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From the Editor

This is a rather strange edition of the Bulletin, as I am seeing many of the included articles for the first time. I offer my thanks for this to Dr Gethin Pugh who has both commissioned and edited the training themed content. He has reduced my workload considerably.

The mantra is that training is lifelong, and this cannot be denied. The change that follows CCT is really one of responsibility. Time while a trainee builds on knowledge and skills – procedural competence, but must allow space to develop confidence and decision-making.

The College recognises this and explicitly supports progressive loosening of the reins. As individual trainers, we must facilitate this and then provide appropriate support to newly appointed colleagues. As Irene Dalton points out in her, as ever measured and insightful, address to trainees, today’s tyro might be looking after us and ours tomorrow.

Dr Pugh describes the commissioned articles in his guest editorial. They are diverse in subject and content, but it is clear to me that the authors are aware of their responsibilities and have developed themselves for excellence in their future roles.

Four important areas of College-based activity/development are also described in this issue. Jeremy Langton, Editor of Continuing Education in Anaesthesia Critical Care and Pain (CEACCP), details how this Journal will evolve over the next few months. CEACCP has provided high-quality material to support trainees and consultants for 14 years and will be renamed BJA Education in the near future. The content will be more closely linked to BJA reviews, and moving MCQ’s and other supporting material online will create additional space in the print version. Compiling articles with a common theme into additional issues will be welcomed by all.

Output from completion of the online MCQ’s can be readily uploaded into the College CPD diary and Chris Kennedy describes how use of this resource has increased steadily since launch. Improved functionality will be developed over coming months.

The ‘Lives of the Fellows’ project has been in gestation for more than quarter of a century, but will finally be launched in a new area of the website – College Heritage – on June 1. Anne Thornberry and a select few have done a fantastic job to reach this point. Her article describes the scope of the project and content of the area, as well as some of the significant obstacles that have been bettered.

The final, and most far-reaching initiative described in this edition, is the award of a Health Foundation grant to support a national perioperative Quality Improvement programme. This programme is a long-stated aim of the NIAA’s Health Services Research Centre, and Professor Mike Grocott and Dr Ramani Moonesinghe lay out their ambitious plans. This is not about focusing on individual anaesthetist’s outcomes, important as these are. It is about looking at overall perioperative risk and using data-collection and improvement science to reduce the significant burden of mortality and, importantly, morbidity. Think of the National Emergency Laparotomy Audit and associated EPOCH trial, but with a much larger scope. This deserves the uncompromising support of all as it develops. In it lies our future! Perhaps an overstatement but maybe not given the thoughts of some commentators.

With the election looming, I sat in on a Health Foundation debate discussing a five-year NHS plan. The funding gap is likely to be £30 billion in the current model. How can this be managed? The view of the Right was that better care is needed – eliminate mistakes and save money – all £30 billion!

Integration of health and social care featured, and the Left talked about prevention, empowerment and taxation, of course. With 3% of the population consuming 50% of the budget and with 50% of individual consumption being in the last six months of life there was a surprising absence of the ‘expectation’ word.
You can’t always get what you want
‘But if you try sometimes, you just might find you get what you need’
[Mick Jagger and Keith Richard]

The year 2015 has thus far been dominated politically by the election campaign; hopefully normal service will be resumed in early May and we can start to address the important issues for healthcare in the UK which affect our Fellows, patients, and the hospitals in which we work and train. During the election campaign, health care organisations came together in the production of a series of ‘challenges’ for the incoming government. Key service demands included:

- Detail concrete plans to make mental health services as accessible as physical health services by the end of the next parliament.
- Commit to adequate funding for health and social care.

Let’s see what the first 100 days brings in terms of addressing these demands, once we have got past the pre-election rhetoric.

Shape in our hands?
The UK Shape of Training Steering Group issued a statement earlier this year, outlining the way forward for the implementation of the Greenaway proposals on the future of medical education. The Steering Group comprised representatives from government bodies, the Academy of Medical Royal Colleges, BMA, GMC, trainees and employers. A series of ‘next steps’ has been delineated, which include:

- Further work on describing how doctors’ training can be more generic, to better meet the current and future needs of patients.
- The development of the careers of doctors who are outside formal postgraduate training and who are not consultants, such as SAS grade doctors.
- Steps to better prepare doctors to work across the interface between primary care, secondary care and the community, with more flexibility in training between the sectors.
- Supporting the GMC to develop and pilot credentialing.

The College has already begun working towards delivering these objectives, and happily the specialty is well represented in all of the ongoing discussions on this topic.

Number theory
The Centre for Workforce Intelligence has finally published its in-depth review on the anaesthetics and intensive care medicine (ICM) workforce in England. The review somewhat optimistically identifies key drivers of demand and supply that could affect the anaesthetics and ICM workforces over the next 20 years! Unsurprisingly, the report recognises that population demographics will result in an increased demand for anaesthetists and intensive care clinicians if current levels of service provision are to be maintained.

