that clinical educators have some experience of thinking about their clinical and educational practice in order to understand it better and to change or reinforce it for the future. We aim to encourage educators to develop their reflective practice further, and to think about how to teach it to their trainees and support trainees’ reflective practice in turn.

What do we mean by ‘reflection’?
While reflection is a familiar part of practice for most clinicians,⁴,⁵ they may understand it in different ways. Sandars’ systematic review⁶ quotes three definitions from the literature and offers one of his own. Common to all of these is thoughtful consideration of a situation, experience or idea in order to gain better understanding.

Sandars also notes that this is intended to inform future encounters with similar situations. Structured consideration and orientation towards learning for the future, distinguish reflection from mere thought.⁷

One of the major aims of reflection is to effect change in understanding or practice. Dewey⁸ thought that reflection begins with a problem or ‘perplexity’. In his view, reflection is about gathering information, reviewing possible explanations and testing these. Mamede and Schmidt⁹,¹⁰ showed that these ideas can be developed to improve medical decision-making.

Schon¹¹ retained Dewey’s ideas about gathering information and testing explanations. However, he argued that in reflection professionals should go deeper and rethink the way they ‘frame’ practice situations – not only ‘Why do I do this?’ but ‘Why do I choose to think about it this way?’ Mezirow also suggested that reflection should lead to a change in the way we understand our situation, and so to a transformation of the assumptions and expectations underlying our thoughts and behaviour.¹² Writers such as Habermas,¹³ Brookfield¹⁴ and Fook¹⁵ see such transformative reflection as growing out of a critical understanding of the social forces that influence our beliefs and expectations.

Studies of anaesthetists’ approach to their work suggested that this is either reactive or interpretative in nature.¹⁶,¹⁷ Those taking an interpretative approach were said to demonstrate a greater awareness of the patient as an individual and of the inherent uncertainties of anaesthetic practice than those taking a reactive approach. The latter viewed anaesthesia more in terms of patterns of patients and responses, and had a mechanistic view of the information received and expected responses. The authors¹⁶,¹⁷ argue that routine reflection may lead to an increased awareness of the subtle interplays between the patient and anaesthetic perioperatively. This may lead to a more nuanced anaesthetic with an assumption of improved patient experience. Reflection on the ordinary may encourage recognition of uncertainty in practice and development of uncertainty to this.¹⁸

Triggers for reflection
A major trigger for reflection is when the need for change is apparent, when our usual ways of viewing or dealing with a problem do not work. This leads to a gap between expectation and outcome, which should lead the practitioner to question the premises on which he approaches the problem.¹⁹ In this model of reflection, typical triggers include Serious Untoward Incidents and ‘difficult’ cases which did not progress as expected. Such ‘disorientating crises’⁵,¹²,¹⁹ are thankfully rare in clinical practice, although well devised simulation may have a role in increasing the number and range of such ‘crises’ to which the trainee is exposed.

Because such incidents are rare, our models are not often challenged in this way. This may result in patient care which is ‘good enough’ but falls short of ‘best’, yet these episodes may not ordinarily act as triggers for reflection – they are just ‘the job’. This may be countered by developing a practice of ‘reflecting on the ordinary’. This approach is advocated by the tradition of mindfulness²⁰ or examen²¹ and is a component of many worldviews. Reflection on the ordinary requires what Cowan describes as a ‘commitment to reflect’²² which implies a similar commitment to notice.⁶ Within this, triggers may come from a patient, from the intervention of another or from a comment from a colleague.
There are a variety of formal triggers to reflection. These range from the portfolio requirements for ARCP or revalidation, to learning journals and activities incorporated into educational activities. Evidence that these improve the depth of reflection is weak.\textsuperscript{18,23} Compulsory portfolio reflections are often of poor quality\textsuperscript{24-26} and may be resented by trainees, but may not represent the true extent or depth of a practitioner’s reflection.\textsuperscript{5,27} Some trainees who decry portfolio reflection still use written reflective techniques\textsuperscript{28} and there is some evidence that the act of writing reflections encourages sense-making and emotional release.\textsuperscript{6}

**The process of reflection**

Having identified an experience, incident or idea to reflect about, how can we best go about it? Schon\textsuperscript{11} suggested that professionals often reflect while they are actually ‘in action’, that is, while they can still change what they are doing. Realistically, there is often not enough time for true ‘reflection-in-action’ and reflection normally happens after the event.

**Reflective frameworks**

Once triggered, reflection may include cognitive, emotional and social aspects. Most reflection in medical practice concentrates on the cognitive aspects: the content of a situation or the process of resolving it.\textsuperscript{19} Many people find it helpful to use a framework of prompts or questions to make sure they don’t miss important things out. In fact, we are using a simple version of Driscoll’s framework to structure this article:

- **What?** – What shall I reflect about? This was the basis of the previous section on stimuli to reflection.
- **So what?** – What does this mean, what conclusions shall I draw? This is the present section, which one might call analysis.
- **Now what?** – What shall I do about what I have learned? This is the basis of the final section, on implications of reflection.

We suggest you explore a number of recognised frameworks to see which helps you most (see box). You could try out reflections, guided by a particular framework, on a range of experiences or events. You might decide different frameworks are helpful to you in different reflective scenarios. Most frameworks cover similar ground, and there are no comparative studies showing which are most effective.

The trainee is gradually exposed to aspects of practice other than providing anaesthesia. These include alleviating patient anxiety and suffering, providing optimal preoperative preparation and surgical conditions, and organising the team and list management.\textsuperscript{30} Using this as a structure for reflection may help the trainee develop in all areas. Guidance from the supervisor may encourage development in areas in which the trainee is weaker or which he has not considered. Similar lists could be constructed for critical care and pain medicine.

**Different viewpoints**

One mark of mature reflectors is that they try to get many different perspectives on the subject they reflect about. Brookfield\textsuperscript{14} describes four ‘lenses’ to get different perspectives:

- **Your own history** – how does this incident, idea or experience fit into your previous experience, beliefs and value system?
- **Your students** – what feedback did you get from your students on the experience? (If you were reflecting on a clinical incident, this would be the patient/carers.)
- **Your peers** – did you get peer review, or discuss the incident with peers?
- **The literature** – what educational research or theory bear on the experience?

Deeper reflection includes consideration of the biases and premises underlying the situation (‘Why do I view it like this?’), the lenses through which it is viewed (How does it look or feel to others?) and the socio-political culture in which it took place (‘Why do we conceive of it this way?’).\textsuperscript{12,20,31} This may lead to change in culture as well as understanding.

**Emotion**

A few people feel that emotion has no place in reflection. Boud\textsuperscript{32} considered that strong emotions could get in the way of reflective thought, and that they needed to be discharged to allow reflection to proceed. Sandars, on
and Schmidt’s concepts.20 Schon and one’s mental processes than Mamede deeper degree of critical awareness of clinical problems. Epstein described however, the reflection in their studies the presence of strong emotions.’6 Emotional responses could be generated by a clinical situation or by a patient or colleague whose personal belief systems may differ from that of the anaesthetist.31 Moon described three ways in which emotion could interact with reflection:7
- It could be part of the process of reflection.
- It could provide the content of reflection.
- It could impinge on the process of reflection.

We would encourage you to evaluate your emotional reaction as you would what you did or said.

Understanding your own thinking – metacognition
Dewey’s early descriptions involved critical awareness of one’s own thought processes. Mamede and Schmidt applied this insight and showed that this could improve some aspects of diagnosis.10 However, the reflection in their studies was mainly aimed at solving specific clinical problems. Epstein described ‘mindful practice’, which involves a deeper degree of critical awareness of one’s mental processes than Mamede and Schmidt’s concepts.20 Schon and Mezirow, among others, focus on reflectively questioning the way we frame our understanding – ‘Why do I think about it this way?’2122 Trainees have described metacognition using metaphors such as exploration, viewing a video, processing and comparison with an idealised self-portrait.28

Implications
What are the implications of this for anaesthetists as practitioners and as educators?

Firstly, failure to achieve deeper levels of reflection may result from unexamined negative emotion (avoidance), from lack of imagination or literal-mindedness leading to lack of curiosity or limiting responses.20

Second, we could benefit from viewing reflection as a social activity. Discussion helps us identify the reasoning behind a course of action and articulating these makes them explicit. It can also help us question these assumptions and re-frame our approach to problem solving.33 Case presentations may have a role here. Much social reflection is undertaken informally, introduced by: ‘What do you think about this one then…?’, but the formal input of a colleague or facilitator may guide the reflection into new or deeper areas.16

One important educational task is to facilitate and develop reflection in our students and trainees to promote their own personal and professional development. Some have advocated a structured approach to aid this, others feel this might itself be constraining.34 The facilitator needs to draw upon a range of attributes:27,35
- Offering role models of reflection that students can relate to and ask advice from.
- Feedback on trainee reflection, with guidance on further development.
- Offering resources to your students that contain examples of sophisticated reflection. Moon7 offers several resources you can copy freely to use with your own students
- Challenge assumptions whilst maintaining support and encouragement.
- Handle the potentially strong emotions which such a challenge can arouse.
- Work with ambiguity as they help their colleagues deconstruct and refashion reality.3033 It can be an untidy process with the temptation to rush to a premature conclusion.

Although there has been no research on the effect of the educational environment on reflection, we suggest that an environment in which reflection is valued and encouraged probably improves the chances that trainees will develop as reflectors.

This begs the question as to who is best placed to facilitate such reflection, particularly with trainees – it may not be the educational supervisor. There is emerging evidence that reflection in practice differs from reflection for portfolio with the latter being limited by its being submitted for the ARCP.44 27,35 Deep or critical reflection includes a degree of openness and vulnerability. There is inevitably a power differential between trainee and educational supervisor, and the trainee may not be willing to be vulnerable within this relationship. Any hint of evaluation or surveillance based on reflection may exacerbate this. The skill set is similar to that required of mentors, and it may not be seen in people who are otherwise excellent trainers or educational supervisors.

Not all trainees find reflective writing easy. Students comment that they frequently reflect but find it difficult to record their reflections. Alternative methods of recording to formal reflective writing include audio or video recording or blogging.6 Reluctant trainees may prefer one of these media.

Conclusion
Both significant and everyday events may act as triggers for reflection. If followed through, reflection has the potential to challenge and change both our understanding and our practice, culture and systems which lead to its development and continuation.
Reflection should include a wide variety of viewpoints and a number of frameworks exist to encourage this. It may benefit from being conducted as a more social activity than is traditional. Supporting reflection draws upon a wide range of skills. Most of us do this routinely; we hope that this article has suggested ideas to make reflection more productive.

Further reading
Moon’s book gives an excellent overview of the development of our understanding of reflection, and contains lots of practical ideas for helping your trainees reflect more effectively.6 For a brief overview, Sandars’ review for AMEE is a good place to start.6

1 Dorman T, Cooper A. Anaesthetists as adult learners. RCoA Bulletin 2014;84:17–19.
34 Aronson L. Twelve tips for teaching reflection at all levels of medical education. Medical Teacher, 2011;33:200–205.
Negligence, standard of care and the legal status of clinical guidelines

Dr E Combeer, Consultant Anaesthetist, Frimley Park Hospital NHS Foundation Trust

In order to prove that a doctor has been negligent in the care of his patient, it must be demonstrated that his actions fell short of an expected standard. Following Bolam, the expected standard was established through the evidence of expert witnesses, whose testimony would often be accepted at face value. This allowed clinicians to determine acceptable practice within the profession, thus setting the ‘professional standard’ in medical negligence cases. More recently, the courts have started to scrutinise the evidence of such witnesses, analysing it for its logic, therefore putting the courts back in charge of determining whether a doctor’s actions have breached expected standards. The first part of this article looks at this change in more detail.

Concerns exist that the courts may use clinical guidelines as a written statement of what the standard of care in a given situation should be. In such a scenario, deviation from a guideline in association with patient harm might be used to prove negligent action on the part of the doctor. The second part of this article addresses the role that clinical guidelines have, and might have in the future, in such cases.

Establishing negligence in an era of deference

Negligence is a tort, a civil (rather than criminal) wrong that any person may inflict on another, resulting in liability for compensation to the injured person. Clinical negligence occurs when a patient suffers harm due to the action (or inaction) of a healthcare professional. In order to prove that a doctor has been negligent, the claimant must prove three things: that the doctor owed him a duty of care; that the care provided by the doctor fell short of the standard that it should have been; and that the patient suffered harm as a direct consequence of the breach of standards.

Traditionally, Bolam set the standard against which a doctor’s actions were considered. Bolam sustained fractures during electro-convulsive therapy (ECT). He claimed that the doctor had been negligent in failing to warn him of the risks of ECT, in failing to use muscle relaxants, and in failing to use restraints. However, the judge found that the doctor had acted ‘in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular area’. Bolam’s claim of negligence therefore failed because although he had suffered harm, and certainly his doctor owed him a duty of care, it was not proven that the doctor had breached that duty of care.

What followed was an era of deference to the medical profession in negligence case law. When facing differing opinions from expert witnesses about the correct course of patient management, the judiciary rarely attempted to analyse the rationality of the opposing views (as would have happened in negligence cases concerning any other profession). Instead, even a single witness testifying that the accused doctor’s management approach was acceptable satisfied the judiciary that the doctor had acted appropriately.

Establishing negligence after Bolitho

Bolitho altered the common interpretation of the Bolam ruling. Bolitho concerned a young child admitted to hospital with breathing difficulties. Twice the child’s breathing deteriorated and twice the paediatric registrar was called to see him but failed to attend. Each time, the child’s breathing recovered. Later, the child deteriorated and suffered a respiratory arrest with consequent brain damage. The defence asserted that although the doctor should have come to see the patient when called, failure to do so had not changed the outcome. Only intubation would have averted the respiratory arrest and this would not have been warranted earlier as the child’s condition had improved. Expert medical opinion on whether the child should have been intubated in advance of the respiratory arrest differed, and the judge decided that he was unable to scrutinise the validity of those differing opinions, in accordance with the usual stance following Bolam. He was therefore of the opinion that the harm suffered by the child could not be causally linked to the doctor’s actions.

However, when Bolitho reached the House of Lords, their Lordships agreed with the outcome of the case but disagreed with the trial judge regarding whether the evidence of medical expert witnesses could be scrutinised. They stated that in the majority of cases the
merek fact that a distinguished expert held an opinion was sufficient to deem it a reasonable opinion but that, on rare occasions, if ‘the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible’. Their Lordships did not believe that they were rewriting the rules in this instance, even though this had not been the common interpretation of the case law until that point in time. In Bolam, the words responsible, respectable and reasonable were used to describe a body of medical opinion that could offer support to a defendant’s actions. The courts, their Lordships said, are justified in satisfying themselves that this is the case.

Case law evolves, influenced by changes in societal attitudes and norms. The public and judicial view of doctors has changed. Previously, the judiciary had sympathy with the hard-working, caring, altruistic doctor, feared that successful negligence claims might breed defensive medicine, and felt that use of National Health Service funds on defending negligence claims was inappropriate. However, the reputation of doctors has been undermined by scandals such as Bristol and Alder Hey, and patients are more knowledgeable and prepared to assert their rights.

The change in approach of the courts between the case law that followed Bolam and the analysis in Bolitho demonstrates well that the outcome of a case cannot necessarily be determined or pre-judged on the basis of what has gone before.

Clinical guidelines as a standard of care
The purpose of clinical guidelines is to bring evidence and research into practice, thus assisting doctors in the provision of good medical care. Some guidelines also ration healthcare or dictate on the provision of a particular clinical service. Concerns exist that they can be excessively prescriptive thus stifling clinical autonomy, may not reflect what is truly happening in safe, common practice, and yet may be used legally as a written statement of what the standard of care should be in a given context.

Previously, a clinical guideline would not be admissible as evidence in its own right as it would be deemed hearsay, evidence that cannot be substantiated in court. For example, it was decided in Loveday v Renton that written guidance from the Department of Health and Social Security could not be ‘relied upon as though it was evidence of qualified experts not called as witnesses’. However, the Civil Evidence Act 1995 made hearsay evidence admissible, but charged the judiciary with a responsibility to assess such evidence for its applicability in the given context.

Analysis by the courts of clinical guidelines
The courts have demonstrated a willingness to assess the applicability of guidelines in the context of medical negligence cases, and this should offer some reassurance to those who fear that the courts will blindly accept a guideline as a self-evident statement of best practice. Early v Newham offers an example of a doctor successfully defending a negligence claim by appropriately following a guideline. The claimant suffered a period of awareness following a failed intubation attempt. In managing the situation, the anaesthetist had followed a locally-developed failed intubation guideline. The expert witness for the claimant tried to persuade the court that the anaesthetist was negligent and that the guideline he had followed was flawed. However, the judiciary assessed the manner in which the guideline had been developed and adopted (by discussion at a departmental meeting of predominantly consultant-grade anaesthetists, and recorded in the minutes) and agreed with the view that whilst application of the guideline might increase the risk of awareness in a failed intubation, it reduced the risk of hypoxia, the consequences of which are much more serious.

Failure to follow guidelines does not result in an automatic finding of a doctor’s negligence in the event of patient harm if good clinical reasons have necessitated the deviation. A doctor prescribed gentamicin for a patient with bacterial endocarditis at higher doses and for a longer duration than was advised by (amongst other guidelines) the British National Formulary and the product data sheet. The patient suffered vestibular damage. Expert witnesses assisted the judiciary in deciding that the guidelines were too cautious, that gentamicin was commonly prescribed at higher doses for similarly good clinical reasons, and that, perhaps, the dosages stated by the manufacturers were low in order to limit their own potential liability. Similarly, a surgeon who deviated from guidelines and performed a colonic resection without histological evidence of cancer was found not negligent. It was decided that the surgeon was able to demonstrate good clinical reasons for his actions.
The courts have also used an analysis of guidelines to help decide that doctors have been negligent when they have failed to follow guidelines without reasonable clinical justification. DF was delivered by ventouse delivery when her mother was not yet at full dilatation. She suffered a subgaleal haemorrhage with consequent cerebral palsy. The court found that recent guidance issued by the Royal College of Obstetricians and Gynaecologists gave a clear prohibition of such practice and would have been widely disseminated. There was no clinical justification for having deviated from the guidance and so the doctor was found negligent.

So many guidelines, such little time…

The case concerning DF raises an important issue – there is a plethora of guidelines written by a multitude of different sources. It can be difficult for clinicians to ensure that they are following all appropriate guidance relevant to their practice at all times. This issue has been addressed in the courts. In 1953, a patient brought a claim in negligence against his anaesthetist after suffering a brachial plexus injury due to his arm being kept in an extended position intraoperatively for the purposes of blood transfusion. This complication had been described in The Lancet six months previously and initially the anaesthetist was therefore found negligent. However, when the case reached the Court of Appeal, Lord Denning stated that doctors cannot be expected to read every journal article in the medical literature, but that ‘[t]he time may come in a particular case when a new recommendation may be so well proved and so well known, and so well accepted that it should be adopted’. The four key components to this ‘Denning’s Test’ might be as applicable to clinical guidelines as to medical literature: proof, dissemination, acceptance, adoption. More recently, the courts have reinforced the responsibility of doctors to stay up-to-date in their practice through reading of ‘mainstream’ literature whilst accepting that it was unreasonable to expect them to have read the ‘more obscure journals’.