In its response, the College supported the report’s proposal that UK governments should continue to maintain the number of training posts. Whether the anticipated requirement for 11,800 fulltime equivalent consultants by 2033 can be delivered, will require further negotiation and a regular review of healthcare priorities. The College will undertake a workforce census in 2015 to help identify trends in working patterns.

The report highlighted that the contributions to ICM by anaesthetists should be monitored. Whilst the majority of the ICM workforce has traditionally been derived from an anaesthetic background, the advent of the standalone CCT in ICM may dramatically change this.
The President’s Statement

We were pleased to see that the report highlighted the need for the developing role of anaesthetists in the provision of preoperative assessment and an increased involvement with perioperative care.

Green and pleasant land
An area of increasing interest to the College is the sustainability of healthcare provision. The UK has well-established multidisciplinary medical groups who lobby widely on the adverse effects of alcohol, smoking, obesity, etc. on the health of individuals and the impact on healthcare services. Interestingly, no such group exists to lobby for sustainable healthcare. Colleges have been encouraged to join with the BMA, RCN and others to provide a common voice for UK health on the necessity to develop policies in sustainable healthcare delivery. The College is ahead of many in having a sustainability officer, Dr Tom Pierce, who provides regular reports and recommendations to the College. Tom has identified a number of areas where anaesthetists and anaesthetic departments can look to change or modify practice to enhance sustainability. The College will seek to ensure that our standards for training, clinical quality, education and research are developed with sustainability as a core goal.

The winner takes it all
Congratulations to those 19 anaesthetists who were successful in the 2014 round of national Clinical Excellence Awards (ACCEA) and the way in which it operates is currently under review and the College has made extensive comment in response to that consultation. There is an expectation that the 2015 process will go ahead, and newly elected Council member William Harrop-Griffiths will be leading the review of applicants seeking College support. Details of the College timetable and process will be posted on the website once ministerial approval to proceed has been given.

So long, farewell
In January Kevin Storey announced that he would be retiring in 2015. Kevin has been our CEO at the College for the past 14 years, and prior to that its Finance Director; during his stewardship the College has grown and changed immeasurably. The profession owes him a huge debt of gratitude for his sterling work in developing the College and its Faculties into the organisations they are today, with over 17,000 Fellows and members, and housed in bespoke premises in Red Lion Square. It would be fair to say that there is no corporate memory within Council regarding the process for appointment of a new CEO. It was therefore considered appropriate to engage a firm of recruitment consultants to advise and manage the appointment process, which began in February and hopefully will be complete by the time of publication of this Bulletin. As a part of the review of the CEO job description, Council have decided to increase the size of the senior management team and appoint new directors of Finance and Communication, in addition to our existing directors of Clinical Quality, Education and Research, and Training and Examinations.

And finally…
One duty that Kevin is most keen to officiate at – for a final time – is the annual Diplomates Ceremony on the Friday before the May Bank Holiday weekend. Newly appointed Fellows by examination in Anaesthesia, Intensive Care and Pain Medicine will be joined by those awarded College prizes and medals in recognition of their contribution to the work of the College and the wider specialty. In addition we will be awarding Fellowships to Clifford Mann, President of the Royal College of Emergency Medicine, and to Terence Stephenson, Chair of the GMC and immediate past Chairman of the Academy of Medical Royal Colleges. Both have been strong supporters of College policies and initiatives, and both hold the College in high regard. Terence has agreed to be our guest speaker at this event; he has had a long career in medical education and the delivery of healthcare policy, both key College activities, and it is therefore most appropriate that he should be addressing our diplomates as they embark on their careers. We will also be acknowledging the lifetime of service to the College and its activities of Anna-Maria Rollin in awarding her the College’s Gold Medal. This is the College’s highest award to a Fellow and Anna-Maria is a truly worthy recipient.
Beyond the Curriculum

Welcome to this Special Trainee Edition of the Bulletin.

In this issue, we take the opportunity to look at some of the many interests that anaesthetists in training develop outside the curriculum to explore their own interests, for the benefit of the communities in which they live and to raise awareness of major health issues. I would like to thank all of our contributors who have worked hard to highlight some of the diverse and rewarding projects that anaesthetists in training are engaged in across the United Kingdom and beyond.

Time to develop your interests does not necessarily equate to a need to take time out-of-programme. Some of the authors illustrate how ideas can be developed to produce effective projects locally that will have a real impact on the care of patients.

In this special edition, we look forward to the choices that all of us in training will ultimately face upon completion of training. Five anaesthetists who have recently completed training reflect on their own choices post CCT and discuss the relative merits and pitfalls of the different options for CCT holders today.

In January of this year, the Royal College of Anaesthetists launched its vision of Perioperative Medicine, a new collaborative programme for the delivery of perioperative care across the UK. Dr Ramai Santhirapala and Dr David Walker of University College London discuss the challenges they encountered in developing the new Masters Programme in Perioperative Medicine. This innovative online and interactive Masters programme offers core skills and learning, delivered by experts, for a multidisciplinary group of healthcare professionals.

Dr Gareth Roberts shares his experience of resuscitation training for school-age children, and outlines how a simpler approach to basic life support can be an effective framework for educating local communities. This inspiring project aims to provide resuscitation training and public-access defibrillators for every sports club, school and remote community in Wales.

Sibonile Mathe, from the Lifebox Foundation, introduces us to the first two Lifebox Foundation Fellows and anaesthetists in training: Dr Nicholas Owen and Dr Rachel Freedman, who will be taking time out-of-programme to undertake clinical duties at different sites in Africa, as well as participating in quality improvement projects tied to Lifebox’s area of work. We also learn of some of the immense challenges faced by individuals undergoing surgical procedures in low-resource countries and the central role anaesthetists can have in making surgery safer.

Dr Aidan Devlin, former Education Fellow at the College, looks back over a year at the College, and provides some guidance for intermediate trainees thinking of enhancing their interests with time spent out-of-programme.

As this edition of the Bulletin arrives on your doorstep, I will be nearing the completion of my term as a member of the RCoA Trainee Committee and indeed completion of my training. As a Specialty Registrar, I have seen many changes: a new curriculum, the move away from paper-based assessments to e-portfolio, the formation of the Faculty of Intensive Care Medicine, and more recently the Shape of Training Review.

As training progresses, it can be all too easy to focus on the requirements of the curriculum and associated examinations. Indeed, for many, the College itself is synonymous with the latter. Like Aidan, my time with the RCoA Trainee Committee and the Welsh School of Anaesthesia, has provided an invaluable insight into the wider work the College and its representatives are involved in. I have been fortunate to meet many individuals who have a genuine passion for improving the way
training in Anaesthesia and Intensive Care Medicine is delivered in the United Kingdom.

During my time with the RCoA Trainee Committee, we have moved to a system of regional representation, with each school of anaesthesia having a representative on the Anaesthesia Trainee Representative Group (ATRG), with members of the Trainee Committee being elected from the ATRG. This has been supported by a number of trainee-centered engagement events. We have also seen the development of a number of inventive resources including a comprehensive resource for doctors new to our specialty in the form of the RCoA Guide for Novice Trainees.

I hope that you will be inspired by some of the accounts included in this edition, be it to develop your own quality improvement project or educational resource, or to consider standing for local or national representation. It is these activities that will influence the future direction of our specialty, be it at home or further afield. Challenge yourself; you may be surprised by the results.
In January 2015, the College CPD and Revalidation Team launched a survey asking members to rate their experience of using the CPD and revalidation resources provided by the College. The survey was designed to publicise these resources and to seek members’ experience of using them, as well as inviting suggestions for any further developments. The survey ran between 22 January and 13 February and 718 responses were received. What follows is an overview of the findings.

The first section of the survey focused on the CPD Online Diary, and 439 respondents, or 78.5% of all users of the system, rated it as ‘Excellent’ or ‘Good’. The features which were rated as particularly helpful included the reporting functionality/summary PDF report, with the users’ reflective comments (150 responses), and that the CPD online diary was linked to events which had been approved by the College for CPD (54 responses).

Some suggestions were made as to how the CPD online diary could be improved, including the development of additional guidance for its use, an extension of the PDF reporting functionality, and the possibility of it being able to communicate with other systems so as to ‘auto-populate’ completed CPD activities.

Another part of the survey focused on the CPD web app and, with this only being launched in September 2014, it was perhaps not surprising that only about a third of respondents had so far used it. However, of those respondents who were using the CPD web app, 72.5% rated it as ‘Excellent’ or ‘Good’. A number of respondents commented that they did not know about the CPD web app, and so further awareness-raising, plus the development of additional user-guidance, will be taken forward as actions by the College CPD and Revalidation Team.

The survey also included questions on the revalidation guidance produced by the College; this was generally well regarded, with respondents mentioning that it had helped them in preparing for their appraisals and revalidation. Positive comments included: ‘The guidance was very helpful and made my preparation for revalidation less stressful’. Responses about the RCoA Patient Feedback Questionnaire included: ‘I used a pilot version of this and found it useful. I read the piece in the Bulletin about it and will use it for my next patient feedback which is due in three years’ time.’

Some comments were received that the guidance was too long or that Trust or local guidance was used instead, whilst suggestions for further enhancement included emphasising the Checklist from the Supporting Information document, and exploring how the patient-feedback questionnaire could be further developed to include functionality to collate, anonymise and report on the replies.

Some responses to this part of the survey again encouraged further awareness-raising of the College guidance. For example, ‘Ensure that all anaesthetic departments have a responsible person or at least a poster that boldly illustrates all the excellent features available from the College website.’ One of the aims of the survey was to publicise the College resources available to support doctors with their CPD and revalidation. This initial aim has been successful, and an update on the further actions in response to the survey’s findings will follow in the next edition of the Bulletin.