**The legal weight of national guidelines**

It is possible that some guidelines may carry greater weight than others in a legal setting. Guidelines issued by the Royal Colleges and the General Medical Council, for example, will benefit from being developed by an expert working party with the back-up of adequate literature searching and access. Such bodies are also more able to ensure widespread dissemination of their guidelines. In this way, these guidelines are likely to fulfill the criteria of ‘Denning’s Test’. Although not a clinical negligence case, when discussing management of patients in a persistent vegetative state in Bland, their Lordships studied British Medical Association guidance on the matter. They were satisfied that a doctor acting in compliance with this guidance would be following a ‘responsible and competent and relevant body of professional opinion as required by the Bolam test.’ Despite authorship by a national body, the fact that their Lordships studied the guidance and did not take it at face value is demonstrative of the fact that the courts want to retain control as the ultimate arbiter of the appropriate standard of care.

The National Institute for Health and Care Excellence (NICE) was established in 1999 as a non-departmental public body with a responsibility for reducing variations in health care across the country. In developing their guidelines, NICE claims a reputation for ‘rigor, independence and objectivity’. NICE is accountable to the Secretary of State and their guidance is supported by government policy. For these reasons, it has been argued that NICE guidance will carry greater weight in court than other guidelines. The possible legal consequences of harm resulting from central line insertion performed without ultrasound guidance was addressed in the *British Journal of Anaesthesia*, ten years after NICE disseminated its guidance on the matter. The authors suggested that it would not be possible to defend a negligence claim in the event of complications arising from accidental arterial cannulation if ultrasound was not used, and criminal charges would be possible if death was a consequence. However, their stance was not based purely on the fact that the guidance was authored by NICE, but because they felt the weight of evidence involved in production of the guidance, and the outcomes of more recent studies, are so compelling in their support of ultrasound use. A flurry of letters of objection to such strong statements ensued from prominent members of the anaesthetic community, raising issues such as a need to continue to learn a landmark technique, the sometimes non-availability of ultrasound equipment and the lack of a compelling evidence base for use of ultrasound at all times. Others have raised concerns about NICE guidance generally, criticising its sometimes proscriptive guidance and sometimes great difference to ‘pragmatic medical practice’.

It is my view that where NICE guidance has not achieved unanimous approval and endorsement, it will not be used by the courts as self-evident standards of care, and that the judiciary will be as keen to analyse
NICE guidance for its applicability to the given situation as much as any other guidance. Very clear justification, however, might well be necessary for deviating from it. Only time will tell if this is the case.

Conclusion
The era of deference by the courts to the medical profession has passed, and expert witnesses should expect to have their opinions appraised for their logic. There are an ever increasing number of clinical guidelines in existence, and these are now admissible in court as evidence. However, like expert witnesses, these will not be accepted at face value by the courts: they will be analysed for their applicability to the given situation, the evidence base that supports them, their dissemination, and whether there are any clear clinical reasons to deviate from them. And indeed, there will be reasons not to follow guidance: the Royal College of Anaesthetists states that their own guidelines ‘do not replace the need for experienced clinical judgement exercised by individual anaesthetists in the best interests of their patients, but they are very much intended to support this’.22 Doctors have a duty to maintain their knowledge and skills, and keeping up to date on the clinical guidelines that are relevant to their practice is no exception. If it is not appropriate to follow guidelines in certain situations, care must be taken to document the reasons. Reasons that will not be found compelling justification by the courts are those of pure personal belief, if that belief is not based on reasonable grounds.

‘...that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique, if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying ‘I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century.’ That would clearly be wrong.’

Mc Nair J, Bolam

References
2 Bolam v Friern Hospital Management Committee (1957) 2 All ER 118.
3 Maynard v West Midlands Regional Health Authority (1985) 1 WLR 685, (1985) 1 All ER 659.
4 Chatterton v Gerson (1981) 1 All ER 257
5 Bolitho v City Hackney Health Authority (1998) AC 232.
6 Roe v Minister of Health (1954) 2 QB 66 at 86.
12 Loveday v Renton (1990) 1 Med LR 117
13 Civil Evidence Act 1995 c.38.
14 Early v Newham Health Authority (1994) 5 Med LR 214.
16 Ratty v Haringey Health Authority (1994) 5 Med LR 413.
17 DF (by her litigation friend and mother CF) v St George’s Healthcare NHS Trust (2005) EWHC327.
18 Crawford v Board of Governors of Charing Cross Hospital (1953) Times, 8 December, CA.
21 Airedale NHS Trust v Bland (1993) 1 All ER 821.
Workforce planning is about ensuring that there are enough staff, with the right skills available to care for patients. Sounds pretty simple? Well actually, it really isn’t simple at all and there are several well-publicised examples, both from the UK and abroad of it going very wrong.

Within the UK there is currently a high-profile workforce shortage within Emergency Medicine, although other specialties are also reporting recruitment and retention difficulties. Outside the UK the rising unemployment amongst Canadian cardiac surgeons has garnered large numbers of column inches, and older readers of this publication may well remember the issues that Obstetric and Gynaecology had with unemployed CCST holders in the UK in the late 1990s.

The consequences of inadequate workforce planning are significant and far-reaching. Patients are affected because the care they need is not obtainable locally – or worse, not obtainable at all, or they are forced to use a stretched service. The wider UK economy is also affected since taxpayers fund medical training, and unemployed doctors opting to move abroad represent a significant financial loss. Individual doctors and their families are also affected as failure to secure a suitable consultant post can force relocation, retraining or unemployment. In a less obvious but equally important way, recruitment difficulties affect existing consultants and doctors in training because they end up working within understaffed and stretched departments, thus impacting adversely on the working and training conditions for those in post.

Therefore it is vitally important to try to get workforce planning right. Healthcare is a devolved issue, and thus responsibility for workforce planning falls to each country within the UK resulting in a variety of approaches and prioritisation of the issue.

UK anaesthesia has reacted by establishing the national Workforce Planning Strategy Group comprising representatives from the RCoA, AAGBI, Clinical Directors Network, each of the devolved UK nations and anaesthetic trainees, with input from outside bodies, including Health Education England and the Centre for Workforce Intelligence (CfWI). The RCoA has recently appointed a full time Workforce Planning Coordinator to assist with this growing area of work, although it is probably worth noting that other colleges (e.g. the Royal College of Physicians) have much larger and more established medical workforce units.

Planning a medical workforce is difficult, primarily due to the long training time to produce a fully-trained Consultant. Decisions taken now about specialty training numbers will affect the output of consultant anaesthetists in 2022 as RCoA data suggests that it takes the average trainee around eight years to complete training. If manipulations to medical school numbers are proposed the lead-time is even longer (15 years plus).

Calculating the future workforce requires that the demand or need for anaesthesia in the future be estimated alongside the supply of trained doctors – multiple factors influence both demand and supply. On the demand side an ageing population, increasing survival with chronic illness, evolving surgical technology and the funding situation of the NHS all have a role to play. Whereas on the supply side the future workforce can be estimated by looking at college census data, predicting retirement ages, reviewing participation rates (how many sessions the average consultant works per week) and deciding upon adjustments to accommodate the changing expectations of the workforce.

Predicting future participation rates is challenging – more trainees than ever before are working less than full time (LTFT), and data
from the GAT/RCoA workforce planning survey in 2012 suggests that 38% of those currently working LTFT wish to continue doing so into Consultant life. However, contemporary data collected for the RCoA shows that most former LTFT trainees take up full time consultant posts.

A further muddying factor is the increasing separation of intensive care medicine from anaesthesia and how this will impact upon the anaesthetic workforce.

It should by now be apparent that this is a fairly complex process!

The CfWI in depth review

The Centre for Workforce Intelligence (CfWI) is a private sector organisation which has been commissioned by the Department of Health and other government bodies, including Health Education England (HEE), to carry out a series of projects looking at the health and social care workforce across a range of diverse disciplines, including: medical ophthalmology, public health, adult social care and general practice.

During 2013/4, the CfWI have been undertaking an HEE commissioned in-depth review of the future workforce needs for anaesthesia and intensive care medicine in England until 2033.

The CfWI has refined a scenario based predictive modelling tool that is designed to estimate future workforce requirements. These methods have been utilised during the work on anaesthesia and intensive care medicine in England until 2033.

The CfWI methods have been described fully elsewhere and are described in detail on their website (www.cfwi.org.uk). These methods comprise four stages.

1. Horizon scanning
2. Scenario generation
3. Workforce modelling
4. Policy analysis

In practice, Horizon scanning involved a series of telephone interviews with members of the profession to elucidate factors (drivers) that could affect the future supply and demand for anaesthesia. This was supplemented by a literature review also looking for drivers changing the need for anaesthesia and supply of trained staff.

Scenario generation comprised a face-to-face workshop with invited clinicians, who were challenged to create scenarios incorporating the drivers from horizon scanning. These scenarios were then used to help predict the influence of outside economic and political factors (e.g. less funding for the NHS) on the supply and demand for anaesthesia. Lastly the scenarios were summarized and circulated amongst an expert panel as part of a ‘Delphi’ exercise in an attempt to numerate the effects. The cumulative results of the Delphi exercise will contribute to the workforce modelling exercise.

As I write, the full report has not yet been released (publication is expected in September 2014), however, preliminary results suggest that there is currently unmet need for anaesthesia that increases over the prediction period for all four modelled scenarios. The extent to which unmet need exists varies according to the health economy scenario used, but in all a gap exists between the care required and the care that can be provided. This obviously has implications for patients.

The current situation

At a crude level, the number of consultant jobs advertised appears to be roughly equivalent to the number of CCT holders produced (Figure 1).

Anecdotally, there is a significant amount of regional variation – in London, where I currently work, there are significant numbers of post-CCT Fellows and Locum consultant posts in evidence with CCT holders appearing to queue for a substantive job, whereas in Scotland, where I trained, consultant posts, even in previously desirable teaching hospital locations, are becoming difficult to fill and the vast majority of recent CCT holders are moving straight into substantive Consultant posts. There are probably a number of reasons for this – including the widespread adoption within Scotland of 9:1 contracts, which has been discussed elsewhere, and consultant resident on call. The
evolution of consultant resident on call is not restricted to Scotland and working patterns are changing elsewhere in the UK to accommodate a diminishing number of trainees.\(^8\)

Regional variation in employment opportunities cannot be explained merely by the contracts on offer. The current cohort of trainees appears to have a different attitude to life and their careers than in the past. The RCoA/GAT survey\(^4\) asked recently appointed consultants to rank the factors that influenced their choice of post – the top-ranking factor was location. Other commentators have also noticed changing attitudes to employment.\(^9\) The days of new CCT holders relocating to far flung areas to obtain a consultant job appear to be over.

It therefore appears that one of the driving factors in future workforce planning will be about ensuring that relocation is unnecessary to fill consultant posts. This may mean that training numbers need to be redistributed within the UK.

An added pressure is that recruitment into anaesthesia training posts is challenging – the fill rate for ST3 in August 2014 was around 86%. The reasons for this are multifactorial, but I wonder if trainees, in the aftermath of core training and primary FRCA, are looking ahead at the implications of seven-day working and choosing to pursue careers in other specialties or countries. However, this cannot be the only driver as general practice, which has a well publicised contractual opt out of anti social hours, is also struggling with recruitment and retention.

There is growing pressure within LETBs to address the growing shortage in other specialties (GP/Psychiatry/Emergency Medicine) by diverting resources often at the expense of other specialties. In England, anyway, anaesthesia appears to be losing out. The decision-making for 2015 training posts has just taken place, and anaesthesia is going to lose posts. This decision was made despite the preliminary findings of the CfWI demonstrating that anaesthesia has a growing supply and demand problem, and a lengthy joint submission from the RCoA/AAGBI outlining the reasons why anaesthesia needs a larger workforce.\(^10\)

The other devolved nations are making different decisions. Scotland is intending to increase anaesthetic training posts in 2015.

In summary

Workforce planning is challenging, and anaesthesia appears to be facing a challenging period with threatened cuts to training posts, recruitment difficulties and growing expectations of a 7-day service. Data from individual anaesthetists and departments is invaluable in informing the workforce planning process.

The forthcoming RCoA anaesthetic workforce census will be an invaluable resource for workforce planning, both now and in the future. Therefore, I urge all of you to ensure your departmental data is submitted in a timely and accurate fashion. I wish to thank all who have contributed in the past to the census and other surveys and ask for a similarly strong and helpful response now.

Acknowledgments

Dr Paul Spargo and Richard Bryant advised on content of this article. Afsana Choudhury was invaluable in providing facts, figures and permission for graphics.

References


5 Correspondence with RCoA LTFT training advisor Dr C Evans.


8 Rimmer A, Operations could be cancelled if anaesthesia posts are diverted to general practice. BMJ Careers, January 2014.


I am undertaking a review of the current Certificate of Completion of Training (CCT) curriculum during my Out-of-Programme Experience (OOPE) year, based at the Royal College of Anaesthetists. This article summarises the progress and future direction of the review.

**Why review the Curriculum?**
The Curriculum for a CCT in Anaesthetics was revamped in 2010, and there have been major changes in the organisation of postgraduate medical education in England since then, as well as the publication of the Shape of Training Review in October 2013. In addition, the GMC requires specialty training curricula to be reviewed on a regular basis.

**What is the Shape of Training Review?**
The Shape of Training review made far-reaching recommendations on postgraduate medical training in order to prepare the medical workforce for the changing demographics faced in the UK. The main recommendations include an emphasis on generalism rather than specialism and shifting training towards the community. It also recommended maintaining flexibility within postgraduate medical training by identifying competences that could be transferred from one specialty to another, and developing ‘credentials’ for some specific specialty areas, probably to be attained after completion of training programmes.

**Survey results**
To identify areas of focus for the review, we undertook an electronic survey of trainers and trainees in the UK for two weeks in April 2014. There was a huge response, and I would like to thank everyone who participated.

There were 3,069 responses to the survey, 1,078 from trainees and 1,991 from trainers. The response rate was calculated using the number of active e-Portfolio users within the three months prior to the survey. This gave a response rate of 41.7% overall, 49.9% for trainers and 31.9% for trainees.

The answers to the questions are shown in Table 1 below:

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with the contents of the Curriculum</td>
<td>0.6%</td>
<td>3.8%</td>
<td>11.0%</td>
<td>34.8%</td>
<td>49.7%</td>
</tr>
<tr>
<td>I can easily find the information I need</td>
<td>1.7%</td>
<td>9.8%</td>
<td>22.2%</td>
<td>53.1%</td>
<td>13.2%</td>
</tr>
<tr>
<td>The volume of learning outcomes is too great</td>
<td>1.0%</td>
<td>5.5%</td>
<td>49.2%</td>
<td>34.1%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Some areas are irrelevant to the practice of a consultant anaesthetist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The current structure of anaesthetic training meets the needs of a new consultant</td>
<td>41.2%</td>
<td>30.4%</td>
<td>28.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Shape of Training review suggests shortening training to 4-6 years. Is this feasible in anaesthetics?</td>
<td>3.4%</td>
<td>15.2%</td>
<td>29.8%</td>
<td>48.0%</td>
<td>3.6%</td>
</tr>
<tr>
<td>‘Spiral learning’ is a sound principle on which to base anaesthetic training</td>
<td>44.0%</td>
<td>30.7%</td>
<td>7.5%</td>
<td>13.0%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>
The tick-box answers affirm that the Curriculum is generally fit for purpose, that the length of training should not be shortened and that the 7-year training programme is tightly packed.

Respondents were given the option of entering free-text responses if they had strong feelings about a particular question. These responses mostly fell into the following themes:

**Structure of higher/advanced training**

There were numerous comments on the structure of the Higher/Advanced training years. There was a perceived lack of flexibility in this period due to mandatory cardiac and neuro-anesthesia blocks in Higher training.

“...having to revisit these subspecialties has the effect of decreasing the time available...to gain experience in fields that would be more useful to me...”

**Workplace-based assessments (WPBAs) detracting from training**

Many respondents felt that the volume of workplace-based assessments was excessive, and said they spent time ‘chasing’ assessments to the detriment of other more valuable training opportunities. This is reinforced by e-Portfolio data showing a large spike in assessments in the months of May and June.

“...our life is all about paperwork paperwork...”

“It is better to do a few assessments well as opposed to hundreds not very well.”

**Variability of requirements between schools of anaesthesia**

During a recent review of school workbooks I found that some schools require many more WPBAs than the minimum requirements of the curriculum. Several trainees commented that requirements are unduly onerous and are detracting from training.

“My school is WPBA-mad. They require us to do a WPBA for around 75% of the items listed on the curriculum...being expected to complete over 200 WPBAs for higher training. This devalues them as learning tools and sometimes forces trainees to...hunt down the elusive WPBAs rather than gaining a more rounded experience.”

**Training v Service**

Comments on the tensions between training and service principally concerned out-of-hours cover of intensive care and, to a lesser extent, obstetrics at the expense of general anaesthesia. Some trainees said that they felt inadequately trained in emergency anaesthesia.

“...time spent in ICU and labour ward eats massively into our training time. I didn’t get to anaesthetise a patient for an emergency laparotomy until I was ST5- because not enough time is devoted to ...emergency anaesthesia”

“...some programmes have a very large commitment to cover ITU out of hours. Therefore some trainees are reaching higher training with little experience of emergency theatre work.”

**The Curriculum as a document**

Although the results above suggested that most people are able to find the information they require, there were requests for the document to be condensed and reorganised.

Following the survey, I undertook site visits to West Suffolk Hospital, a District General Hospital in Bury St. Edmunds, and Salford Royal Hospital, a teaching hospital. The results of the survey were corroborated by interviewing trainees and trainers at these two sites, as well as talking to other trainees in London.

We plan to:

- Examine the structure of Higher training.
- Review the current system of workplace based assessments.
- Look at the use of workbooks by schools and the variable assessment requirements across schools.
- Introduce measures to ensure trainees receive adequate experience in emergency anaesthesia.
- Make it easier to access the Curriculum from the College website.
- Consider revising the Curriculum document to make it more accessible.
- Improve links between e-Portfolio and the curriculum.
- Improve the assessment and delivery of the Annex E competences in Advanced training (Team working/ Leadership/Management etc.).
- Make trainers and trainees aware of some common misconceptions about training and the curriculum (See ‘Myths’ article in this issue).
- Engage with the recommendations of the Shape of Training Review, when adopted by the Departments of Health.

We will keep you up to date with future developments as the review progresses. If you would like any further information or to add your views, please get in touch at ADevlin@rcoa.ac.uk.
Dr A Devlin, RCoA/Kent, Surrey and Sussex Education Fellow, Training Department, RCoA

Training and Curriculum myths

There are lots of misconceptions surrounding training and assessment which cause confusion and stress for trainers and trainees. These were the most common myths that I came across in the recent electronic curriculum survey.

‘You want a DOPS for a cannula at ST6?’
Higher and Advanced trainees should focus on case-based discussion (CBDs) and anaesthesia list management assessment tool (ALMATs), which are more appropriate tools for assessment at this level, and not directly observed procedural skill (DOPS). In fact, only two units in Higher training (Airway and Regional) require DOPS.*

‘I can’t do an assessment for you because your epidural didn’t work’
Workplace-Based Assessments (WPBAs) can provide useful feedback when trainees are learning a new technique, or just having a bad day! There is a tick-box on the e-Portfolio for “formative feedback” only, where the assessment is used for guidance and development. The assessment should be repeated later, when performance in that particular area is more reliable.