Major milestone reached for the CPD Online Diary

Back in February, a major milestone was reached when the number of registered users for the CPD Online Diary reached 7,000. With a total of 998 registered users in November 2011, the number has steadily increased since then.

Dr Rafi Khan, Consultant in Anaesthesia & Pain Medicine at the Ninewells Hospital, Dundee became the 7,000th registered user when, as a new consultant, he wanted a system that would keep all his CPD work in one place, ready for annual appraisals and revalidation. Dr Khan writes: ‘I wanted to know how the College could help me, and I found the CPD Online Diary. Registration was quick through a link from the College website and the CPD Online Diary allows me to enter all my CPD activities which can be linked to the CPD Matrix’.

Dr Khan noted that past and future events can be searched for in the CPD Online Diary, and that a Personal Development Plan can also be added. He commented: ‘In one click the report is ready for the whole year. Thanks to the College and the CPD Team, I am sorted for my coming appraisals and revalidation.’
GET THE NEW CPD WEB APP!

✓ Record and reflect upon your CPD at a time which suits you
✓ Offline functionality – you can add your CPD information even when your device doesn’t have an internet connection
✓ Exclusive to RCoA members
✓ Fully linked to the College list of approved CPD events
✓ You can generate a certificate of your completed CPD activities and your reflective comments

Full compatibility with iPads and iPhones, Android devices and Windows Phones

Further information is available from: www.rcoa.ac.uk/cpd or cpd@rcoa.ac.uk

Scan here to go to the CPD Online Diary from your mobile device and select the mobile or tablet option
Moving up to CCT

Ms I Dalton, Chairman, The Lay Committee

As this edition of the Bulletin is centred on trainees, I am addressing this Patient Perspective principally to them. I wish you all well on this road, which will hopefully end with a fellowship and appointment as consultant anaesthetist in a good hospital. As a qualified doctor, working towards CCT status, you will already have developed your own style of interaction with patients in a number of clinical situations – diagnostic, procedural, investigative, advisory, and explanatory. This style will inevitably be an amalgamation of your own personality, your broad perceptions of what a doctor should ‘be like’ and ‘what patients want,’ and will be much influenced by the way in which more senior doctors have been seen to deal with patients – some positive behaviours emulated, some poor behaviours rejected.

More than clinical competence

As a consultant, your clinical competence is taken as given by patients, and the rigorous standards set by the College in examinations assure that this assumption is justified. But as a consultant you will be responsible for far more than clinical competence. As one at the top of your profession, you will become increasingly responsible for setting and maintaining standards of care to junior doctors and other medical and care staff; sometimes even to your peers: in short, for clinical leadership in its highest form. Now, it is not possible to set standards by simply telling people what to do or ensuring that they follow safety checklists: if your own behaviour does not model the highest standards in all your interactions with patients then you really do not have any standards. This will be obvious and others will cut corners too. I have been struck by the differing reactions by ward and admission staff to the mention of a particular doctor’s name. In some cases they definitely sit up straighter and even say how that doctor impresses them. In other cases there are no, or even negative, feelings expressed. While much of leadership is done by teaching, consistently good professional conduct and example, sometimes you have to confront poor standards head on. So, are you ready to pick up those who are not behaving as you would wish, even if these are your peers?

Whistle blowing

Which brings us to whistle-blowing, a popular fashion with politicians. Over 30 years ago I attended a session taken by a barrister, G.R. Barrell, on teachers and the law. He flashed up a number of tabloid headlines, including ‘Headmaster Dances Naked in the Snow with Primary Pupils’. His audience of heads and deputies fell about laughing until we were silenced by his remarking that it was far from funny, because it had not started there, and someone should have picked this man up years before so that the bizarre behaviour leading to his downfall would never have occurred. The recent ‘revelations’ about Jimmy Savile, inter alia, as well as grim reports on poor hospital care, underline the point. Whistle blowing should not be regarded as a dramatic and exceptionally courageous feature of professional behaviour, distinguished by special terminology: it should be part of the job of leadership at all levels, whether or not one is in an exalted position. As well as issues of patient safety and good care, picking up even minor misconduct or unprofessional behaviour and doing something about it matters for your own clear conscience, your colleagues, their careers and their future.

The buck can not be passed indefinitely, and do remember that if you ignore something once, and are known to have ignored it, you will be on very shaky ground if you do ever decide to take action. Fears about ‘causing trouble’ or ‘what the trade unions might do’ are excuses – no-one can defend the indefensible in 2015. It will be too late when a furious relative sues for damages or you are pilloried in the press for failing to act. More importantly, at bottom, your professional honour is in question and that, for most of us, is sufficient sanction even when nobody knows. ‘Letting I dare not’ wait upon ‘I would’ should not be an option.