‘Doing a CBD, A-CEX and DOPS for every module takes forever’
The module assessment requirements are not all the same. Have a look at the relevant Annex in the Curriculum, which will show you the requirements for each module at your stage of training – it may be less than you think.*

‘Linking several competences to one assessment? That’s cheeky!’
Several competences can be linked to one WPBA, providing they are relevant. If several issues have been touched on in the case, then this is to be encouraged, as it reduces the burden of assessments for trainers and trainees. See the Assessment Guidance on the RCoA website: www.rcoa.ac.uk/node/2178/.

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**Figure 1** Example of essential learning outcomes and core clinical learning outcomes in a typical unit of training

**Critical incidents**

**Learning outcomes:**
Build on the knowledge and skills learnt during basic training and develop skills at managing more complex critical incidents with distant supervision.

**Core clinical learning outcomes:**
- To demonstrate leadership in the management of critical incidents as and when they arrive
- To provide assistance/leadership to more inexperienced colleagues if called to assist in the management of critical incidents
- To demonstrate leadership in ensuring good team work and communication to help reduce the risks of harm from critical incidents

**NB:** All competencies annotated with the letter “E” can be examined in any of the components of the Final examination identified in the FRCA examination blueprint on page C-73.

**Knowledge**

<table>
<thead>
<tr>
<th>Competence</th>
<th>Description</th>
<th>Assessment methods</th>
<th>GMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI_K_01</td>
<td>Discusses the importance of significant event analysis or root cause analysis to examine a locally reported incident</td>
<td>C5</td>
<td>1,2,3,4</td>
</tr>
<tr>
<td>CI_K_02</td>
<td>Discusses the importance of regular practice of response protocols using simulation and their place in the development of team working and communication between professional groups</td>
<td>C5</td>
<td>1,2,3,4</td>
</tr>
</tbody>
</table>

**Skills**

<table>
<thead>
<tr>
<th>Competence</th>
<th>Description</th>
<th>Assessment methods</th>
<th>GMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI_S_01</td>
<td>Demonstrates leadership in resuscitation room/simulation when practicing response protocols with other healthcare professionals</td>
<td>D5</td>
<td>1,2,3,4</td>
</tr>
<tr>
<td>CI_S_02</td>
<td>Demonstrates appropriate use of team resources when practicing response protocols with other healthcare professionals</td>
<td>D5</td>
<td>1,2,3,4</td>
</tr>
</tbody>
</table>
‘Solo lists are a waste of time because I can’t get any assessments done’

This is the ideal time to do an ALMAT by discussing the list with the supervising consultant. ALMATs can be used instead of anaesthesia clinical evaluation exercises (A-CEX) at Intermediate and Higher level, and CBDs can be done retrospectively using case notes. Solo lists are important in developing independent practice, particularly towards the end of training.

‘We need an assessment for every single competence in the curriculum’

The important parts in the curriculum are the learning outcomes and the core clinical learning outcomes, which are in the blue box at the top of each unit (Figure 1). You must achieve these to pass the unit. To prove that you have done this, you need a range of assessments from the competences listed in white. Assessment of every single competence is not expected.*

‘Competent to anaesthetise for a CABG after 20 sessions? I can’t sign that!’

Some trainers were concerned about signing off units of training. The learning outcomes for units may be less complex than you think, for example in Cardiothoracic anaesthesia at Higher level, at the end of the unit trainees are not expected to be able to manage bypass cases independently. If you are unhappy with what you are being asked to sign, have a look at the module learning outcomes in the curriculum or discuss with your College Tutor.

‘Only consultants can carry out assessments’

Apart from the Initial Assessment of Competence, and the Initial Assessment of Competence in Obstetric Anaesthesia, SAS doctors and senior trainees can carry out assessments, providing certain criteria are met (Curriculum for a CCT in Anaesthetics 2010; p.87). Speak to your school administrator to register on e-Portfolio.

I hope this has clarified some common issues with training and the curriculum. If you have any questions about training or the curriculum, have a look at the training pages on the College website, or get in touch at the addresses below:

ADevlin@rcoa.ac.uk
training@rcoa.ac.uk

*Some schools of anaesthesia have different requirements; check your local workbook or school website for details.
The Perioperative Physician: leading patient centred care

Perioperative medicine is here – but what does it mean for the future of our specialty?

“The patient must be the first priority in all of what the NHS does. Within available resources they must receive effective services from caring compassionate and committed staff working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.”

The words of Robert Francis encapsulate the view of the College and that across the wider world of healthcare. Yet we know that there continues to be both a systematic failure to deliver co-ordinated, patient-centred care, and limited communication or information sharing. The realities of the ever-increasing financial challenges and service pressures have negatively impacted performance, morale, and ultimately, the patient experience.

We know that change is essential, and there does appear to be a consensus on this need for change, yet little clarity on how to affect the seismic shift that is required. The challenges we, and our colleagues face, are how to secure agreement on, and implement, the necessary changes required within the NHS, with such disparate organisations and interests involved.

The College

We believe that there is a role for the College to step up to this challenge and drive perioperative medicine as a significant part of the solution.

As the largest single medical specialty, we are uniquely positioned to lead the further development of this collaborative care solution. Better integrated care of the high-risk patient undergoing major surgery will improve patient outcome. Perioperative medicine makes surgery a more effective and successful treatment, because we minimise the loss of quality of life when complications develop. Perioperative medicine is already within anaesthesia, and many of us have implemented perioperative solutions, particularly around pre-assessment and enhanced recovery.

We recognise that the patient travels on a surgical care pathway and anaesthetists are privileged to care for patients at each step of the hospital pathway – pre, intra and post operatively. Yet we are not advocating that good patient care is dependent on one doctor or specialty taking ownership of a patient’s problems. Conversely, that as a patient is passed from one health care professional or team to another under the ultimate care of a named surgeon, dependent on their needs, effective interventions are made to ensure this pathway is tailored specifically to achieving the very best outcome for that patient and consequently the system. Care must follow the patient and be co-ordinated to meet their needs. This will take a collaborative effort from all of our medical colleagues.

Speaking at the EBPOM (Evidence Based Perioperative Medicine) meeting in July, the RCoA President, J-P van Besouw reiterated that perioperative medicine is widely accepted (and expected) practice and the time has come for the RCoA to support the profession by expanding our existing standards and setting and delivering the future training to enable the specialty to deliver this care across the entire NHS. Putting our patients at the centre of everything that we do, and offering them an informed choice about their treatment, can positively influence their outcomes.

**The RCoA perioperative medicine programme**

I have been asked by our President, to lead a Task & Finish Group, and to develop this programme of work over the next 1–3 years. The RCoA, multi-disciplinary Task & Finish
Group will:

1. Present the RCoA as the relevant body of expertise to lead the delivery of the major elements of in-hospital perioperative care
2. Set and develop existing standards and design services for this perioperative care
3. Deliver a training programme which reflects the broad role of the Perioperative Physician, in line with the recommendations of the Shape of Training report
4. Embed continuous quality improvement into the care of our surgical patients through a joined up perioperative care pathway.

It is anticipated that from the establishment of these areas of work in the next three years to maturity may take 10–15 years.

I introduced our plans for the RCoA perioperative medicine programme at the College Tutors’ meeting in June earlier this year, and I have met, or plan to meet with, a number of key stakeholder including the Presidents of the Royal College of Surgeons and Royal College of Physicians. Moving forward we intend to present our plans to the wider medical profession and to our perioperative colleagues.

A review of 3,000 responses to a survey of anaesthetic trainees illustrated that trainees see perioperative medicine as the future of the specialty, with one respondent stating that they ‘... believe this (perioperative medicine) is the area where anaesthesia can have the biggest impact in the years to come.’

Our hospitals are struggling to cope with the challenge of an ageing population and a spectrum of morbidities. The development of perioperative medicine is a multidisciplinary reaction to this change, and will require improved formalisation of care pathways in which specialists will come together to address the complex needs of the patient. As part of our planned work we will define the high risk patient and conduct a Sprint National Anaesthesia Project style audit to measure the current situation of where and how surgical patients are cared for in the UK.

Going back to our opening paragraph on the need for change, many doctors believe it will be impossible to enact change in such a large and complex part of the NHS; in fact, there are already several hospitals around the UK where part or all of this solution has been introduced and is working well. The recent successful spread and adoption of Enhanced Recovery pathways in the majority of the NHS in England is a testament to our ability to change rapidly.

Next steps

Continuing success will be dependent on consensus within our specialty and a multi-disciplinary approach. As such, these outputs will be relevant to the surgical care team as a whole.

In a specialty built around team working, we recognise that in order to lead the delivery of consistent and cohesive in-hospital perioperative care, collaboration with our stakeholders will be essential.

The College will be holding a Stakeholder Engagement Event at Churchill House on Friday 23 January 2015 to illustrate our thoughts and plans and to enhance the process of collaboration with our partners.

We are inviting representatives from a wide range of bodies, including the Regional Adviser and Training Programme Director networks; our colleagues in perioperative care, including physicians, surgeons and nurses; patient groups; specialist societies, and the Department of Health.

Working together, we aim to build on the components of the enhanced recovery programme to ensure a perioperative approach to healthcare delivery for all.

Contact Maddy Bell mbell@rcoa.ac.uk.

References

Anaesthetic Critical Incident Drills (ACID): a simulation training package

‘Simulation enables people to train for rare events that will not occur often enough for experiential learning to be of real benefit.’ This statement, by the Chief Medical Officer of England and Wales in 2008, was part of a report endorsing the increasing use of simulation in medical training. The report recommended the integration of simulation training into programmes for clinicians at all levels of training, but also highlighted the benefits of simulation for training in emergency situations that may be encountered infrequently in clinical practice.

Novice anaesthetists in the UK, during their Basic Training in Anaesthesia, are required to gain competence in managing common critical incidents encountered in the operating theatre. However, exposure to these critical incidents in theatre is variable, and trainees may or may not get the opportunities to manage some of these in the real clinical setting.

The Scottish Centre for Simulation and Clinical Human Factors (SCSCHF) runs an immersive simulation course for novice anaesthetic (0-6 months into training) trainees in Scotland. The course includes opportunities to manage critical incidents in a simulated theatre. The pre-course reading consists of a handbook with text descriptions of how to manage the 12 critical incidents detailed in the 2010 Curriculum for a CCT in Anaesthetics.2

The simulation faculty running this course observed that trainees often lacked a structured approach to systematically managing simple critical incidents in theatre. As a result of this, a significant amount of time was spent during scenario debriefs discussing a basic approach to the management of critical incidents, rather than discussing more complex aspects of performance.

It was felt that trainees would benefit from being given basic plan or ‘drill’ to allow them to approach any critical incident in a systematic manner.

Methods
A simple, low-fidelity simulation training package – Anaesthetic Critical Incident Drills (ACID) – was designed to give novice anaesthetic trainees a basic plan for management of each of the 12 critical incidents. The package was designed to be delivered locally by individual anaesthetic departments, using equipment they already had, with no training from faculty required. The package was provided free to any department wishing to use it. It was advertised via the SCSCHF website, local meetings, and word of mouth. The ACID training package (Figure 1) is available via www.scschf.org.

Trainees attending the SCSCHF were asked at the start of their course to provide information about any training they had received (Table 1) regarding managing the 12 critical incidents (Table 2), including whether they had been given a basic plan for management. The same information was collected about managing failed intubation, which is not a critical incident as defined in the curriculum. This was carried out in the year prior to releasing the ACID training package – Year 0 (August 2011 intake.
of trainees – Group 0), and the first year of release – Year 1 (August 2012 intake of trainees – Group 1). Trainees were also asked if they had been given training using the ACID package, and if they had, over what time period (the package is designed to be delivered over 2 half-day sessions). Group 1 was then subdivided into Group 1A (i.e. those who had not received ACID training), and Group 1B, (those who had received ACID training).

Table 1 Level of training received by trainee

‘Regarding the management of critical incidents, I have’:

<table>
<thead>
<tr>
<th>Read about…</th>
<th>Seen in theatre…</th>
<th>Had formal teaching on…</th>
<th>Had informal teaching on…</th>
<th>Been given a basic plan for…</th>
<th>Rehearsed management of…</th>
<th>Performed DOPS assessment on…</th>
</tr>
</thead>
</table>

Table 2 The 12 critical incidents

<table>
<thead>
<tr>
<th>Critical Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased airway pressure</td>
</tr>
<tr>
<td>Fall in minute volume</td>
</tr>
<tr>
<td>Unexpected Hypoxia</td>
</tr>
<tr>
<td>Fall in end tidal CO2</td>
</tr>
<tr>
<td>Rise in end tidal CO2</td>
</tr>
<tr>
<td>Rise in inspired CO2</td>
</tr>
<tr>
<td>Cardiac/Respiratory Arrest</td>
</tr>
<tr>
<td>Unexpected hypotension</td>
</tr>
<tr>
<td>Unexpected hypertension</td>
</tr>
<tr>
<td>Sinus Tachycardia</td>
</tr>
<tr>
<td>Arrhythmias</td>
</tr>
<tr>
<td>Convulsions</td>
</tr>
</tbody>
</table>

Results were tabulated using Microsoft Excel, and analysed using Chi-squared testing to look for a statistical significance between Groups 0 and 1A, and Groups 1A and 1B.

Results

In Year 0, information was collected from a total of 46 trainees. 23 (50%) trainees had not received training with ACID (Group 1A), and 23 (50%) had (Group 1B). Of the 23 who had, 7 (30%) had been given the recommended 2 half days or more, with 10 (43%) receiving one half-day and 6 (26%) less than half a day.

The results for Group 0 and Group 1A (no ACID training) showed less than 25% of trainees had been given a basic plan to manage any one of the 12 critical incidents, and there was no statistically significant difference between these groups. The number of trainees in Group 1B (those having received ACID training) reporting having been given a basic plan was significantly higher than that in Group 1A (Figure 2, Table 3).

Similarly, there was little difference in the Groups 0 and 1A for the numbers of trainees reporting having rehearsed the 12 critical incident drills, whereas there was a statistically significant difference between Group 1A and 1B (Figure 3, Table 4).

There was no significant difference between Groups 0 and 1A, and Groups 1A and 1B for the number of trainees reporting having read about, seen or had informal teaching on the critical incidents.

The number of trainees reporting having received formal training was higher in Group 1B than in Groups 0 and 1A, but the differences were not statistically significant, except in the case of management of increased FiCO2, where p=0.03.

Table 3 Chi-squared results for Group 1A and 1B (basic plan)

<table>
<thead>
<tr>
<th>Critical Incident</th>
<th>Group 1A (No ACID)</th>
<th>Group 1B (ACID)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed intubation</td>
<td>14</td>
<td>17</td>
<td>0.59</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>5</td>
<td>17</td>
<td>0.01</td>
</tr>
<tr>
<td>Dec. MV</td>
<td>3</td>
<td>15</td>
<td>0.01</td>
</tr>
<tr>
<td>Inc. Airway Pressure</td>
<td>5</td>
<td>15</td>
<td>0.03</td>
</tr>
<tr>
<td>Dec. ETCO2</td>
<td>5</td>
<td>19</td>
<td>0.01</td>
</tr>
<tr>
<td>Inc. ETCO2</td>
<td>3</td>
<td>17</td>
<td>0.01</td>
</tr>
<tr>
<td>IncInsp CO2</td>
<td>3</td>
<td>14</td>
<td>0.01</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>5</td>
<td>14</td>
<td>0.04</td>
</tr>
<tr>
<td>Hypotension</td>
<td>6</td>
<td>16</td>
<td>0.03</td>
</tr>
<tr>
<td>Hypertension</td>
<td>4</td>
<td>14</td>
<td>0.02</td>
</tr>
<tr>
<td>Sinus tachy</td>
<td>5</td>
<td>16</td>
<td>0.02</td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>4</td>
<td>15</td>
<td>0.01</td>
</tr>
<tr>
<td>Convulsions</td>
<td>2</td>
<td>14</td>
<td>0.01</td>
</tr>
</tbody>
</table>
For failed intubation (which is not one of the 12 critical incidents, and not included in the ACID training package), there was no statistically significant difference between any of the groups, for any of the questions. In Group 1B, 74% of trainees had been given a basic plan for failed intubation, compared to 76% for group 0 (p=0.94) and 61% for group 1A (p=0.59). In Group 1B, 83% of trainees had rehearsed management of failed intubation, compared with 71% for group 0 (p=0.60) and 57% for group 1A (p=0.48).

**Conclusions**

The comparison of Group 0 with Group 1A demonstrates that the trainees in these two consecutive years had very similar responses regarding the 12 critical incidents. In other words, whatever other critical incident training that may have been occurring throughout the region, it did not have any significant impact. The comparisons of Groups 1A and 1B demonstrate a real impact of the ACID training package.

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Introduction of Rotational Thromboelastometry (ROTEM) to guide haemostatic resuscitation in a major trauma centre

Major haemorrhage is a significant factor contributing to early mortality in trauma patients. Bleeding is responsible for 30–40% of trauma deaths and accounts for almost 50% of the deaths in the first 24 hours.\(^1,2\)

Trauma patients also frequently present with coagulopathy, which is associated with increased numbers of transfusions, greater risk of organ injury, septic complications and prolonged stays in the critical care unit.\(^3,4\) Both shock and coagulopathy on admission have been independently associated with massive transfusion and increased mortality.\(^5\)

Early recognition of the nature of the clotting defect is important so that replacement of relevant and specific clotting factors may be done in a targeted fashion, in addition to replacing circulating volume and red cell mass. Recognition that different aspects of the coagulation pathway may be at fault, combined with pathway-specific product replacement is essential to improve outcome and reduce costs.

Routine coagulation tests (international normalised ratio, activated partial thromboplastin time, etc) reflect only the initiation phase of haemostasis at the point of testing (laboratory environment), with significant time lag between testing and availability of results. They are limited in guiding real-time blood product replacement in the rapidly evolving resuscitation of the coagulopathic trauma patient receiving massive transfusion. Rapid, point-of-care testing (bedside), which identifies blood component deficiency and allows guided product replacement therapy is desirable in haemostatic damage control resuscitation.

Rotational thromboelastometry (ROTEM) is a point-of-care testing device measuring the visco-elastic properties of whole blood during real-time clot formation (or lack thereof). Using a sample of citrated whole blood, measurements are made on the interactions of coagulation factors, inhibitors and cellular components during the phases of clotting. The test is able to rapidly identify coagulopathy secondary to dilution, consumption, factor deficiency and hyperfibrinolysis, thus providing rapid distinction between causes of bleeding and allowing haemostatic resuscitation to be individualised to patient needs. This reduces the risks of both under-transfusion (increased risk of bleeding) and over-transfusion (increased risk of Acute Respiratory Distress Syndrome, acute lung injury, sepsis and multi-organ failure), and may potentially improve patient outcomes. ROTEM use may reduce transfusion requirements, re-exploration rates, health resources consumption and cost by reduced blood product use.\(^6-11\)

The Royal London Hospital

The Royal London Hospital is a major trauma centre dealing with over 2,000 trauma calls each year. The ‘Code Red’ system for managing haemodynamically unstable trauma patients is activated by a senior member of the trauma team or the Helicopter Emergency Medical Service prior to hospital arrival. Code Red calls initiate the massive transfusion protocol. Between February 2013 and the end of October 2013 there were 230 Code Red trauma calls, 164 activated pre-hospital and a further 66 activated in the emergency department.
A collaborative effort between the departments of Anaesthesia, Emergency Medicine and Trauma Surgery was initiated to provide a ROTEM capability for this cohort of patients.

A ROTEM machine was placed on a bespoke mobile trolley in the emergency department. This mobile ‘unit’ is available for use during the admission phase of a Code Red trauma patient and is able to move with the patient to the intervention radiology suite or the operating theatre for ongoing testing and decision making.