Not much time

In practice, anaesthetists spend little time face-to-face with conscious patients, unless their needs are very complex. But bedside manner still matters, particularly as the anaesthetist meets the patient when they are probably feeling at their most anxious and vulnerable as an operation is imminent. Remember always that when in hospital much of our protective coloration has been stripped away. Frank Zappa once shouted to an anti-war, hippy audience, ‘Everyone in this room is wearing a uniform, and don’t you forget it!’ We all dress to impress on others some aspect of our persona, and whether we do this by prancing around in cycling gear, seated
resplendent in three thousand pounds worth of tailoring, or belligerently exhibiting armfuls of tattoos and eye-watering piercings, our dress covers our psychological as well as physical nakedness. Doctors and nurses retain this protection and patients do not. Tight white stockings, a slit hospital gown and paper knickers considerably diminish all but the most confident when confronted by those on whom our fate and health depends.

Consider this
What helps a patient (at least this patient) to trust you and feel safe in your hands during a consultation? And what fails to reassure, switches us off from listening and even raises the blood pressure? In no particular order:

An important element is a degree of warmth – not a 'captain of the 1st XV' beaming smile or anything soppy, but the ability to look into the patient’s eyes and establish empathy.

Many of your patients are very frightened ‘people’, and none is just part of a list. Don’t ask them what they want to be called in a way that puts pressure on them to get on Christian name terms.

Some doctors are very good at picking up clues from patients about their state of anxiety and their depth of ignorance about what is going to happen to them; some work to a sort of script. “Reading” the patient is particularly important when you are raising issues of risk to gain realistic informed consent. Are you really listening or waiting to impart information?

Showmen are off-putting; quiet confidence is reassuring. Those who brandish their intellect and self-confidence like a weapon always seem more interested in themselves and their brilliance than in you.

Remember that any batch of patients is both mixed-ability and mixed in class, whatever their age, sex, dress code or racial background. Appearing to talk down to anyone is less than helpful. Of course, the atmosphere on the ward or in the waiting room will have been picked up already by the patient – if staff there have spoken to other patients patronisingly, this will have set up the wrong expectations of what will happen when they meet you. You may need to exercise leadership to stop this happening.

Do not assume that very intelligent people understand everything you say – check for understanding. The articulate often pretend to a higher level of comprehension than is the case, not wanting to appear more stupid than their doctor.

It is very useful if patients know that as well as rendering them senseless to pain on the operating table you also play a part in the management of post-operative pain. We expect invasive procedures to hurt and anything which can reassure us at this point will help. It also raises the anaesthetist in our estimation, and later the anaesthetist as well as the surgeon will share the credit!

Despite the current trend towards informality, maintain a professional distance; for example, always introduce yourself as ‘Dr X’. Perhaps this is particularly important for anaesthetists and radiologists as many people do not know that they are fully qualified doctors. All part of building the patient’s confidence in you. You are not a friend, nor do we want you to be. From my own experience in education, teachers who try to be friends end up being laughed at or in trouble.

Good luck with the next few years!
Towards a national Perioperative Quality Improvement Programme (PQIP)

Dr R Moonesinghe, Deputy Director, NIAA HSRC Health Foundation Improvement Science Fellow, PQIP Lead
Professor M Grocott, Director, NIAA HSRC

One of the original aims of the NIAA’s Health Services Research Centre was to develop and implement a national case-mix programme for measuring quality and outcomes in perioperative care. With the award of a Health Foundation grant to support work towards this goal, we now have recognition of the value of such a programme and are in a position to be able to develop a pilot initiative.

The National Perioperative Quality Improvement Programme (PQIP) will be implemented in approximately ten NHS Trusts in 2016, as a prelude to a wider roll-out aiming to engage at least 75% of NHS Trusts within five years.

‘ICNARC for Perioperative Care?’

Most of us are familiar with the Intensive Care National Audit and Research Centre’s Case-Mix Program (ICNARC-CMP), which analyses data collected by local staff on ICU patients in over 90% of UK hospitals. The challenges of setting up a similar system for perioperative care are considerable. With an estimated 10 million surgical procedures taking place in the NHS per year, it is clear that prospective manual data collection on all these cases would be impossible. We would also not want to establish a system that duplicates data collection from existing national clinical audits. These would include the ICNARC-CMP and established audits supported by the Healthcare Quality Improvement Partnership (HQIP), such as the Bowel Cancer Audit, the National Joint Registry or the National Emergency Laparotomy Audit. There are also well-known initiatives that analyse ‘administrative data’ (routinely collected hospital coding data) to report on quality and outcomes: Dr Foster reports use Hospital Episode Statistics (HES) data in this way.

That said, there are areas which these initiatives do not focus on, and which offer great opportunities to improve patient outcomes. For example, current audits do not measure quality in a number of high-risk surgical procedure groups, such as major urological surgery or hepatobiliary surgery. Existing initiatives also often focus on mortality as their primary outcome measure; there are few data collected regarding postoperative morbidity (complications) and accurate figures (apart from for a few specific surgical complications) are not currently retrievable from HES data. Patient-reported outcome is not widely audited outside the mandatory Patient-Reported Outcome Measures programmes in primary hip and knee replacement, varicose vein and hernia repair. Crucially, as mortality is low in many procedures, it is only through the measurement of morbidity and patient-reported outcome, that we may truly be able to identify variation in outcome, and therefore targets for quality improvement.

Looking across the Pond: ACS-NSQIP

Some of these issues have been addressed in different healthcare settings. The American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) has collected risk-adjusted morbidity and mortality data on patients undergoing major surgery for over two decades. Rather than aiming for data collection on all patients, each participating hospital collects data on a random sample of patients, thereby reducing the burden of trying to recruit hundreds of patients each week. Important and sustained improvements in quality and outcomes have been achieved, and a number of important epidemiological findings have been published leading to changes in service provision and driving further improvement.

Who is going to do all the work?

There is no doubt that collecting data for HQIP National Clinical Audits, NCEPOD studies, NAPs, SNAPs, ASAPs and a plethora of other initiatives place a huge burden on clinical departments. Many hospitals rely on clinical staff, often junior trainees, to collect data in their spare time. There is a clear contrast between this UK philosophy and the US system. Hospitals participating in the ACS-NSQIP use trained, dedicated staff (known as Surgical Clinical Reviewers, SCRs) to collect data; they have no clinical responsibilities, and are also responsible for engaging with clinicians and supporting quality improvement initiatives based on the data captured. Participation in the ACS-NSQIP comes at a cost of between $10,000 and $29,000 per year per hospital (paid to...
in addition to the cost to the hospital of paying an annual salary of at least $40,000 to the SCRs (who are generally registered nurses with a Bachelor’s degree and at least one year’s clinical experience). Such a level of resourcing is not available to support this current pilot, nor is it likely to be available within our healthcare system in the foreseeable future.

**What’s the point? How will we actually improve patient outcome?**

We acknowledge that it is critically important to the success of the project, and the engagement of clinicians, to be mindful of these issues. However, we believe that the goal – to reduce variation and improve quality of care for thousands of surgical patients – is worth striving for. So how do we plan to support trusts to participate in this programme? We are only in the very early stages of development and discussion, but will focus on a number of areas, including minimising the dataset and using a sampling strategy to reduce the data collection burden using technology (for example, apps) to aid data collection, and potentially developing model business cases to aid departments in seeking support from their trust for data collection. Furthermore, from the outset, a key aim of the pilot study will be developing mechanisms for maintaining momentum, supporting clinicians to actually use the data and therefore hopefully driving sustainable and successful local improvement. We know that while generally, in healthcare we are quite good at ‘counting’ or ‘auditing’, actually responding to the results and then trying to improve them, is considerably harder. There is evidence that whether audit leads to improvement depends on a variety of elements, including how the feedback is delivered, having clear goals to strive for and knowing clear strategies that can be implemented to head towards achieving those goals. With the support of the Health Foundation, we have started a programme of research aimed at developing novel evidence-based methods of helping clinicians to use data for improvement. We will then test these methods in our pilot sites and conduct an ‘ethnographic’ study – an anthropological evaluation of the role that local culture and context plays in how individuals, departments or hospitals respond to data feedback. This research will be used to develop strategies to help local departments use their audit data to improve their patients’ outcomes – and therefore to deliver some tangible benefits for all the hard work which is invested locally.

### The time is now!

Anaesthetists are uniquely placed to lead multi-disciplinary efforts aimed at improving the quality of healthcare in a broad range of surgical subspecialties. There is real enthusiasm and drive amongst trainees and established consultants to engage with quality improvement, and the pQIP will provide an ideal vehicle to support and train our future consultants in improvement science. It is hard to justify not knowing our patients’ outcomes and the resulting inability to get off the starting blocks with efforts to improve them. We hope therefore, that we will be able to engage successfully with our colleagues across the UK in order to deliver our collective aspirations for improving the quality of perioperative healthcare.

If you are interested in participating or finding out more, please get in touch with us at pqip@rcoa.ac.uk.

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**Morgan Cenan**

It is with great sadness that the College announces the death of Morgan Cenan, a former employee at the College from 2008–2013.

As the first coordinator for the National Institute of Academic Anaesthesia and the Health Services Research Centre, Morgan played an intrinsic role in establishing both organisations and making them the success they are today. Morgan will also be remembered for the high level of support she provided to ACTA.

Morgan was highly regarded by her friends and colleagues at the College and will be remembered as a valued member of the team. We will miss the sense of fun that she always brought with her, her laughter, and her caring attitude towards others.