Operating Department Practitioners were identified as the smallest group of practitioners with the most consistent contact with Code Red trauma patients. As part of the activated trauma team they attend the emergency department with the anaesthetist. If the patient is severely injured, they then follow the patient through to any immediate subsequent treatment in theatres or interventional radiology with the anaesthetist. Consequently, they were considered the most appropriate group to train to perform ROTEM testing. Group and individual training on machine handling and test performance was delivered. Training competencies were defined and successful candidates were signed off as proficient. Further training was delivered if competency was not achieved.

For ROTEM interpretation, a pro-forma algorithm was produced (Figure 1). This simplified ROTEM interpretation and blood product replacement therapy into binary steps, allowing it to be straightforward and reproducible. Training on interpretation was delivered to the anaesthetic department consultants and trainees. A Standard Operating Procedure (SOP) booklet was developed as an aide-memoir and attached to the ROTEM machine.

ROTEM testing was introduced for routine use in Code Red trauma patients in November 2013 after a 4-month preparation period. Creation of a mobile unit allowed the machine to follow the patient on their entire admission journey. Use of a simple SOP and an algorithmic approach to targeted blood product replacement therapy has allowed for rapid uptake and widespread use of this technology in a busy trauma centre. Typically a ROTEM test may be run for anything up to 30 minutes. However interpretation may be done within 5-10 minutes, and analysis may be repeated within 15 minutes of administration of blood products with an expected response to therapy, and to guide further management.

**Conclusion**

Haemostatic resuscitation for major trauma patients using ROTEM may be introduced into a major trauma centre in a relatively short period of time and with relative ease. Creating a mobile unit, choosing a small, targeted population of personnel to train, and using a simple algorithmic approach to interpretation, and therapeutic decision making ensured the process was straightforward and easy to utilise. Consequently ROTEM has been added as an adjunct to haemostatic resuscitation in this busy trauma centre in the effort to further improve and refine management of this critically ill population.

**References**


### Consultations

Please see below consultations that the Royal College of Anaesthetists has responded to in the last two months.

<table>
<thead>
<tr>
<th>Originator</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>Draft scope for care of the dying adult</td>
</tr>
<tr>
<td>Royal College of Surgeons of England</td>
<td>RCS co-ordinated care survey</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>Quality standards process guide update – public consultation</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>Fit and proper person requirement for directors and duty of candour for NHS bodies</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Changes to Mental Health Act (1983) Code of Practice</td>
</tr>
<tr>
<td>Freedom to speak up</td>
<td>Freedom to Speak up review</td>
</tr>
<tr>
<td>Nursing and Midwifery Council/Health Education England</td>
<td>Shape of Caring Review – call for evidence</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Strengthening the GMC adjudication function</td>
</tr>
<tr>
<td>Academy of Medical Royal Colleges</td>
<td>Foundation Programme Curriculum Revision 2016</td>
</tr>
<tr>
<td>Faculty of Pharmaceutical Medicine</td>
<td>Code of Good Medical Practice in Pharmaceutical Medicine</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>Guidance for all providers of health and adult social care services on meeting the fundamental standards, and on CQC’s enforcement powers</td>
</tr>
</tbody>
</table>
Supporting the emergency department

An informal meeting in 2012 by a group of Welsh airway enthusiasts led to the birth of the All Wales Airway Group (AWAG). AWAG has since grown into a successful society which runs three annual courses provides online training resources and consensus recommendations.1 The mission statement is simple:

‘AWAG aims to promote excellence in difficult airway management in Wales by providing a forum for networking and communication, disseminating updates and guidance, helping coordinate training, and fostering airway-related research and audit.’

Emergency department RSI
Advanced airway support is known to be challenging in the emergency department. Assessment is difficult, the risk of aspiration is high, and help often far away. Patients may be hypoxaemic or shocked, making management even more difficult.2 A recent census suggests that approximately 1 in 800 emergency department attendees will require rapid sequence intubation (RSI).3 In this census, 80% of these intubations were performed by anaesthetic staff and 20% by emergency physicians.

While the role of emergency physicians in performing rapid sequence intubation remains contentious4, they are undoubtedly important members of the intubation team.

The UK emergency medicine curriculum specifies that drug-assisted intubation and other advanced airway management skills should be well-practiced during training, and also acknowledges the importance of teamwork.5

A unique collaboration
In January 2013, it was proposed that AWAG might help establish an airway course for emergency medicine trainees, run jointly by anaesthetists and emergency physicians. This, to our knowledge, was a unique collaboration in Wales but the benefits were clear. All agreed it was time to break down the inter-specialty barrier and work together. Anaesthetists could help develop responsive team members and emergency medicine doctors could acquire knowledge, skills and attitudes critical to patient care.

Developing the course
Developing the course required a great deal of time and organisation. AWAG held an initial meeting in May 2013.

The scope of the course was discussed, and a topic analysis performed. To reflect adult learning styles, interactive workshops and simulation sessions were chosen. Morning workshops were proposed including airway assessment, basic airway management, rapid sequence induction, failed intubation, cricothyroidotomy and post-intubation care. Afternoon simulation sessions comprised airway management for patients with head injury, sepsis, life threatening asthma, and following cardiac arrest.

The Cochrane Building in Cardiff, containing a simulation suite run by Cardiff University, appeared to be the most appropriate venue. An anaesthetist from Cardiff with an interest in simulation fortunately supported making this possible.

Anaesthetic and emergency medicine consultants collaborated to develop a course manual, delivered electronically to delegates as pre-course reading. Chapters were based broadly on the workshop topics. This up-to-date manual provides a succinct overview of advanced airway management, including useful resources such as the DAS failed intubation algorithm and NAP4-endorsed ‘intubation checklist’. To reinforce this knowledge base a pre-course MCQ was developed in the style of popular advanced life support courses.

Faculty members with simulation experience from both anaesthetics and emergency
An emergency medicine trainee is helped by his team

competence at managing airways in the emergency department simply by attending the course. However, with the ACCS–EM trainees now completing a dedicated anaesthetic job, and evidence suggesting that properly trained emergency medicine physicians can offer safe airway support\(^7\), we should be positive about sharing our knowledge and skills with them. The NAP4 report eloquently concludes;

‘the specialty of the person managing the airway is less important than the competencies of that individual and the underlying processes that support effective clinical care and patient safety’.\(^2\)

Acknowledgements

We would like to thank the faculty of the Cochrane Building in Cardiff for making this possible and the Medical Illustration Department for the excellent photographs.

References

1. All Wales Airway Group (www.allwalesairwaygroup.co.uk).
5. The College of Emergency Medicine: Curriculum for EM core and higher training (www.collemergencymed.ac.uk/Training-Exams/Curriculum/Curriculum%20from%20August%202010).

In the spirit of AWAG, the course was priced to cover costs only. Promotion was by distribution of posters, and the website was updated to facilitate registration and online payment. CPD points were requested through the College of Emergency Medicine. Delegates were allocated to sessions, and name-badges produced. Most importantly arrangements were made for lunch!

Finally, a dress-rehearsal took place on the day before the course – very useful as one of the simulation manikins was in need of some resuscitation himself!

The big day

The inaugural AWAG emergency medicine airway course was held on the 17 December 2013, with 30 emergency medicine doctors from around Wales attending. Fortunately, the event went superbly. Delegates were enthusiastic and keen to learn, and even faculty enjoyed the day! Following completion of the course, feedback was requested via the website, after which delegates were issued an electronic certificate of attendance.

Feedback for the course was excellent:‘\(^6\)

‘Thank you. This was a quality course. I’d rate it almost the best post-graduate course I’ve done. It was clear from the outset (pre-course reading) to completion that a great deal of thought and time had gone into setting it up. Really appreciated.’

“Excellent course, very affordable price and good food too. Keep up the brilliant work. Thank you all for the extremely hard work you all have put in.”

To improve the course, delegates suggested an ‘introduction to airway anatomy’ session, more simulation scenarios and smaller group sizes, thereby increasing the opportunities to lead and intubate. It was also suggested that delegates of similar experience should be grouped together and that a two-day course might enhance opportunities for practice and experience. Faculty suggested that, given the increasing availability of second-generation supraglottic airway devices, delegates should also be introduced to these.

The next step

There is no doubt that the course was an overwhelming success. We are running the course again this year, and have even been asked to run a consultant-only course for emergency medicine consultants!

We must point out that the course was run with a disclaimer that delegates should not expect to achieve
The impact of Physicians’ Assistants (Anaesthesia) at Heart of England NHS Foundation Trust

The concept of Physicians’ Assistants (Anaesthesia) or PA(A)s has been established for 10 years. The initial proposal for the administration of anaesthesia by non-physicians in the United Kingdom arose due to a predicted future shortage of medically trained anaesthetists. The ‘New Ways of Working in Anaesthesia Programme’ was established in 2003. (www.rcoa.ac.uk/node/1457/). The product of this was Anaesthesia Practitioners (now called PA(A)s), and training commenced in January 2004. The plan for the PA(A) role was to enable one Consultant Anaesthetist to supervise two PA(A)s administering anaesthesia in geographically co-located theatres.

The original plan to initiate ‘two-to-one’ working proved initially challenging for various reasons, including concerns regarding patient safety, whether the model would offer value for money and whether it would reduce training opportunities for junior anaesthetists. Some ten years later, perhaps due to the realisation of the workforce shortfall, PA(A)s are becoming a more obvious choice to many departments. Successive audits of PA(A) activity have shown that initial concerns were unfounded, and they continue to enjoy the support of key stakeholders. PA(A)s have continued to steadily increase in numbers and NHS hospitals have started to see the benefits of a permanent, reliable, enthusiastic and skilled workforce.

Heart of England NHS Foundation Trust (HEFT) adopted the model of one Consultant Anaesthetist supervising two PA(A)s in 2011. Since then, significant benefits have been demonstrated. Crucially, quality and safety have been maintained using this model. Improvements have been identified in clinical standards, and there has been a real cost benefit realised in the anaesthetic budget through using this relatively modern way of working in the United Kingdom. Consultant Anaesthetists have nurtured this model and the individual practitioners, and the service is now integral to the anaesthetic workforce. In the last three years, the team of six PA(A)s have anaesthetised over 10,000 patients in this model, as ratified by the Trust’s recording systems. Each PA(A) is involved in 700-900 cases per year, covering a range of specialties and anaesthetising patients for minor, intermediate and some major operations, all under the supervision of a Consultant Anaesthetist.

The supervising consultant’s day
Fran Murray (Consultant Anaesthetist Heart of England NHS Foundation Trust)

The supervision of PA(A)s has added a new and interesting dynamic to the role of the Consultant Anaesthetist. At first it may appear daunting to have responsibility for two operating theatre lists, running side by side, but this can be an exciting and rewarding challenge.

The day begins with a meeting with the individual PA(A)s to discuss the content of the operating list and a proposed anaesthetic plan for each patient which will then be signed off. Depending on the number and complexity of cases the pre-operative assessments may be performed by the PA(A) and/or the Consultant Anaesthetist. As it is necessary for the Consultant to be present at the induction of anaesthesia, the commencement of each list needs to be agreed, but in reality there are rarely any conflicts of timing. The Consultant will divide his/her time during the lists moving between theatres, as required, but also allocating time to particular cases as dictated by clinical priority. In addition, the Consultant will ensure that relevant postoperative drugs
‘As the PA(A)s are now an established and experienced part of our anaesthetic team it now allows us to conduct lists with increasing confidence in that they are reliable, consistent and highly professional in their work.’

and fluids are prescribed. If the PA(A) has achieved competence in extended practice in regional anaesthesia, the Consultant will supervise this practice. Although there are certain constraints to managing two lists, the flexibility of having three skilled individuals means that the Consultant can take an active role in list management, leading to improved productivity. Although one would imagine that conflicting clinical priorities could interfere with the timely response of the Consultant, in practice this is not a problem.

As the PA(A)s are now an established and experienced part of our anaesthetic team, it now allows us to conduct lists with increasing confidence that they are reliable, consistent and highly professional in their work. In addition, as permanent staff, they are free from some of the pressures and constraints associated with trainees.

Do PA(A)s deliver quality care?

In order to answer this question, an audit was conducted in our department to ensure that clinical standards were being maintained. The data compared the changes between the ‘sole anaesthetist model’ and the ‘two-to-one model’ with PA(A)s. A total of 159 patient notes were reviewed. The two groups were matched for physical status and surgical procedure (Phillips, Dixon and Murray 2013).

Performance indicators were compared; pain score on arrival into recovery, requirement for additional analgesia in recovery, occurrence of nausea/vomiting in recovery requiring rescue anti-emetic and unplanned overnight admission. They concluded that in adopting the ‘two-to-one model’ the performance indicators were not just maintained but in fact improved upon when compared to the ‘sole consultant anaesthetist’ model (Phillips, Dixon and Murray 2013). This study won the first prize at the British Association of Day Surgery conference in 2013.

Are PA(A)s ‘worth’ it?

HEFT reviewed the cost implications of using the ‘two-to-one model’, finding that a 22% saving was achieved by using this model in two operating theatres, over five days per week. They scrutinised actual cost using the zero model rather than notional costs. Based on these actual cost values it was determined that one consultant-delivered clinical session equated to £445.20 and one PA(A) delivered session was £125.07. Therefore the cost of two Consultants staffing two operating theatres was £890.40, whilst the cost of two PA(A)s plus one consultant session was £695.34, making a saving of £195.06 per session. Utilising the ‘two-to-one model’ over a five-day week, fifty weeks per year (allowing for ten statutory NHS Bank Holidays) yielded an annual saving of £97,530 and an annual saving of 22% (Phillips et al 2012). At HEFT, four operating theatres five days per week are staffed in this model.

Surgical case mix

Initially when this model of working commenced at HEFT, PA(A)s were deployed in day-case theatres anaesthetising ASA 1 and 2 patients having routine day-surgical procedures. Over the last 18 months a natural divergence into other specialties and cases has been allowed to occur in order to enhance the value of PA(A)s. Now PA(A)s have job plans and regular operating lists, and they will anaesthetise for the same surgeons on a weekly basis.

This has allowed a good relationship to develop. The case complexity has increased from day-cases to inpatient procedures such as hysterectomies, joint replacements and major laparoscopic surgery.

Skills, knowledge and continuing professional development

The Association of Physicians’ Assistants (Anaesthesia) recommends that all PA(A)s should aim to achieve a minimum of 25 CPD points per year to demonstrate continuing competence and up-to-date skills and knowledge. At HEFT all PA(A)s are given ‘non-clinical-time’ throughout the year to enable this process to occur, and all practitioners are advanced life support providers.

Each PA(A) works within the boundaries of their job description and national and locally agreed guidelines. The PA(A) course, is delivered by the University of Birmingham (www.birmingham.ac.uk/postgraduate/courses/taught/med/physicians-assistant-anaesthesia.aspx). The university academic training does not currently examine students on how to perform regional anaesthesia. In response to this, HEFT locally developed a range of education and training packages which PA(A)s need to have ‘signed-off’ to allow them to administer such techniques. To ensure that the PA(A)s can work to their maximum potential, they have been trained to perform spinal anaesthesia in addition to femoral nerve, ilioinguinal, fascia iliaca, transversus abdominis plane, interscalene, ankle, wrist and sub-tenon blocks. The educational packages were designed in-house by the PA(A) service lead in conjunction with two Consultant Anaesthetists.

The team

The PA(A) team at HEFT is led by Mike Phillips (PA(A)), Dr Fran Murray and Dr Richard Crombie (Consultant Anaesthetists). Monthly governance meetings take place with the Clinical leads, the Clinical Director and the directorate manager. This enables
future planning to occur, team issues to be discussed and safety/quality issues to be reviewed.

Leading the service
Mike Phillips (Service lead, Physicians’ Assistant (Anaesthesia) Heart of England NHS Foundation Trust

The PA(A) service at HEFT emerged from a major service re-design of support services within the Anaesthetic Directorate. My initial role as leader was to tailor the services provided by the PA(A)s toward service requirements. These needs, as in any large acute Trust, evolve and change periodically, and so maintaining that focus has been an essential objective. Early challenges included recruiting support from both inside, and outside the existing anaesthetic workforce.

Setting out the objectives of the role and potential function of the team was integral to gaining support. Some anaesthetists, theatre staff and surgeons were sceptical of what some perceived as a rather radical transformation to the provision of anaesthetic services within the Trust. A cohort of extremely supportive Consultant Anaesthetists emerged fairly quickly, and once the benefits already discussed in this article became more obvious, the support and enthusiasm diffused throughout the perioperative specialties.

An ongoing part of the lead role is to audit and evaluate all of the team’s activities. This includes specific aspects of the team’s work, such as the use of locally developed education and training packages, adherence with drug administration packages like Patient Specific Directives, as well as ensuring overall maintenance of quality, safety and financial viability. The team’s success has been the product of excellent recruitment to the PA(A) posts. The practitioners have worked above and beyond their roles to not only provide the clinical service, but also to act as ambassadors for the role both within, and outside the Trust. The support of Consultant Anaesthetists and senior managers within the Trust has been invaluable, and without their enthusiasm and brave commitment to sponsoring such innovative practice, there would have been no development.

The anaesthetic directorate has embraced the PA(A)s and welcomed them into the department. We made a very early commitment that any activity undertaken by PA(A)s would not disenfranchise other staff groups within the department, and would not impact upon the training of junior anaesthetists. This is a commitment we have kept, and we are able to cite many examples of an actual benefit to junior doctors in training. The activities of the team have been seen to normalise over the past 18 months, and the two-to-one model is now ‘how we do it’ in four of our operating theatres every day of the week.

It has been our pleasure to welcome visitors from many other trusts in the UK who are exploring the potential benefits of employing PA(A)s, and we would encourage other trusts to take up this offer. From the conversations we have with visitors, we recognise that there is an increasing desire to grow the national PA(A) workforce.

National support
Special thanks to Dr Tom Clutton-Brock and the University of Birmingham for supporting the training, and the Royal College of Anaesthetists for its continued support. The PA(A) role is entering its second decade and in some places is an embedded and essential part of the anaesthetic workforce. With the increasing demands on Consultant Anaesthetists there is a feeling that it will become established in many more anaesthetic departments throughout the UK.

Association of Physicians’ Assistants (Anaesthesia)
The 7th annual conference of the Association of Physicians’ Assistants (Anaesthesia) will take place on the 15 May 2015 at the University of Birmingham, entitled ‘Enhancing the Anaesthetic Workforce with Physicians Assistants (Anaesthesia)’. We hope to see you there. This year’s event will focus on how PA(A)s continue to enhance the anaesthetic workforce in order to improve quality, safety and financial efficiency. A variety of eminent speakers will talk of their experiences and involvement in the delivery of services utilising PA(A)s from both clinical and non-clinical perspectives. The challenges of integrating the role into departments of anaesthesia, making a sound business case for training of PA(A)s and how to make further success of this, and similar non-physician supported services – will also feature in this stimulating agenda.

References

St Thomas’ Hospital from long ago
After sixty years, and counting

There was a certain spirit, a touch of confident pride, in the old St. Thomas’ that I knew. They were good, and they knew it. But I could not know that until I walked into the place myself and caught the flavour on that very first day. It was a cold January morning in 1955, and somebody in the main hospital foyer, close to a rather grimy marble statue of Florence Nightingale, directed me to the Department of Anaesthetics. It was across the street, on the other side of Lambeth Palace Road, and I had to identify by its number the small house that contained the Department office. It was there that a new epoch in my life began.