Morgan’s family meant the world to her and she leaves behind two young daughters, Jizel and Leyla and her husband, Kem. Our thoughts are very much with them at this difficult time.
Do anaesthetics influence the likelihood of cancer recurrence and survival following surgery? In 29 years of involvement in anaesthetic research I have not encountered a topic of greater interest to anaesthetists. Several retrospective studies imply that the answer to the question is yes. However, the data from available prospective clinical trials provides insufficient evidence for an influence of anaesthetic technique on long-term prognosis.

There is an understandable sense of urgency in this research field, and the pace of publication is increasing. Last year the British Journal of Anaesthesia (BJA) published a special online issue entitled Anaesthesia and Cancer. The issue was inspired by a BJA research workshop hosted by the College of Anaesthetists of Ireland in Dublin, focused on Anaesthesia and Analgesia in Cancer. The workshop was an excellent opportunity to meet with leaders in this important field. Participants authored a carefully considered consensus statement. We made a series of five recommendations, which recognise the existence of conflicting evidence and emphasise the need for additional data. The first sets the appropriately cautious tone of the document: ‘While the concept that anaesthetic or analgesic technique might affect cancer outcomes is intriguing, there is currently insufficient evidence to support any change in clinical practice’. The final recommendation states, ‘Based on recent experimental research, the expert group calls for randomized clinical trials to evaluate the effect of adjunct medications used during anaesthesia for primary cancer surgery on cancer recurrence or metastasis’.

It will be important to give careful consideration to the design of future clinical trials; and unfortunate if a link between anaesthesia and cancer is overlooked. It is unlikely that there will be funding for many sufficiently powered clinical trials. For the greatest chance of success, trials must be informed by rigorous pre-clinical research investigating the actions of anaesthetics on all aspects of cancer biology.

**Possible beneficial effects of local anaesthetics in cancer**

Several retrospective analyses support a positive association between regional anaesthesia with local anaesthetics and a reduced likelihood of cancer recurrence following surgical tumour excision. Regional nerve block reduces the requirement for general anaesthesia and opioids, factors that may adversely affect the stress response, the immune system and natural killer cells. Through these mechanisms, general anaesthetics and opioids may reduce the clearance of circulating cancer cells during the critical perioperative period. Therefore, by lowering the requirement for general anaesthesia and opioids, local anaesthetics may provide an indirect beneficial effect.

Local anaesthetics may also have direct beneficial effects. Some are anti-inflammatory and/or interact with second messenger systems to reduce cell proliferation and migration. Furthermore, the presence of voltage-activated sodium ion channels (VASCs) on metastatic cancer cells (including those from prostate, lung, breast and colon tissue) may provide a direct target for beneficial effects of local anaesthetics. Indeed, we have demonstrated that lidocaine and ropivacaine potently inhibit the activity of NaV1.5 channels expressed by metastatic colon cancer cells, reducing their capacity for invasion. This is potentially very important in cancer progression, because a cancer cell’s ability to invade correlates with its metastatic potential. This suggests that systemic local anaesthetic might contribute to the apparent beneficial effect of regional anaesthesia during tumour excision by directly inhibiting VASC activity on cancer cells.

**Maximising the likelihood of beneficial direct effects of local anaesthetics**

While regional anaesthesia may help reduce cancer recurrence and metastases following tumour excision, direct local anaesthetic administration, either intravenously or onto tumours, would probably maximise any direct beneficial effects. A drawback of such an approach is the possibility of systemic toxicity, which occurs largely through the blockade of ion channels in cardiac tissue and other excitable cells.
The NaV1.5 channel, which may contribute to beneficial direct effects of local anaesthetics on metastatic breast and colon cancer cells, is also found in the heart where its blockade would be detrimental to cardiac function. This raises the critical question of how to inhibit VASCs on cancer cells without adversely affecting the heart. NaV1.5 channels on metastatic breast and colon cancer cells include a neonatal variant, which is not found in the adult heart.11 This may provide an opportunity to target VASCs on cancer cells while sparing cardiac function. In addition, metastatic colon cancer cells have a membrane potential that is considerably more depolarised than the resting potential of cardiac cells and neurones. This results in a predominance of NaV1.5 inactivation in colon cancer cells. The inactivated state of VASCs is only briefly visited under normal physiological conditions in excitable cells. Therefore drugs that bind preferentially to the inactivated state of NaV1.5 channels may preferentially target cancer cells.

Targeting voltage-activated sodium ion channels on metastatic cancer cells

In a BJA-funded research project we have been testing a variety of local anaesthetics to determine which, if any, preferentially target VASCs in metastatic colon cancer cells, with the aim of using the information to inform future clinical trials. Lidocaine, levo-bupivacaine and ropivacaine inhibit the activity of both adult and neonatal NaV1.5 VASCs. These local anaesthetics do not discriminate between either NaV1.5 variant. We are testing additional local anaesthetics and other therapeutic VASC inhibitors, but at present selectivity for the neonatal NaV1.5 alone appears unlikely to be sufficient for avoiding cardiac toxicity.