But what led me there in the first place? I was just a young bloke from faraway Adelaide, having learned some basic anaesthesia tricks in Philadelphia. Overall that had been a good place. At the University of Pennsylvania I became personally acquainted with Robert Dripps, James Eckenhoff and Leroy Vandam. Together they were a potent team, and later all of them became great leaders in different universities. But all I knew about British anaesthesia was that the best, most complete book on the subject was written by two Englishmen named Wylie and Churchill-Davidson. And they had written their book out of a place in London called St Thomas’. That meant little to me. But as a young Australian heading for a career in the southern hemisphere, I knew that British credentials of some sort were a sine qua non, and I had better do time in London. Surely St Thomas’ would be a sensible place to enquire. So from Philadelphia I sent off a simple letter to London, telling them of my plans to visit the Department soon, in January.

His reply was immediate, and I still remember the words exactly: ‘Oh! So you’re Brandstater! I’m Sanger, Cyril Sanger. How would you like a job?’

What was that that he said? He took me into the office where, seated in secretarial majesty, was the great Miss Davenport. Two other men were in there, leaning against the fireplace and arguing vigorously about a burning issue of the day. Was it best to inject atropine and neostigmine as separate doses, or was it safe to mix them in the same syringe? Miss D introduced me: This is Dr Wylie and Dr Churchill-Davidson. Amazing! The two great men, themselves, in flesh and blood! I had struck pay dirt. Yes, they did offer me a locum registrar’s job. And when they learned my wife was in late pregnancy, they referred me to a friendly Miss Hurter.

Within days I started work as a registrar. It was not plain sailing; this was a long way from Philadelphia. In my very first orientation session with Derek Wylie he impressed on me the terrible consequences of a phase-2 block after succinylcholine. It was something hardly mentioned in Philadelphia, where our intubations were done using decamethonium. But Wylie said how reassuring it was to see some sign of recovery from depolarizing block before loading a patient with tubocurarine. Well, on that first gallbladder I missed seeing the reassuring signs, but got them in spades as, when the first towel clip bit him, the patient rose towards the chandelier in protest.
Soon afterwards I had a session with Sanger. From the beginning I was impressed by the finely made, polished wooden box that he carried with him into the theatre. It had a sturdy brass handle on its hinged lid, and on its side in large block letters was the word ‘RESUSCITATOR’. It sat on the floor alongside the Boyle machine, and for two hours I puzzled about why it was kept so handy during ordinary cases. When eventually I asked him, Sanger deigned to explain. Oh, he said, that is essential. Ceremoniously he opened the box’s lid, and there inside stood nothing but a stately teapot. But at Thomas’, I found, the theatre sister was usually a reliable source of mid-morning resuscitation. Later Sanger asked if my wife had yet seen that highly-regarded Miss Hurter. Well, in fact we had both been to her office, and had met an engaging woman, with straight hair and minimum adornment, wearing a tweedy suit and rugged outdoors shoes; feminine touches were out of sight. She might have just returned from a partridge shoot or from hiking in the moors. ‘Oh you’ve seen her!’ said Sanger. ‘Good!’ And after a pause: ‘Nice fellow, isn’t she!’

The Waterloo Hospital was a different proposition. It was an aging, inauspicious place where most cases seemed to be done with a basic Magill circuit and high gas flows, unfamiliar to me, and very different from the to-and-fro canister I had used for giving cyclopropane in Philadelphia. What sticks in my memory from the Waterloo was its stream of patients with varicose veins. We seemed to do little else there, and as a registrar I was left very much to my own devisings. Once I was in stride, things went well.

For a naive newcomer like me, other clinical challenges left a deep impression. I had never seen E.C.T. before, but here they were abundant. A bit brutal, I thought, with barely enough thiopental plus a little sux. But theirs was not to reason why...so I pressed on. With more tangible focus were the outpatient bronchoscopy clinics. I watched their sword-swallowing technique, quickly learned to copy it, and from that time, all through my Beirut years, before the era of fiberoptics, a rigid bronchoscope became part of my theatre armamentarium.

Amongst other memories of St Thomas’, I was deeply impressed by the quality of young women who were staff nurses, and also students in the Florence Nightingale School of Nursing. This was a place where skillful service and a caring attitude was an honored and sacred tradition. Most young women I dealt with were outstanding members of the upper class: they had stately carriage, excellent diction, and were quick of wit. We had no recovery rooms, so recovering patients had to be sent by mobile stretcher back to a ward somewhere, often remote, accompanied by a guardian nurse. It was our job to give verbal instructions to such nurses, sometimes complex, with drug doses and warning signs, before sending them on their journey. How impressed I was by the comprehension with which those nurses would look me straight in the eye and spit back at me the orders I had just listed verbally. I felt like a ship’s commander on the high seas.

One event of special note deserves to be mentioned here: a meeting organized by the St Thomas’ Hospital Medical Students Society. I learned that this was a periodic event that was much respected by the whole Medical School community. In content the events themselves were usually cultural rather than medical-scientific. Invitations to speak were something to be coveted, of sufficient prestige to be a mark of achievement in the wider world of human affairs. During my months of sojourn at St Thomas’ the Medical Students’ Society announced a meeting at which the great Sir Russell Brain would speak on a subject on which he was the topmost scholar: the life and work of the great lexicographer Samuel Johnson. This invited guest, who later became Lord Brain, was famous as president of the Royal College of Physicians, and author of the large and authoritative textbook on...what else?...neurology.

For a close-up look in the lecture room that night, I took a front seat, and the great man arrived, accompanied by an honour guard. His first words to us were an apology. He had decided, very late and without seeking permission, to change his subject. He had already spoken often in London on Samuel Johnson, and he felt it might be more helpful if he addressed us on the obscurities of modern poetry. Then he launched forth on a survey, with illustrations from a large corpus of English poetry, both classic and modern, including some contemporary verse that to my ear was an insult to my mother tongue. At first hearing it was a garbled sequence of meaningless words. But Sir Russell proceeded to explain why it had merit. And placing classic and modern side by side, he shed unsuspected, astonishing light on this previously worthless verse. To me, stuck in Keats, Tennyson and Kipling, Brain’s lecture was a revelation. He established forever in me the ideal that a man accomplished in medical science must balance his life with expertise also in one of the humanities: history, music, literature, art, religion, philosophy.

Before quitting my temporary posting at Thomas’, Dr Wylie invited me, with wife and newborn baby, to spend an evening at home with him and Mrs Wylie. What a gracious evening it was! So kindly, so well-wishing. Apparently they had learned that I had some keyboard skills, and no one had touched their piano for decades. So they invited me to play a tune. It was a simple thing to reel off, playing by ear, a few traditional English, Scottish and Irish folk songs that were everyday currency in my teenage years at high school. And with genuine encouragement from our hosts, I even added a few rousing patriotic songs from the recent war: ‘Till the Lights of London Shine Again’, ‘The White Cliffs of Dover’, ‘Old Father Thames,’ and others.
This awakened another side of the Wylie persona. I was reminded of it years later when the great Derek was an honored guest lecturer for the British Council in Beirut. He had become Dean of the Faculty of Anaesthetists of the Royal College of Surgeons, a distinguished man in British medicine, and I had become the anaesthesia department chairman at the American University of Beirut. I was now serving as his host. At that time, more exciting for him than his dry anaesthesia subjects, was the music that was playing loudly all over Beirut: the newly released Julie Andrews singing ‘My Fair Lady’. Every time Wylie heard snatches of it, his face would light up, and he would wave his hand in unison with the melody. He was proud that British artistry was asserting itself once again in distant lands!

There was life in London after St Thomas’. But after some Thames-side adventures I found my way to the American University of Beirut. Even in distant Lebanon, my linkage with St Thomas’ continued, though it was episodic. Wylie’s colleague Harry Churchill-Davidson also showed up to lecture in Beirut. In those years it was a sophisticated town, and for an evening’s diversion I took C-D to dine at the famous Casino du Liban, where he sat through a magnificent, and uncensored, stage production imported from the Folies Bergère in Paris. Here again, I discovered, was a blue-blooded Englishman whose mastery of anaesthesia science had been balanced by a finely honed taste in the aesthetics of female anatomy.

Years later I was pleased to host C-D yet again for another lecture visit, this time at Loma Linda University in California. Much later, in the 1980’s, while giving a lecture at The John Radcliffe Hospital in Oxford, I was gratified to learn that Felicity Reynolds, obstetric anaesthetist of Thomas’ fame, had been an advocate for something dear to my heart. She had sounded forth on behalf of the multi-orifice epidural catheter that I had designed, fabricated and tested in Beirut in the early sixties. With difficulty I had persuaded the Portex Company to produce it, sure that the market would grow. Dr Reynolds could not have known the catheter’s provenance, but I felt good, hearing that I still had friends on the Thames.

For me a highlight of my long and warm association with the St Thomas’ Department was an invitation from Dr Wylie in 1963 to give an evening lecture to London anaesthetists. The distinguished man was there himself in a hosting role. I had just completed a year’s research in San Francisco, working with Ted Eger on MAC studies, and also, with a genius we knew as John Severinghaus, on cerebral blood flow at high altitude. It was heady stuff, but I chose to speak that night on something new and exciting that was hot from the San Francisco laboratories—pulmonary surfactant. It’s old news now, but what a difference that new knowledge made to our understanding of lung mechanics and respiratory distress syndrome. At the end of the lecture I was gratified to be questioned by a certain Keith Sykes, who was then making a name for himself at Hammersmith. He too lectured later at my place in Loma Linda, a welcome guest from his eminent position as Nuffield Professor at Oxford.

What remains to be said? Thank you, St Thomas’, for welcoming so kindly in 1955 a wandering and directionless young Australian. After all these years I am now one of your more antiquated Old Boys. But I am a grateful one. You gave me good starting directions, and friendships that lasted for decades. On a more recent visit, in 2002, I saluted again the marble statue of the great Florence, and my wife and I spent a couple of hours in the Nightingale Museum, recalling her battlefield courage in Crimea and the political courage she wielded in Westminster. It is an inspiring tradition, and one that I hope the newer generations of anaesthetic luminaries will keep vigorously alive.
On Monday 30 June 2014, the NIAA Grants Committee met to consider the first round of applications for 2014 on behalf of The Association of Anaesthetists of Great Britain & Ireland (AAGBI) and *Anaesthesia*; The Association of Paediatric Anaesthetists of Great Britain & Ireland (APAGBI); The *British Journal of Anaesthesia* (BJA) and The Royal College of Anaesthetists (RCoA); The British Society of Orthopaedic Anaesthetists (BSOA); the Obstetric Anaesthetists’ Association (OAA), and the Vascular Anaesthesia Society of Great Britain & Ireland (VASGBI).

The committee considered 36 applications over 7 categories for a requested sum of £1,341,210, and made a total of 7 awards to a value of £206,143. Success rate: 19%.

A list of the successful applicants can be found in the following table and abstracts can be viewed at: [www.niaa.org.uk/article.php?newsid=1151#pt](http://www.niaa.org.uk/article.php?newsid=1151#pt).

### AAGBI/Anaesthesia Small Research Grant

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<tr>
<th>Applicant</th>
<th>Project Description</th>
<th>Funding</th>
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| Dr Tom Clark
Dr Charles Gibson
Dr Gary Minto
Plymouth Hospitals NHS Trust        | Comprehensive mouth-care to reduce post-operative pneumonia (CUPPA)                | £7,428  |
| Dr Louisa Chrisman
Royal Surrey County Hospital       | Surgicric 2: A comparative bench study with two established emergency cricothyrotomy techniques in a porcine model | £9,750  |
| Dr Rob Sanders
University College London         | Predicting perioperative risk in patients with acute coronary syndromes           | £51,222 |

### BJA/RCoA Project Grant

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<th>Applicant</th>
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| Dr Gudrun Kunst
King's College Hospital, London    | A novel proteomic analytic approach to identify potential biomarkers of acute kidney injury and failure | £62,548 |
| Professor Blair Smith
University of Dundee                | Preparing exercise and physical activity as a complex intervention for chronic pain | £42,784 |

### OAA Medium Project Grant

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<tr>
<th>Applicant</th>
<th>Project Description</th>
<th>Funding</th>
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| Dr Daqing Ma
Imperial College London           | Novel strategy in preventing the neurotoxicity of nitrous oxide when used for labour pain relief | £14,996 |

### VASGBI Project Grant

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<th>Applicant</th>
<th>Project Description</th>
<th>Funding</th>
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| Professor Dave Lambert
University of Leicester              | Effects of opioids on angiogenesis                                                 | £17,415 |
Communications and the College

Mr C McLaughlan, Deputy Chief Executive and Director of Clinical Quality

The Royal College of Anaesthetists supports and guides more than 17,000 Fellows and Members during every stage of their career. By setting, examining and monitoring the standards of anaesthetic training and professional development, the College ensures that patients are seen by fully-trained, capable anaesthetists. However, attempting to get across this positive message about highly-trained and professionally competent specialist doctors to patients and the public has not always been successful.

In addition, the message that anaesthesia is the largest single hospital specialty in the NHS and that anaesthetists engage with approximately 70% of all hospital patients is also important and worthy of greater publicity. Much less well known about this statistic is that much of this engagement takes place outside operating theatres and especially in critical care and pain medicine areas, and there is also a slowly growing realisation that anaesthetists are uniquely placed to lead the development of all aspects of perioperative medicine.

To explore how we may increase our profile and media engagement approximately two years ago the College engaged the services of a media adviser for one day a week. The adviser, Mr Simon Scott, was an ex-journalist and had managed the media agenda for other healthcare organisations. Simon primarily took on the role of media scanning for stories involving or seen to be of interest to anaesthetists, to inform the President and Council. He also facilitated responses to current healthcare issues and statements on the College’s position on important topics to broadcast and print media. This was a new initiative for the College, as previously the relationship with the media had been completely reactive.

We have learned much from this initial ‘toe in the water’ of national media engagement, and recently we employed an interim media manager, Ms Sonia Larsen – a senior media and marketing manager, to take this initiative much further. In particular, Sonia has advanced media project developments for the College’s fifth national audit project (NAP5) on accidental anaesthetic awareness, and for our Anaesthesia Clinical Services Accreditation (ACSA) Scheme.

The following key areas for media engagement and profile enhancement have been identified:

- **Training** – highlighting that the College is the single UK provider of the anaesthesia curriculum to support trainees in the attainment of anaesthesia competencies.
- **Education** – further defining the College’s provision of: events, e-learning, further qualifications, sub-specialty recognition and continuous professional development.
- **Innovation** – publicising our support for national research, and sharing of knowledge, insight and clinical expertise.
- **Protection** – highlighting the quality and integrity of the specialty of anaesthesia and sub-specialties of critical care and pain medicine.
- **Professionalism** – providing members with up-to-date knowledge and guidance based on the highest clinical, quality and safety standards from regulators, national healthcare organisations and other professional bodies.

This renewed focus has offered the College the opportunity to both work to and disseminate a clearer message on its purpose. However, this communications and engagement initiative aims to enhance and promote identified programmes of work, each of which then supports College and national strategies for patient safety and healthcare quality initiatives.

In order to do so the College would further consider:

- Clarity of purpose – what does it do and who for? – **Mission**.
- Define its longer aim and where it wants to be – **Vision**.
- Stating what it believes in and what guides its behaviour – **Values**.
- Identifying its key aims – what it wants to deliver and how – (Programme of Priorities) **Strategic Aims/Objectives**.

The College will seek to engage with Members and Fellows in helping to clarify and progress these areas. In addition to the current routes of information exchange with the membership, the College will conduct a survey in the next few months for your views on where we are today and what the direction of travel should be to drive improvement across all routes of communication. The survey will be announced on the website and tweeted to our Twitter followers.
Dear Editor,

I read with interest Dr Wicker’s account of difficulty in being ‘signed off’ for rapid sequence induction (RSI) in the July edition of the Bulletin. Their survey of current practice adds further valuable insight into the evolution of the technique from the original description over forty years ago1 to the present day; considerable variation in practice between individuals and hospitals is demonstrated but modification of technique in different clinical circumstances was not investigated.

Controversy surrounding the optimal combination of drugs and physical measures for RSI remains2 and perhaps we should stop viewing it as a single technique, a ‘classical’ or ‘modified’, and see it instead as a spectrum with a common outcome aim – that of preventing aspiration of gastric contents. The RSI for an elective Nissen’s fundoplication in a starved patient may after all be very different to that performed after traumatic brain injury or for emergency aneurysm repair. Annex B, the Basic Level Training section of the RCoA curriculum requires demonstration of correct RSI sequence however it seems that one single correct method no longer exists and it is this that I believe we should be teaching to those starting their careers in anaesthesia.

James Stevenson
ST7 Anaesthesia, Hull and East Yorkshire Hospitals NHS Trust

References

Dear Editor,

Towards a new understanding of RSI

Dr Wicker and colleagues ask ‘Do we practice what is preached?’ in their survey of Rapid Sequence Induction (RSI).1 They refer to the sequence reported 40 years ago by Stept and Safar (originally termed ‘rapid induction/intubation’)2 and use this as their ‘classical’ benchmark in comparing modern practice.

Stept and Safar list 15 steps, which we group into four.

Those steps in the first group are reliably used today, such as monitoring, pre-oxygenation, intravenous access and application of cricoid force (at least in the UK).

Those in the second group, such as the injection of a fixed dose of thiopental followed immediately by succinylcholine are less well observed in the survey.

Those in the third group are uncommonly used, such as induction with the patient positioned in a semi-sitting, V-position with trunk elevated about 30 degrees’.

Finally, there is one step that is no longer performed; the administration of a defasiculating dose of d-tubocurarine to attenuate the rise in intragastric pressure generated by succinylcholine administration.

So, it is clear that no one is adhering to the ‘classical’ sequence and so there are now a variety of approaches and opinions, with resulting confusion. We suggest that the introduction of new terms by the authors, such as ‘neoclassical’ RSI can only lead to greater confusion.

The purpose of any RSI technique is the placement of a tracheal tube in circumstances where aspiration lung injury is an appreciable risk. The real priorities are oxygenation and protection from lung injury, in that order. ‘One size RSI’ does not fit all. We need ‘context-sensitive airway management’,3 whereby risks and benefits of a particular sequence are evaluated carefully, tailored for the individual patient. Modifications may well be justified; indeed Stept and Safar explicitly mention alternative drug choices, using scopolamine, halothane or cyclopropane in the ‘critically ill, conscious patient’ and gallamine or ‘local anaesthetic’ to attenuate the fasciculations of succinylcholine. Whilst these choices are generally not available to us now, the principle of therapeutic modification endures.

‘Rapid Sequence Induction’ as a generic, accepted technique did not exist then, nor does it exist now. Should the acronym ‘RSI’ be retained, we suggest a new definition: RSI means ‘Reasonable Sequence Induction’, reasonable for a patient and their problems.

Matthew Lawrence, CT2 in Anaesthetics
David R Ball, Consultant in Anaesthetics
Dumfries and Galloway Royal Infirmary, Dumfries, UK

References

We are pleased that our article on Rapid Sequence Induction (RSI) has attracted such interesting debate. We agree with both letters in that an anaesthetic should be individualised to the patient. Aspiration risk is a continuous spectrum and there can never be a defined threshold for change of technique.

More letters can be found at www.rcoa.ac.uk/letters
My first visit this morning was to Signor Piccini. I found him dressed ready to go out. He seems to live in a good way; he has a good house and many servants and attendants about him. He has a son studying at the University of Padua. I asked him about the conservatories, and especially about the age of admission and quitting. He said that boys are admitted from 8 to 10 and stay till 20 years of age – when taken in young they are bound for 8 years; but when more advanced it is difficult to get in unless they are already far advanced in the study and practice of music. After having been in for some years, if no genius is discovered they are dismissed to make way for others.

Mr Jamineau and Dr Cirillo both say that it is absolutely forbidden to castrate boys in these music schools – that they chiefly come from Leccia in Puglia, but are first tried here or elsewhere as to the likelihood of voice and then taken out by their parents to be cut: but this is forbidden under severe penalties unless with the consent of the boy, and there are instances of its being done even at the request of the boys themselves, as was the case of the detto il Grassetto at Rome. But as to these previous trials of the voice, it is my opinion that this cruel operation is but too frequently performed without trial or at least without sufficient proofs of a dawning and improvable voice – otherwise there could never be found such numbers of them in every great town in Italy without any voice at all, or at least without one sufficient to compensate for the loss. They are maimed in body and their voice is good for nothing, and nothing in Italy is so contemptible as a Eunuch that cannot sing.

Three methods of performing the operation were traditionally available. In the first the child was bathed in warm water and decoctions of plants and the testicles were pressed and bruised with the fingers so as to break them down and so prevent their further growth. No cutting of the skin was necessary. A second made the testicles so frigid as at last quite disappear and vanish, this is done by cutting the Vein that conveyed their proper Aliment and Support, which makes them grow lank and flabby, till at last they actually dry up and come to nothing. Another Method was to take the testicles quite away at once, and this operation was commonly effected by putting the Patient into a Bath of warm Water, and some small time after they pressed the Jugular Veins, which made the Party so stupid and insensible, that he fell into a kind of Apoplexy, and then the Action could be performed with scarce any Pain at all to the Patient.

Report of meetings of Council

At a meeting of Council held on Wednesday, 16 July 2014, the following were admitted to the Board of Examiners:

- Dr T Kuwani
  Northwick Park Hospital, Harrow
- Dr C Mearns
  East Surrey Hospital
- Dr J L Norman, St George’s Hospital, London
- Dr J R Prout, Royal Free Hospital, London
- Dr R Sethuraman, The Princess Alexandra Hospital, Harlow
- Dr J P Stone, Great Western Hospital, Swindon
- Dr P Thomas, Royal Devon and Exeter Hospital
- Dr C J Weir, Ninewells Hospital & Medical School, Dundee

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

**Regional Advisers**

There were no appointments/re-appointments this month.

**Deputy Regional Advisers**

There were no appointments/re-appointments this month.

**College Tutors**

**Anglia**

Dr H C Goddard, Norfolk and Norwich (in succession to Dr C Reavley)

**North Thames Central**

Dr J Prout, Royal Free Hospital (Acting Tutor)
Dr O Dulan, Royal Free Hospital (Acting Tutor)

**Mersey**

Dr B Neary, Warrington and Halton Hospitals NHS Trust (in succession to Dr S Burns)

**Wessex**

Dr J Bell, Basingstoke and North Hampshire Hospital (Acting Tutor)
Dr J Hull, Dorset County Hospital (in succession to Dr J Chamber)

**Leicester & South Trent**

Dr E Copley, Kettering General Hospitals (in succession to Dr R Ferrie)
Dr S Francis, Leicester Royal Infirmary
Dr P Ray, Leicester Royal Infirmary (in succession to Dr C C Elton)

**Head of Schools**

There were no appointments to note.

At a meeting of Council held on Wednesday, 17 September 2014, Fellowship ad eundem was awarded to:

- Dr T Fernandez, Imperial School of Anaesthesia, London
- Dr A A Kalbag, Charing Cross Hospital, London
- Dr B K John, Nevill Hall Hospital, Abergavenny
- Dr C A Jamison, Ulster Hospital, Belfast
- Dr F J Burns, Royal Alexandra Hospital, Paisley
- Dr M K P Prasanna, Walsall Hospital NHS Trust, West Midlands
- Dr M O Shields

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

**Regional Advisers**

There were no appointments/re-appointments this month.

**Deputy Regional Advisers**

**West of Scotland**

Dr G Hilditch (in succession to Dr M Smith)

**South Thames East**

Dr S Leonard (in succession to Dr C Lanigan)
West Midlands North
Dr S Agarwal, New Cross Hospital (in succession to Dr R N Avatgere)
Dr S Sockalingam, Stafford Hospital (in succession to Dr T J Parker)

Head of Schools

North West
Dr S Thornton (in succession to Dr C Till)

To note 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.

July

Anglia
Dr Mehdi Raza *
Dr Victoria Howell

Mersey
Dr Peter Delve
Dr Michael McGovern
Dr Adrian Morrison
Dr Mahboobul Haq Khan
Dr Leanne Callaghan
Dr Tushar Dixit
Dr Neil Coulson

North West
Dr Edward Denison Davies *
Dr Shilpa Munirama
Dr Khaled Girgirah

Northern
Dr Chris Ghosh

Northern Ireland
Dr Jane Wilkinson

Oxford
Dr Samantha Perera
Dr Martin Birch
Dr Nicholas Love *
Dr Wassim Shamsuddin
Dr Mark Scarfe
Dr Marietjie Slabbert *

Severn/Bristol
Dr Matthew Williams
Dr Reston Smith *
Dr David Windsor *
Dr Keith Davies *

South West Peninsula
Dr Timothy Wilson
Dr Abigail Hine
Dr Thomas Clark *

Tri-Services
Dr Amanda Edward

Wessex
Dr Nicholas Goddard
Dr Nicola Bosley
Dr Phillip Dickinson *

Birmingham
Dr James Hutchinson
Dr Michael Allan
Dr Joanne Connell
Dr Jonathan Bilmen

Warwickshire
Dr Saravanakumar Manickam

Wales
Dr Louise Webster
Dr Gareth Mula
Dr Catherine Cromey
Dr Graeme Lilley
Dr Branislav Telgarsky
Dr Richard Smith
Dr James Williams *
Dr Shabana Anwar *

West Scotland
Dr Gordon Stewart
Dr Patrick Chrystie
Dr Shashi Timalapur

West Yorkshire (Leeds/Bradford)
Dr Fiona Gibson *
Dr Manish Gupta
Dr Wendy Lim

East Yorkshire (Hull/York)
Dr Muhammad Riaz
Dr Aamir Nazir
Dr Papanna Ramakrishnan

August

Anglia
Dr Maria del Rocio Ochoa Ferraro

South East
Dr Darreul Sewell

North Central
Dr Kathryn Wessels
Dr Mark Lambert
Dr Carlos Kidel
Dr James Turnball
Dr Colleen Woo
Dr Sara Bowman
Dr Ahilan Pathmanathan
Dr Sagar Saha
Dr Kryspin Michal Stepien
Dr Dmitry Gennadiievich Kruglov

Imperial
Dr Sian Griffiths
Dr Pigi-Maria Manolis
Dr Katie Louise Gough
Dr David John Patrick O’Callaghan *
Dr Nicholas Gilfillan
Dr Robert David Sanders
Dr Michael Newman Dean *
Dr Robert Akini Emanuel John

St. George’s
Dr Andrew James Toner
Dr Nikunj Shah *
Dr Richard Timothy George
Dr Daisy Yun Kwun Tong
Dr Sophie Louise Childs
Dr Tatiana Cotruta

Kent, Surrey, Sussex
Dr Simon Sparkes *
Dr Andrew Whelan

East Midlands
Dr Kirankumar Bhagwartrao Sachane

Tri-Services
Dr Joanna Wheble *

Wessex
Dr Denny Levett *

Birmingham
Dr Alifia Tameem

Warwickshire
Dr Amar Singh Bodh
Dr Shefali Chaudhari
Dr Tamil Selvan Rajamanickam
Dr Ganesh Kumar Ramalingam
Wales
Dr Anna Sian Roberts
Dr Piret Hamer

South East Scotland
Dr David Coad
Dr Shankar Ramaswamy

North Scotland
Dr Moira Anne Hendrie

West Scotland
Dr Nina Tatarkowska
Dr Kathryn Puxty *
Dr Katrina Ellen Bramley *

West Yorkshire (Leeds/Bradford)
Dr Ramamurthy Ganesan Baskaran
Dr Thomas Lawton *
Dr Edward Anthony Rothera
Dr Matthew Richard Tinker
Dr Gemma Louise Woodward

Leicester
Dr David Welburn Popple *

Mersey
Dr Christopher Goddard *

North West
Dr Christopher Haley
Dr Tina Mehjabeen Pasha

North of Scotland
Dr Manish Chhablani
Dr Colin Patterson
Dr Moira Anne Hendrie

Northern
Dr Robert Jonathan Thompson *
Dr William Samuel Burnside
Dr Ming Hiu Wong
Dr Chris Mark Perry
Dr Joanne Melanie Smith
Dr Christopher Edward Izod

Northern Ireland
Dr Jenna Binu Mathew
Dr Claire Mary Shevlin *
Dr Suresh Babu Selvaraj
Dr Emma Louise McQuillan
Dr John Samuel Campbell

Oxford
Dr Charles Thompson *
Dr Corinna Jane Hughes
Dr Andrew Christopher Jacques *

Severn/Bristol
Dr Patrick John Morgan *
Dr Ruth Murphy

South West Peninsula
Dr Graham Kenneth Simpson
Dr Alexander Mills
Dr Nicola Louise Mather
Dr Thomas Scarrott
Dr Rukinder Birk *

East Yorkshire (Hull/York)
Dr Zakuilla Belagodu *
Dr Lana Vestarkis
Dr Zafarulla Mohmed
Dr Ramesh Ananth Manohar

September
Leicester
Dr Simon William Malcolm Scott *
Dr Livia Malanjum *
Dr Andanagouda Patil
Dr Nur Khairi Md Shah
Dr Arindam De
Dr Reena Patel

Nottingham
Dr Vishal Thanawala
Dr Sadiq Salim Bhayani
Dr Rahul Bhansali

Barts
Dr Saowarat Snidvongs
Dr Desikan Rangarajan
Sr Stephen Rhys Ford *
Dr Christopher Barringer
Dr Geoffrey Muller *
Dr Alla Mohamed Belhaj

South East
Dr Rajesh Aggarwal
Dr Chandrasekaran Subramanian
Dr Muhilan Kanagarathnam
Dr Robert Andrew Fearnley

North Central
Dr Daniel Soltanifar
Dr Corinne Stannard
Dr Maryam Jadidi

St. George’s
Dr Rachel Elizabeth Savine
Dr James Francis Wilson

Mersey
Dr Mari Roberts

North West
Dr Laura Jane Bowes
Dr Robert Augustine Hartley
Dr Inese Kutovaja

Northern Ireland
Dr Emma Totten
Dr John Adam Strange *
Dr Stephen Millen
Dr Edmund Skibowski
Dr Ben Alexander Goodman
Dr Ruth Anne Ford

Oxford
Dr Graham Nicol Barker *
South East Scotland
Dr Claire Gillan

Tri-Services
Dr Guy James Sanders

Birmingham
Dr Peter James Rose
Dr Payal Kajekar
Dr Sunil Bellam

Warwickshire
Dr Felicity Jayne Elizabeth Clark *
Dr Neil Harvey Crooks *
West Scotland
Dr David Griffith *
Dr Rebecca Anuratha Jadhav

West Scotland
Dr David Griffith *
Dr Rebecca Anuratha Jadhav

West Yorkshire (Leeds/Bradford)
Dr Claire Catherine Tordoff *
Dr Manik Chandra
Dr Amy Stasia Elizabeth Mayor
Dr Richard Charles Briscoe *
Dr Thomasina Briony Livingstone
Dr Julian Scott-Warren
Dr Matthew Stephen Atkinson *
Dr Caroline Marion Pruefer
Dr Ian Alexander Clegg

Northern
Dr Alexandra Beckingsale
Dr Claire Williams
Council received and approved the list of Fellows by Examination from June 2014:

Abeyesundara Anura Bandara
Abul Magd Essam Adel Yehea Ali
Aires Natalya
Alcorn Stephen James
Aldam Poppy Sarah
Alder Rachel
Ali Usman
Al-Rais Andrew Sanharib
Al-Rifai Ziad
Angusamy Vijay Anand
Armstrong Fiona Claire
Arrick Lindsey Anne
Arrow Kate Marina Rose
Atkinson Victoria Jane
Auldin Mohammed Aumad
Ayyash Reema
Bamford Peter Colin
Bartakke Ashish Anil
Bashford Thomas Henry
Beale Lee
Beattie Elizabeth Mary Louise
Beauchamp Nigel James Francis
Biffen Andrew John
Bishop Luke Gavrilovic
Bishop Thomas
Blackburn James
Bolton Richard James
Bosworth Kate Victoria
Bowler Matthew Richard
Bradley Thomas Cadbury Richard
Brandwood Craig Paul
Briggs Anna Margaret
Brinkler Rebecca Louise
Brown Hannah Ruth
Campbell Matthew James
Carachi Peter Robert
Carlson-Hedges Louise
Celnik Daniel Francis
Chalmers John
Charlton Matthew
Chatziperi Athanasia
Chetcuti Sarah
Cheung Jenny May-Ling
Chu Chee-Fone
Churchill Sara
Clifford-Brown Joanna Elizabeth
Cole Stephen Kenneth
Coley Emma Louise
Collins Clare Marie
Connolly Lewis Michael Raymond
Conway Laura Ann
Conway Deirdre Anne
Cronshaw Helen Lindsay
Crosby Anna Josephine
Cuell James Charles William
Dalay Satinder Kaur
Davies Jack Bryn Seys
Davies Matthew Harding
Dawson Samuel Robert
De Neumann Laura
Deacon Andrew James
Dennison Nicholas Charles
Desai Pallavbhai Virendrabhai
Dixit Anindya
Doddy Amy Eleanor
Durasamy Karthick
Dyson Edward Luke
Edmond Ian Robert
Fadden Sarah Jane
Fahmy Nisreen
Ferry Jennifer Elizabeth
Field Victoria Kate
Fitzgerald John
Fontaine Elizabeth Frances
Fox Joanna Catherine Oram
Foye Roger Alexander Robert
Fraser Kate Victoria
Fraser Victoria
Freeman David John
French Lucy Rosaline Mary
Frostick Emily Jane
Fulton Rachel
Gajree Sumit
Ganska Agnieszka Alicja
Garrard Hywel Gwilym
Garroch Swen Sinclair
Ghaflar Sadia
Greaney David Joseph
Griffiths Benjamin William
Grimaldi Rachael Grant
Grimes Matthew Felix Gerard
Gunawardhana Amila Singankutti
Archchige Irantha
Halcrow Jayne
Hartopp Andrew James
Hayward Susan Jane
Heaton Daniel Anthony
Henderson Mark Allan
Heymann Tal
Hill Simon Andrew
Hill Kathryn Anne
Hird Samuel Charles Chandler
Hope Katrina Anne
Hubbard Emily Jane Steel
Hughes Jonathan James
Hughes Alastair
Hutchison Ross Peter John
Hutley Thomas Edward
Jajur Sheshank Ravindranath
Jayasooriya Gayani Samanthika
Jenkins Nicholas Mark
Johnson Ian
Jones Richard Owen
Jones Vaughan Allan
Kabadayi Selin Sinem
Kapoor Aditya Krishan
Keane Oliver James
Keogh Peter
Khojarytt Saleem
Kodivalasa Mahesh
Kramer Alon
Kurzatkowski Krzysztof
Lantz-Dretnik Sahra Katarina Maria
Lau Hoon Ying
Lawson Cathy
Laxman Shyam Kumar
Le Cheminant Michelle Claire
Leatherbarrow Andrew Craig
Lewinsohn Asher Daniel
Ley Samuel
Liu Shuang
Lo Phillip Chia-Wen
Lo Queenie Kwan
Lyons Marc William Henry
MacDonald John James
Machavarapu Veera Venkatu
Kishore Babu
Mahadik Preeti Jayant
Mahendrayogam Thaamharah
Majeed Adeel
Malhi Gurinder Singh
Malhotra Vikram
Mallett Paul Matthew
Mann Alexander
Marshall Lucy Ann
Martin Lianne
Martin Andrew David
Martin Rebecca Michaela
Mathoulin Sophie Elizabeth
Matthews Laura Jane
Maund Andrew George
McLoughlin Neil James
Mackin Paul
McMaster Eloise Marie
McNeill James Scott
McPhee Hannah Isobel
McRae Laura
Michlig Sam Alexander
Miller Thomas William Royse
**Important Notice**

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

[www.rcoa.ac.uk/election](http://www.rcoa.ac.uk/election)

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**Scottish Advisory Board**

An election to the Scottish Advisory Board of The Royal College of Anaesthetists was held on 12 August 2014.

The result is as follows:

One SAS vacancy was available and the following nomination was returned unopposed:

- Dr Derek McLaughlan, University Hospital, Ayr

The current membership of the Board can be found here: [www.rcoa.ac.uk/node/12838](http://www.rcoa.ac.uk/node/12838).

Contact: Gail Samuel
PA to the Chief Executive
gsamuel@rcoa.ac.uk
020 7092 1612

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**Appointment of Members, Associate Members and Associate Fellows**

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

**Members**

- Dr Ravi Bhatia
- Dr Sonia William George

**Associate Members**

- Dr Gareth Meredith
- Dr Peter Remeta

**Affiliates – Veterinary**

- Mr Sean David Langton
- Mrs Frances Clare Downing

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**Election to Council 2015**

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**Associate Members**

- Dr Gareth Meredith
- Dr Peter Remeta

**Affiliates – Veterinary**

- Mr Sean David Langton
- Mrs Frances Clare Downing
Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

Dr N Arora, Peterborough and Stamford Hospitals NHS Foundation Trust
Dr M Chhablani, Aberdeen Royal Infirmary
Dr F Clark, University Hospital of North Staffordshire, Newcastle under Lyme
Dr I A Clegg, East Lancashire Hospitals NHS Trust
Dr N Crooks, Heart of England NHS Foundation Trust
Dr M Craig Faulds, Freeman Hospital
Dr P J Dickinson, Scarborough Hospital
Dr R A Ford, Daisy Hill Hospital
Dr C Goddard, Southport and Ormskirk Hospital NHS Trust
Dr K L Gough, Luton & Dunstable University Hospital
Dr A C Jacques, Royal Berkshire Hospital
Dr J M Linton, Salisbury District Hospital
Dr A C Norrington, James Cook University Hospital, Middlesbrough
Dr B Panesar, Princess Alexandra Hospital, Harlow
Dr M S Riaz, Tameside General Hospital
Dr G J Sanders, St George’s Hospital, London
Dr S W M Scott, Leicester Royal Infirmary
Dr S Shah, The Royal Brompton Hospital
Dr G K Simpson, Royal Devon & Exeter NHS Foundation Trust
Dr K Subramanian, Royal Derby Hospitals NHS Trust
Dr L Webster, Neville Hall Hospital, Abergavenny, South Wales

Deaths

It is with regret that the College records the death listed below.

Dr Graham Davidson, Cheshire

Please submit obituaries (of no more than 500 words), with a photo if desired, of Fellows, Members or Trainees to: website@rcoa.ac.uk. All obituaries received will be published on the College website (www.rcoa.ac.uk/obituaries).

GUIDELINES FOR THE PROVISION OF anaesthetic services (GPAS) 2015

The Royal College of Anaesthetists is currently looking for anaesthetists to take part in the development of the Guidelines for the Provision of Anaesthetic Services document.

What’s new?
We are updating the process by which we develop the chapters for our guidelines so that they fulfill the standard criteria for accreditation by the National Institute for Health and Care Excellence (NICE). As part of this process, we are looking for anaesthetists to join our Chapter Development Groups (CDG).

What does being a CDG member involve?
One to two face-to-face meetings and email correspondence to discuss the existing literature on the chapter topic and to provide any suggestions or comments to the author as the updated chapter is being developed.

How do I get involved?
Send us your CV, a short statement of interest, what your chapter preference is (see www.rcoa.ac.uk/GPAS2014 for details of which chapters are being included in the current cohort) and any special interests that you have.

CDG Members will be able to claim CPD points for their contribution.

For further information please contact: gpas@rcoa.ac.uk or go to: www.rcoa.ac.uk/GPAS2014.
13–14 November 2014
JOINT WINTER SCIENTIFIC MEETING
(WITH THE SCOTTISH SOCIETY OF
ANAESTHETISTS)
Radisson Hotel, Glasgow
£270 (£205 for RCoA registered trainees)

14 November 2014
FPM ANNUAL MEETING: PAIN
MANAGEMENT IN SPECIAL
CIRCUMSTANCES
RCoA, London
£190 (£135 for RCoA registered trainees)

14 November 2014
JOINT WINTER SCIENTIFIC MEETING
(WITH THE SCOTTISH SOCIETY OF
ANAESTHETISTS)
Radisson Hotel, Glasgow
£270 (£205 for RCoA registered trainees)

17 November 2014
JOINT CLINICAL DIRECTORS MEETING
(WITH THE AAGBI)
RCoA, London
Invitation only

19 November 2014
AIRWAY WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)

20–21 November 2014
INTRODUCTION TO LEADERSHIP AND
MANAGEMENT; THE ESSENTIALS
RCoA, London
£445

20–21 November 2014
CURRENT CONCEPTS SYMPOSIUM
2014: A CELEBRATION OF
ANAESTHETIC SPECIALITIES
RCoA, London
£390 (£295 for RCoA registered trainees)*

22 November 2014
CONTINUING PROFESSIONAL
DEVELOPMENT DAY
RCoA, London
£240 (£180 for RCoA registered trainees)*

* A joint rate of £690 (£370 for RCoA registered trainees) is available for delegates attending the
Current Concepts Symposium and the Continuing Professional Development Day

22–23 November 2014
THE INTERNATIONAL SCIENTIFIC
MEETING IN ANAESTHESIOLOGY
Hong Kong Convention and Exhibition
Centre (please see website for more information)

25 November 2014
ANAESTHETISTS AS EDUCATORS: AN
INTRODUCTION
RCoA, London
£220 (£165 for RCoA registered trainees)

28 November 2014
ANAESTHETISTS AS EDUCATORS:
SIMULATION UNPLUGGED
RCoA, London
£220 (£165 for RCoA registered trainees)

1 December 2014
ANAESTHETISTS AS EDUCATORS:
ANTS (ANAESTHETISTS’ NON-
technical skills) (FULLY BOOKED)
RCoA, London
£220 (£165 for RCoA registered trainees)

2 December 2014
CPD STUDY DAY
RCoA, London
£200 (£150 for RCoA registered trainees)

2 December 2014
LEADERSHIP AND MANAGEMENT:
WORKING WELL IN TEAMS ... AND
MAKING AN IMPACT!
RCoA, London
£220

2–4 December 2014
RECENT ADVANCES IN ANAESTHESIA,
CRITICAL CARE AND PAIN
MANAGEMENT
Manchester Conference Centre
£490

3 December 2014
LEADERSHIP AND MANAGEMENT:
DEALING WITH CHALLENGING
PROFESSIONAL RELATIONSHIPS
Manchester Conference Centre
£140

3–4 December 2014
ANAESTHETISTS AS EDUCATORS:
TEACHING AND TRAINING IN THE
WORKPLACE
RCoA, London
£425 (£320 for RCoA registered trainees)

12–16 January 2015
FINAL FRCA REVISION COURSE
RCoA, London
£395

19–22 January 2015
PRIMARY FRCA MASTERCLASS
RCoA, London
£305

21 January 2015
AIRWAY WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)

2 February 2015
FACULTY OF PAIN MEDICINE:
ALL YOU NEED TO KNOW ABOUT
COMPLEX REGIONAL PAIN SYNDROME
RCoA, London
£170 (£140 for RCoA registered trainees)*

3 February 2015
FACULTY OF PAIN MEDICINE:
MUSCULOSKELETAL SYSTEM
EXAMINATION FOR DIAGNOSING PAIN
PROBLEMS
RCoA, London
£170 (£140 for RCoA registered trainees)*

* A reduced rate of £320 (£255 for registered
trainees) is available for those attending both the
FPM: Musculoskeletal System Examination For
Diagnosing Pain Problems and FPM: All you need
to know about Complex Regional Pain Syndrome
events

4 February 2015
JOINT BECOMING A CONSULTANT
MEETING (WITH THE AAGBI)
AAGBI, London
For fees and booking please see www.
aagbi.org

5 February 2015
CPD STUDY DAY: OBSTETRIC
ANAESTHESIA IN THE NEXT 10 YEARS
RCoA, London
£200 (£150 for RCoA registered trainees)

10–12 February 2015
RECENT ADVANCES IN ANAESTHESIA,
CRITICAL CARE AND PAIN
MANAGEMENT
RCoA, London
£490

24–25 February 2015
ANAESTHETISTS AS EDUCATORS:
TEACHING AND TRAINING IN THE
WORKPLACE
RCoA, London
£425 (£320 for RCoA registered trainees)
■ 26 February 2015
ULTRASOUND WORKSHOP
RCoA, London
£240 (£180 for RCoA registered trainees)
■ 4 March 2015
CPD STUDY DAY
RCoA, London
£200 (£150 for RCoA registered trainees)
■ 6 March 2015
LEADERSHIP AND MANAGEMENT: LEADING AND MANAGING CHANGE; SUCCESS WITH SERVICE DEVELOPMENT
RCoA, London
£220
■ 9 March 2015
BJA/NIAA RESEARCH METHODOLOGY WORKSHOP
RCoA, London
£150
■ 11 March 2015
AIRWAY WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)
■ 11–12 March 2015
ANNIVERSARY MEETING: BEYOND THE BOUNDARIES
The Mermaid Conference Centre
£415 (£315 for RCoA registered trainees)
■ 17 March 2015
AFTER THE FINAL FRCA - MAKING THE MOST OF TRAINING YEARS 5 TO 7
RCoA, London
£165
■ 26 March 2015
CPD STUDY DAY
IET: Teacher Building, Glasgow
£200 (£150 for RCoA registered trainees)
■ 27 March 2015
QUALITY IMPROVEMENT AND PATIENT SAFETY: IMPROVEMENT SCIENCE IN ANAESTHESIA TRAINING
RCoA, London
£150

■ 16–17 April 2015
UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT
Wrexham Maelor Hospital
£450
■ 20 April 2015
JOINT CLINICAL DIRECTORS MEETING (WITH THE AAGBI)
RCoA, London
Invitation only
■ 21–22 April 2015
JOINT UK HSRC PERIOPERATIVE CARE RESEARCH FORUM (WITH THE ANAESTHETIC RESEARCH SOCIETY) MEETING
RCoA, London
Fee TBC
■ 22 April 2015
AIRWAY WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)
■ 29–30 April 2015
CARDIAC DISEASE AND ANAESTHESIA SYMPOSIUM
RCoA, London
£445 (£335 for RCoA registered trainees)
■ 5 May 2015
SAFEGUARDING CHILDREN
RCoA, London
£160
■ 7–8 May 2015
CPD STUDY DAYS
RCoA, London
£355 (£270 for RCoA registered trainees)
■ 7–8 May 2015
INTRODUCTION TO LEADERSHIP AND MANAGEMENT: THE ESSENTIALS
RCoA, London
£445

■ 11 May 2015
PATIENT SAFETY IN PERIOPERATIVE PRACTICE
RCoA, London
£200 (£150 for RCoA registered trainees)
RCoA SPRING SYMPOSIUM
Royal College of Physicians, Edinburgh
£390 (£295 for RCoA registered trainees)
■ 3 June 2015
ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
RCoA, London
£220 (£165 for RCoA registered trainees)
■ 5 June 2015
FPM SUMMER STUDY DAY
RCoA, London
£170 (£140 for RCoA registered trainees)
■ 9 June 2015
CPD STUDY DAY
RCoA, London
£200 (£150 for RCoA registered trainees)
■ 10 June 2015
ETHICS AND THE LAW FOR ANAESTHETISTS
RCoA, London
£200 (£150 for RCoA registered trainees)
■ 17 June 2015
AIRWAY WORKSHOP
Hilton Hotel Metropole, Brighton
£260 (£195 for RCoA registered trainees)
■ 29–30 June 2015
UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT
Education Centre, Solihull Hospital
£450
CURRENT CONCEPTS SYMPOSIUM 2014
A CELEBRATION OF ANAESTHETIC SPECIALTIES

Thursday, 20 November and Friday, 21 November 2014
RCoA, London
£390 (£295 for RCoA registered trainees)
Event organisers: Dr S Patel and Dr P Kumar

Day 1

SESSION 1: ASSOCIATION OF CARDIOTHORACIC ANAESTHETISTS (ACTA)
Echocardiography – fit for general anaesthesia? (2A03, 2A12)
Dr N Fletcher, London

Perioperative management of pulmonary hypertension (3G00)
Professor B Madden, London

A targeted approach to transfusion during heart surgery (2A03)
Dr R Gill, Southampton

SESSION 2: DIFFICULT AIRWAY SOCIETY (DAS)
Management of the obstructed airway (1C01, 2A01, 3A01)
Dr A Patel, London

Videolaryngoscope, the anaesthetist’s third eye (2A01, 3A01)
Dr S Radhakrishna, Coventry

Human factors for airway safety: the fourth dimension (2A01, 3A01)
Dr R Dravid, Kettering

SESSION 3: OBSTETRIC ANAESTHETISTS ASSOCIATION (OAA)
New developments in obstetrics and haematology (2B01, 3B00)
Dr C Elton, Leicester

SESSION 4: NATIONAL INSTITUTE OF ACADEMIC ANAESTHESIA (NIAA)
HSRC collaborative research updates in anaesthesia (3J03)
Dr R Moonesinghe, London

Latest trials in perioperative medicine (2A03)
Dr G Minto, Plymouth

Drinks Reception

Day 2

SESSION 5: ASSOCIATION OF PAEDIATRIC ANAESTHETISTS OF GREAT BRITAIN AND IRELAND (APAGBI)
Intravenous fluids in children (2D04)
Dr C Gildersleve, Cardiff

Postoperative analgesia in children (2D05)
Dr G Williams, London

Paediatric day case surgery in the DGH (2D02)
Dr K Bartholomew, Calderdale

SESSION 6: SOCIETY FOR OBESITY AND BARIATRIC ANAESTHESIA (SOBA)
Co-morbidities for the bariatric patient (3A12)
Dr J Holding, London

The impact of obstructive sleep apnoea on perioperative care (2A07, 3A13)
Dr M Hassan, London

Anaesthesia and WW1
Dr A Robertson, Aberdeen

JOSEPH CLOVER LECTURE
Mapping (un)consciousness: pathological and pharmacological insights
Professor D Menon, Cambridge

PRESENTATION OF COLLEGE PRIZES
Dudley Buxton Medal
Professor P Charters

Humphry Davy Medal
Professor M Leuwer

SESSION 7: REGIONAL ANAESTHESIA UK (RA-UK)
Paravertebral or PECS block for breast surgery (2G01, 2G02)
Dr A Pawa, London

Latest papers in regional anaesthesia (2G01)
Dr C McCartney, Toronto, Canada

SESSION 8: VASCULAR ANAESTHESIA SOCIETY OF GREAT BRITAIN AND IRELAND (VASGBI)
Pre-optimisation of the vascular patient (3A05)
Dr N Schofield, London

Has EVAR changed the management of AAAs?
Dr N Courtois, London

4.45 pm
Close

JOINT RATE
A reduced rate of £490 (£370 for RCoA registered trainees) is available for those attending both the Current Concepts Symposium and the Continuing Professional Development Day. Places for the events will be offered on a first come, first served basis.
CONTINUING PROFESSIONAL DEVELOPMENT DAY

Saturday, 22 November 2014
RCoA, London
£240 (£180 for RCoA registered trainees)
Event organisers: Dr J Nolan and Dr C Frerk

The Continuing Professional Development Day is designed to cover the essentials you need to keep up to date with your revalidation in anaesthesia.

The day will comprise of 12 lectures, running in two different streams and delegates will be able to choose six lectures, one from each stream.

<table>
<thead>
<tr>
<th>Stream A</th>
<th>Stream B</th>
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<tbody>
<tr>
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<td><strong>CLINICAL PRACTICE 1</strong></td>
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<tr>
<td></td>
<td><strong>1A. Accidental awareness during general anaesthesia (2A04, 3I00)</strong></td>
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<tr>
<td></td>
<td>Professor T Cook, Bath</td>
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<td><strong>1B. Fatigue and the anaesthetist (1B01, 2A06)</strong></td>
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<td></td>
<td>Dr P Gregory, London</td>
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<td><strong>CLINICAL PRACTICE 2</strong></td>
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<td><strong>2A. Anaesthesia for the obese patient (3A13)</strong></td>
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<td>Dr C Nightingale, Buckinghamshire</td>
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<td><strong>2B. ß-Blockers, statins and stents in perioperative care (2A12, 3I00)</strong></td>
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<td>Dr P Kakodkar, Northampton</td>
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<td><strong>RECENT ADVANCES</strong></td>
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<td><strong>3A. Acute pain management (2E01, 3E00)</strong></td>
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<td>Dr B Fischer, Worcestershire</td>
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<td><strong>3B. Anaphylaxis (1B01, 2A06)</strong></td>
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<td>Dr N Harper, Manchester</td>
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<td><strong>CRITICAL INCIDENTS</strong></td>
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<td><strong>4A. Emergency laparotomy outcomes</strong></td>
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<td>Dr N Quiney, Guilford</td>
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<td><strong>4B. Preoperative risk stratification (2A03, 2A12, 3I00)</strong></td>
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<td>Dr M Thomas, Bristol</td>
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<td><strong>QUALITY</strong></td>
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<td><strong>5A. Quality improvement made simple (1I05, 3J02)</strong></td>
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<td>Professor C Peden, Bath</td>
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<td><strong>5B. Human factors (1I03, 3J00)</strong></td>
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<td>Dr D Ball, Dumfries</td>
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<td><strong>ANAESTHETIC MANAGEMENT</strong></td>
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<td></td>
<td><strong>6A. How to do ultrasound and how it improves your life (2G03, 3A09)</strong></td>
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<td>Dr C Thompson, Bristol</td>
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<td><strong>6B. Eight new trauma centres – what does that mean for me?</strong></td>
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<td></td>
<td>Dr L McCullough</td>
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</tbody>
</table>

JOINT RATE

A reduced rate of £490 (£370 for RCoA registered trainees) is available for those attending both the Current Concepts Symposium and the Continuing Professional Development Day. Places for the events will be offered on a first come, first served basis.
RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Tuesday, 2 December to Thursday, 4 December 2014
Manchester Conference Centre
£490
Event organiser: Dr R Alladi

Day 1

**Traumatic brain injury: management and prognosis (2F01, 2F03)**
Professor F Lecky, Sheffield

**Awake craniotomy – anaesthetic technique and challenges (3F00, 3I00)**
Dr K Ferguson, Aberdeen

**Dementia and anaesthetic management (2A03, 3I00)**
Dr I Foo, Edinburgh

**Can chronic postoperative pain be prevented? (2E01, 2E03)**
Dr D Graham, Doncaster

**Transfer of critically ill child (3A11, 2D01)**
Dr P Murphy, Liverpool

**Lung protective ventilation – who, when and how? (2C02)**
Dr I Mackenzie, Birmingham

**Non-opioid based adjuvant analgesia in perioperative management (1D01, 1D02)**
Dr J Wilson, Edinburgh

Day 2

**Communications in healthcare (1H02)**
Dr P Hayden, Medway

**Awake shoulder surgery: tips for success (2G01, 2G03)**
Dr M Sheker, Rotherham

**Anaesthesia and cancer outcomes (3I00)**
Professor D Buggy, Dublin

**SAMUEL THOMPSON ROWLING ORATION:**
Lecture title to be advised
Professor M James, Cape Town, South Africa

**Vasoconstrictors – choice and usage in anaesthesia (1A02, 3J00)**
Dr J Berridge, York

**Wound infiltration and catheter infusion techniques for postoperative pain relief (2E01, 2G02)**
Dr M Checketts, Dundee

**Cardiac assist and extracorporeal gas exchange (2C04, 3G00)**
Dr T Clutton-Brock, Birmingham

**Near patient blood testing (1A03, 1A01)**
Dr R Gill, Southampton

Day 3

**Management of post-ICU outreach critical care (2C07, 3J00)**
Professor J Bion, Birmingham

**Fluid resuscitation – current view (2A04, 2A05)**
Dr D Martin, London

**Lessons from NELA (3J00)**
Dr D Murray, North Allerton

**Pain relief techniques in infants and children (1D02)**
Dr D Patel, Manchester

**Challenges to ventilation during airway surgery (3A02)**
Dr A Patel, London

**Quality and excellence in anaesthesia (1J05, 3J02)**
Professor C Peden, Bath

**Medico-legal issues in obstetric anaesthesia (1F01, 1J04)**
Dr F Plaat, London

**Anaesthesia for free flap surgery: current thinking (3H00)**
Professor S Pal, Chelmsford
Working well in teams and making an impact!

Tuesday, 2 December 2014
RCoA, London
£220
Event organiser: Dr C Ralston
CPD Matrix code covered: 3J00

9.30 am
Registration
■ Case scenarios in team working
■ What are the key ingredients of team effectiveness?
■ Do we need to like each other to work well together?
■ Working in multi-disciplinary teams
■ Team effectiveness planning

16.00 pm
Close

At the end of the workshop, each participant will have:
■ Enhanced their understanding of how teams work through the introduction of basic tools and frameworks that can be applied to their own teams.
■ Had the opportunity to practise working in a group setting and explore the challenges this can present.
■ Considered the particular challenges and benefits of working in a multi disciplinary setting.
■ Explored and developed a personal plan for maximising their effectiveness in their own team setting.

Dealing with challenging professional relationships

Wednesday, 3 December 2014
Manchester Conference Centre
£140
Event organiser: Dr C Ralston
CPD Matrix code covered: 3J00

9.30 am
Registration
■ Introduction and Welcome
  Dr C Ralston and Ms V Glenny
  What do I find challenging?
■ Tools and strategies for managing our own challenges
■ Applying tools and strategies to personal examples

13.00 pm
Lunch and close

At the end of the workshop, each participant will have:
■ Been introduced to a number of simple tools and strategies to support working with challenging colleagues
■ Explored how these might be used in workplace relationships

CPD STUDY DAY

Tuesday, 2 December 2014
RCoA, London
£200 (£150 for RCoA registered trainees)
Event organisers: Dr R Verma and Dr N Narula

Lectures on the day may include:
■ Anaesthesia for foot and ankle surgery
■ Regional anaesthesia for day care surgery
■ Enhanced recovery/updates
■ Educating junior doctors and medical students
■ Chronic pain
■ Clinical concepts and principals of day care surgery
■ Goal directed fluid management/updates

Lectures subject to change
ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
Tuesday, 25 November 2014
Wednesday, 3 June 2015
RCoA, London
£220 (£165 for RCoA registered trainees)
CPD Matrix codes: 1H02, 2H01

9.30 am
Registration
- Introduction to adult learning
- Small group teaching
- Presentation skills
- Summary, feedback and homework

Rotational workshops
- Teaching in theatre
  Introduction to teaching in the clinical setting
- Assessment and effective feedback
  Introduction and review of current methodologies
- Supervision
  Principles of effective clinical and educational supervision
- Trainees with problems
  Cause, analysis and remediation

ANAESTHETISTS AS EDUCATORS: TEACHING & TRAINING IN THE WORKPLACE
Wednesday, 3 December and Thursday, 4 December 2014
Tuesday, 24 February 2015
Wednesday, 25 February 2015
RCoA, London
£425 (£320 for RCoA registered trainees)
CPD Matrix codes: 1H01, 1H02, 2H01, 2H02

Day 1
9.45 am
Registration
- Personal learning objectives
- Learning theories
- Learning styles
- Feedback
- Planning learning
- Drinks reception for all

Day 2
8.00 am
Registration
- Workplace teaching
- Assessment of professionals
- Practice teaching debrief

ANAESTHETISTS AS EDUCATORS: SIMULATION UNPLUGGED
Friday, 28 November 2014
RCoA, London
£220 (£165 for RCoA registered trainees)
CPD Matrix codes: 1H01, 3J02

The latest addition to the AaE Programme which aims to equip participants with the knowledge and skills necessary to begin to develop as simulation-based educators.

This course:
- Debunks simulation myths
- Really gets back to the nuts and bolts of what you and your learners need

Suitable for all those interested in delivering simulation-based teaching and learning in their own workplace.

Topics covered:
- Application of educational theory to simulation practice
- Spectrum and scope of simulation
- Range and appropriate level of fidelity
- Techniques and requirements for effective simulation
- Resources required for a successful simulation project

QUALITY IMPROVEMENT AND PATIENT SAFETY: IMPROVEMENT SCIENCE IN ANAESTHESIA TRAINING
Friday 27 March 2015
RCoA, London
£150

Overview: A one day meeting to support the introduction of Quality Improvement and Improvement Science to the Anaesthesia training curriculum.

The aim of the day is to build knowledge, insight, enthusiasm, reassurance and confidence amongst the training community to support the introduction and spread of systematic Quality Improvement using proven Improvement Science methodology. Building on our feedback from last year’s successful event we will move the emphasis of the day to even more hands-on practical experience.
CPD STUDY DAY: PAEDIATRICS

Wednesday, 4 March 2015
RCOA, London
£200 (£150 for RCoA registered trainees)

Event organiser: Dr L Brennan

9.00 am – Registration

- Initial assessment & management of the septic child (2D01)
- Transfer of the critically ill child (2D07)
- Vascular access (2D03)
- Fluid management (2D04)

4.00 pm – Close

- Airway management update (2D02)
- Chronic pain issues in children (2D05)
- Sedation techniques (2D06)
ANNIVERSARY MEETING 2015
BEYOND THE BOUNDARIES

Wednesday, 11 March and Thursday, 12 March 2015
The Mermaid, London
£415 (£315 for RCoA registered trainees)
Event organiser: Dr A Cooper

Day 1
Frailty, futility and critical care (2C01, 3C00)
Dr D Bryden, Sheffield

Critical care rehabilitation (2C07)
Dr C Waldmann, Reading

Is it time to change the model? (2C07)
Speaker to be confirmed

History ITU (2C07)
Dr P Nightingale, Manchester

HDU and MAU? A physician’s perspective (2C07)
Dr D Pandit, Dudley

The acute hospital of the future: the view of the Royal College of Physicians (2A12)
Professor T Evans, London

Cardioversion and the role of anaesthesia (2A08)
Dr A Parnell, Sheffield

Anaesthesia and remote locations (2A10)
Dr K Ruiz, Sheffield

ANNUAL GENERAL MEETING

THE JOHN SNOW ORATION
Lecture title to be advised
Professor N Black, London

The epidemiology of perioperative harm (2A03)
Professor R Pearse, London

The long-term consequences of postoperative morbidity (1I05)
Dr R Moonesinghe, London

5.05 pm
Close and drinks reception for all

Day 2
The child who fits, to transfer or not? (2D01, 2D07)
Dr S Hancock

The scary airway in a child ...everyone’s problem (2D01, 2D07)
Dr T Dorman, Sheffield

Pre-hospital care, a new training programme (2A12)
Dr A Hormis, Sheffield

The anaesthetist and restraint response team (2A08, 2A10)
Dr L Brennan, Cambridge

ECT and the role of the anaesthetist (2A08)
Dr A Goodwin, Bath

PRESENTATION OF COLLEGE AWARDS

MACINTOSH LECTURE
Improvement science for anaesthesia and intensive care (1I05)
Professor C Peden, Bath

Enhanced recovery (1I05)
Mr D McDonald

The shock of the fall – improving patient experience and outcome following fractured ribs (2E02)
Dr A Blackburn, Rotherham

NELA Update (2A07)
Dr D Murray, Middlesbrough

DEBATE
Should outreach be integrated into critical care and be a mandatory 24/7 service? (2C07)
CON – Dr B Marsh, Dublin
PRO – Speaker to be confirmed

9.00 am
Registration

■ Initial management of spinal injury (2F02)
■ Advanced patient monitoring techniques (2A04)
■ Sedation techniques for adults (2A10)
■ Assessment of fitness and risk stratification prior to surgery (2A03)
■ Regional anaesthesia brachial plexus blocks (G202)
■ An update on work based assessments in Anaesthesia and critical care (2H01)
■ The inter-hospital transfer of the critically ill adult (3A11)
■ Pharmacology the development of new drugs in anaesthesia and intensive care (1A02)
■ Evidence in anaesthesia and critical care the major trials and meta-analyses 2014–15 (3J03)

4.55 pm
Close

CPD STUDY DAY
Thursday, 26 March 2015
IET:Teacher Building, Glasgow
£200 (£150 for RCoA registered trainees)
Event organiser: Professor J Kinsella

9.00 am
Registration

■ Initial management of spinal injury (2F02)
■ Advanced patient monitoring techniques (2A04)
■ Sedation techniques for adults (2A10)
■ Assessment of fitness and risk stratification prior to surgery (2A03)
■ Regional anaesthesia brachial plexus blocks (G202)
■ An update on work based assessments in Anaesthesia and critical care (2H01)
■ The inter-hospital transfer of the critically ill adult (3A11)
■ Pharmacology the development of new drugs in anaesthesia and intensive care (1A02)
■ Evidence in anaesthesia and critical care the major trials and meta-analyses 2014–15 (3J03)

4.55 pm
Close
RCOA SPRING SYMPOSIUM 2015

Thursday 14 May to Friday 15 May 2015
The Royal College of Physicians, Edinburgh
£390 (£295 for RCoA registered trainees)
Event organiser: Dr B Shippey

2015’s Spring Symposium will be an informative and thought provoking event, providing an opportunity for consultants and trainees to gain valuable insights into the current issues in anaesthesia followed by an evening social.

The event will feature:
- Lectures
- Workshops
- Exhibition stands
- Social evening for all attendees

JOINT BECOMING A CONSULTANT
(WITH THE AAGBI)

Wednesday 4 February 2015
AAGBI, Portland Place, London
See www.aagbi.org for fees
Event organisers: Dr M Checketts and Dr S Gulati

8.50 am – Registration
- Challenges for the anaesthetist over the next 10 years
- Consultant contracts: Job Planning: now and in the future
- What the Clinical Director wants and Medical Director hopes
- Dealing with difficulty
- Medico-legal pitfalls for the Anaesthetist
- Independent Practice
- Teaching Training and Educational Supervision
- Becoming a Consultant in 2015
- Panel Q & A
5.15 pm – Close

CPD STUDY DAY:
OBSTETRIC ANAESTHESIA IN THE NEXT 10 YEARS

Thursday, 5 February 2015
RCoA, London
£200 (£150 for RCoA registered trainees)
Event organisers: Dr R Verma and Dr N Lucas

The topics for this meeting will cover:
- Maternity critical care
- Safety in obstetric anaesthesia
- Medico legal issues
- Labour ward management issues
Join us to professionalise medical leadership and management for better patient care

Doctors have a long and proud history of defining and expecting high clinical standards as well as establishing the necessary systems of training and development that have led to massive benefits for patients.

In a recent article, Peter Lees, Medical Director at the Faculty of Medical Leadership and Management (FMLM), announced: 'It is now time to recognise the value that medical leadership can add to that history and support all doctors to equip themselves with the leadership skills necessary for their various roles in complex and challenging systems.'

FMLM, established by all medical royal colleges and faculties in the UK, champions leadership development and training for all medical grades and specialties. As part of the effort to serve our membership, one of the key FMLM activities in 2014 will be seven regional conferences to engage members locally. A major topic of consultation at these events will be the standards of medical leadership being developed by FMLM this year for implementation in 2015.

All doctors, dentists and medical and dental students are invited to participate in these events taking place across the UK between September and November 2014 as well as the annual national conference in February 2015. These events will provide an opportunity to learn from experts in management and leadership, share experience and know-how, network and engage in discussions about professionalising medical leadership and management to deliver better healthcare outcomes for patients in the UK. Regional and annual conference places are available at discounted rates for FMLM members and associates.

We are constantly reminded of the huge challenges facing our healthcare system and those worldwide. There’s a growing recognition that medical leadership and management is part of the solution. Your support is hugely important so please join FMLM’s 2000 strong membership, take advantage of the many member benefits and add your voice to ours!

For more information about membership and the regional and national conferences, go to www.fmlm.ac.uk/conferences.

### Schedule of FMLM regional conferences 2014

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<th>Date</th>
<th>Region</th>
<th>Location</th>
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<tr>
<td>12 November</td>
<td>North of England</td>
<td>Leeds</td>
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<tr>
<td>13pm – 14 November</td>
<td>Northern Ireland</td>
<td>Belfast</td>
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<td>19 November</td>
<td>London Central</td>
<td>London</td>
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<tr>
<td>28 November</td>
<td>Scotland</td>
<td>Edinburgh</td>
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Please go to the website [www.rcoa.ac.uk/node/461](http://www.rcoa.ac.uk/node/461) to complete the necessary Terms and Conditions of Business and to submit your advert online.
EBPOM 2015
Institute of Education, London
29th June - 3rd July 2015

14th EBPOM Congress in Evidence Based Perioperative Medicine including:
- Fluids
- Monitoring
- CPEX

Call for Abstracts
We invite you to submit work for poster presentation. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 14th April 2015.
To submit an abstract visit: www.ebpom.org/abstracts

11th Perioperative CPET Course
3rd & 4th December 2014, Guildford
Cardiopulmonary Exercise Testing For Pre-operative Assessment Course
- Only 40 delegate places per course
- Faculty to Delegate ratio 1:4
- Lectures, small group tutorials and workshops
- Underlying Physiology
- Test Interpretation
- Respiratory and Cardiac abnormalities
- Testing Practicalities
- Setting up a new service

EBPOM UK Regional Meetings
Guildford
Friday 5th December 2014

More details will be published shortly.
For latest information on all EBPOM meetings please visit www.ebpom.org or follow us on twitter @ebpom.
The Intensive Care Society

The State of the Art Meeting 2014
Monday 8th to Wednesday 10th December 2014
The ICC, East ExCeL, London
The UK’s largest meeting for Intensive Care Professionals

*Predict, Prescribe, Prognosticate*

Confirmed Keynote Speakers:
Prof. Peter Brindley, Canada
Prof. Daren Hayland, Canada
Prof. John Marshall, Canada
Prof. Antoine Vieilliard-Baron, France
Prof. Xavier Monnet, France
Prof. Jan Wernerman, Sweden
Prof. Greet Van De Berghe, Belgium
Prof. Anders Perner, Denmark
Dr. Adam Deane, Australia
Prof. Mervyn Singer, UK
Dr. Zahid Khan, UK
Dr. Jonathan Goodall, UK
Dr. Bob Winter, UK
Dr. Stephen Brett, UK
Dr. Michael Powers QC, UK
Mr. Alastair Pitblado, Barrister and Official Solicitor to the Senior Courts (UK)

Topics:

Also featuring:
State of the art exhibition, Industry symposiums, research presentations, Research poster presentations, and Intensive Care Foundation James Lind Alliance project

Standard registration available until 23:59 on the 24/11/14*
*full fee breakdown available on the ICS website

Approved for 15 CPD Points

@ICSMeetings
E: events@ics.ac.uk
www.ics.ac.uk

The Association of Anaesthetists of Great Britain & Ireland

WSM London
QEI2 Conference Centre, Westminster

BOOKING NOW OPEN
14 - 16 JANUARY 2015

WSM London is one of the AAGBI’s flagship conferences. It takes place over three days and offers a mixture of updates, leading edge topics, a poster competition, keynote lectures, an extensive industry exhibition and the opportunity to network.

www.wsmlondon.org

Listen to the world of anaesthesia...

with the latest podcasts from the BJA

bjaoxfordjournals.org
THE MSA SAQ WRITERS CLUB

The Writers Club has seen more than 400 trainees through the SAQ Papers with a first-time Pass Rate of between 80 and 90 percent for those who have kept to the necessary disciplines. 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 a Valuable Motivation towards Sustained Revision.

Membership Fee: A Single Payment of £400
Members are entitled to all benefits until successful in the SAQ Paper
Attendance to the SAQ Weekend Course – Free of Charge

Writers Club Motto: ‘Within the Discipline, Lies the Reward’

Candidates are urged to join early for the Autumn 2015 Examinations to reap maximum benefit.

Enquiries to: writersclub.msa@gmail.com

Courses for the Royal College of Anaesthetists Examinations

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<td>Primary MCQ Only</td>
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<td>August 2015</td>
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<td>Primary OSCE/Orals</td>
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<td>Primary Viva Weekend</td>
<td>16 – 18 January</td>
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<td>Final SBA/MCQ</td>
<td>13 – 19 February</td>
<td>August 2015</td>
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<td>Final SBA Only</td>
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<td>Final SAQ Weekend</td>
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<td>Final Viva Weekend</td>
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To see details of all of our courses please visit: www.msoa.org.uk or contact us at: enquiries@msoa.org.uk
CONTACT INFORMATION

**Chief Executive’s Office**
Kevin Storey, Chief Executive and Finance Director
020 7092 1612

Martin Bennetts, Facilities Manager
facilities@rcoa.ac.uk
020 7092 1510

Mark Blaney, Financial Controller
finance@rcoa.ac.uk
020 7092 1581

Richard Cooke, IT Manager
support@rcoa.ac.uk
020 7092 1712

Membership and subscriptions
subs@rcoa.ac.uk
020 7092 1701/1702/1703

**Education and Research Directorate**
Sharon Drake, Director of Education and Research
020 7092 1681

Mary Casserly, Education and Research Manager
events@rcoa.ac.uk
020 7092 1680

Daniel Waeland, Head of Faculties (FICM and FPM)
fpm@rcoa.ac.uk
020 7092 1727

Isma Adams, Human Resources Manager
hr@rcoa.ac.uk
020 7092 1541

e-Learning Anaesthesia
e-LA@rcoa.ac.uk
020 7092 1542

Meetings and Events
events@rcoa.ac.uk
020 7092 1670

National Institute of Academic Anaesthesia
info@niiaa.org.uk
020 7092 1680

**Clinical Quality Directorate**
Charlie McLaughlan, Deputy Chief Executive and Director of Clinical Quality
020 7092 1694

Carly Melbourne, Quality and Safety Manager
standards@rcoa.ac.uk
020 7092 1699

Sonia Larsen, Communications Manager
slarsen@rcoa.ac.uk
020 7092 1532

Advisory Appointments Committees
aac@rcoa.ac.uk
020 7092 1571

Anaesthesia Clinical Services Accreditation (ACSA)
acsa@rcoa.ac.uk
020 7092 1575

Anaesthesia Review Teams (ART)
art@rcoa.ac.uk
020 7092 1571

Bulletin
bulletin@rcoa.ac.uk
020 7092 1692/1693

Guidelines for the Provision of Anaesthetic Services (GPAS)
gpas@rcoa.ac.uk
020 7092 1572

Patient Safety
salg@rcoa.ac.uk
020 7092 1574

Presidential Secretariat
president@rcoa.ac.uk
020 7092 1600

Revalidation and CPD
revalidation@rcoa.ac.uk
020 7092 1699

Website
website@rcoa.ac.uk
020 7092 1692/1693

**Clinical Quality Directorate**
Charlie McLaughlan, Deputy Chief Executive and Director of Clinical Quality
020 7092 1694

Carly Melbourne, Quality and Safety Manager
standards@rcoa.ac.uk
020 7092 1699

Sonia Larsen, Communications Manager
slarsen@rcoa.ac.uk
020 7092 1532

Advisory Appointments Committees
aac@rcoa.ac.uk
020 7092 1571

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acsa@rcoa.ac.uk
020 7092 1575

Anaesthesia Review Teams (ART)
art@rcoa.ac.uk
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bulletin@rcoa.ac.uk
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Guidelines for the Provision of Anaesthetic Services (GPAS)
gpas@rcoa.ac.uk
020 7092 1572

Patient Safety
salg@rcoa.ac.uk
020 7092 1574

Presidential Secretariat
president@rcoa.ac.uk
020 7092 1600

Revalidation and CPD
revalidation@rcoa.ac.uk
020 7092 1699

Website
website@rcoa.ac.uk
020 7092 1692/1693

**Clinical Quality Directorate**
Charlie McLaughlan, Deputy Chief Executive and Director of Clinical Quality
020 7092 1694

Carly Melbourne, Quality and Safety Manager
standards@rcoa.ac.uk
020 7092 1699

Sonia Larsen, Communications Manager
slarsen@rcoa.ac.uk
020 7092 1532

Advisory Appointments Committees
aac@rcoa.ac.uk
020 7092 1571

Anaesthesia Clinical Services Accreditation (ACSA)
acsa@rcoa.ac.uk
020 7092 1575

Anaesthesia Review Teams (ART)
art@rcoa.ac.uk
020 7092 1571

Bulletin
bulletin@rcoa.ac.uk
020 7092 1692/1693

Guidelines for the Provision of Anaesthetic Services (GPAS)
gpas@rcoa.ac.uk
020 7092 1572

Patient Safety
salg@rcoa.ac.uk
020 7092 1574

Presidential Secretariat
president@rcoa.ac.uk
020 7092 1600

Revalidation and CPD
revalidation@rcoa.ac.uk
020 7092 1699

Website
website@rcoa.ac.uk
020 7092 1692/1693

**Training and Examinations Directorate**
Richard Bryant, Director of Training and Examinations
020 7092 1522

Graham Clissett, Examinations Manager
exams@rcoa.ac.uk
020 7092 1525/1526

Claudia Moran, Training Manager
training@rcoa.ac.uk
020 7092 1552/1553/1554

Equivalence
equivalence@rcoa.ac.uk
020 7092 1655

International Programmes Co-ordinator
ip@rcoa.ac.uk
020 7092 1552

Regional Representatives Support
reps@rcoa.ac.uk
020 7092 1573

SAS and Specialty Doctors
cgc@rcoa.ac.uk
020 7092 1552

Trainees
trainee@rcoa.ac.uk
020 7092 1573

Quality Assurance
020 7092 1652

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