State-dependent block on the other hand varies considerably between lidocaine, levo-bupivacaine and ropivacaine. Levo-bupivacaine and ropivacaine cause considerable blockade of NaV1.5 channels in their resting state. This is referred to as tonic block and means that these drugs do not require the channel to be in the inactivated state for their inhibitory effects. By contrast, block by lidocaine of NaV1.5 is highly dependent on inactivation. There is very little tonic block, suggesting that lidocaine will have little effect on cardiac function at concentrations that inhibit VASCs on metastatic colon cancer cells (Elajnef, Baptista-Hon and Hales, unpublished).

A next step will be to examine the effects of serum from patients receiving intravenous lidocaine to treat pain. We will establish whether the analgesic doses of lidocaine in their serum are sufficient to inhibit VASCs and metastatic colon cancer cell invasion. If so, this will provide additional evidence that lidocaine inhibits invasion at concentrations below those that cause systemic toxicity.

Each year colorectal cancer causes half a million deaths worldwide, primarily by metastatic spread.14 Liver metastases contribute to approximately 75% of colorectal cancer deaths.15 Tumour excision is the front line treatment. However, approaches that reduce the spread of tumour cells, by inhibiting invasion, may significantly prolong disease-free survival. Our findings will help identify a candidate local anaesthetic most likely to directly inhibit VASCs on metastatic colon cancer cells while minimising off-target effects. We look forward to working with others investigating the effects of anaesthesia on cancer to design an approach that will maximise the potential beneficial effects of local anaesthetics during the perioperative period. We are also exploring the effects of numerous other therapeutic VASC inhibitors on metastatic cancer cells.

The direct effects of such drugs may also improve cancer prognosis.

References

A day in the life of a Consultant in Pain Medicine

Dr L de Gray, Consultant in Anaesthesia and Pain Medicine; Chair, Regional Advisors in Pain Medicine; Queen Elizabeth Hospital NHS Foundation Trust, King’s Lynn, Norfolk

Pain Medicine is very much part of my life. I have been a doctor for 26 years – 24 of these years have been spent working as an anaesthetist, with the last nine years working as a full-time Pain Medicine Consultant. ‘How on earth can you spend your life dealing with patients with chronic pain?’ is a question I am asked, many a time by other doctors in particular. I smile and reply, ‘with pleasure’. Yes, there are difficult days, but by and large, working with patients who live with pain day in, day out, is a very rewarding and humbling experience. It certainly helps to keep your own life in perspective.

Why is pain medicine a subspeciality of anaesthesia? Divinum sedare dolorem – ‘it is praiseworthy to alleviate pain’ is our motto as anaesthetists, emblazoned on the coat of arms of the Royal College of Anaesthetists. Practising pain medicine, does not always allow me to alleviate pain, but more often than not it allows me to help alleviate the suffering that goes hand in hand with pain. Frey, in his book My Friend Leonard, said: ‘Pain is the feeling. Suffering is the effect the pain inflicts. If one can endure pain, one can live without suffering. If one can withstand pain, one can withstand anything. If one can learn to control pain, one can learn to control oneself.’

As anaesthetists, we have the privilege of seeing patients at their most vulnerable. They trust their lives to our hands, allowing us to carry them through major surgery, face life-threatening events, and dice with death on intensive care or in the resuscitation bay. Our patients trust us to manage, control and take over their lives for some time. In pain medicine, we do the reverse: we help our patients to regain control of their lives once again. Accepting that you cannot cure your patients is hard, as hard as helping patients to understand that you haven’t got the magic fix they are desperately seeking.

In the pain clinic, I frequently see patients who have lost all their faith in the medical profession, ones that have been pushed from pillar to post. There is something joyous in facing a patient who comes into your clinic, angry, upset, frustrated, with no expectations of receiving any help, leaving with the statement that they have finally found someone who after all these years has made them feel believed and set them on the road to understanding why they have pain. Pain medicine tests your abilities to listen without interrupting, to be patient, to explain, and to earn the trust of your patients. These are skills that take years to hone and set them on the road to understanding why they have pain. Pain medicine tests your abilities to listen without interrupting, to be patient, to explain, and to earn the trust of your patients. These are skills that take years to hone but will take you through a journey with your patient. Empathy and understanding are skills your patients will value and respect you for.

Pain medicine calls for skills with the needle (interventions ranging from simple trigger point injections to complex neuromodulation techniques) – skills that require in depth knowledge of anatomy and technical expertise. It also calls for a sound knowledge of basic science and pharmacology – a fact that is much reflected in the curriculum and examination leading to the Fellowship of the Faculty of Pain Medicine. It also requires the ability to work within a team, and to understand timely and effective working with your physiotherapy, occupational therapy, psychology and nursing colleagues. All this underpins the principles of multidisciplinary pain management based on a bio-psychosocial model.

And yes, before you criticise me for only painting a rosy picture, there is a downside to being a pain doctor. Piles and piles of never ending paper-work come to mind, and filling in welfare application reports can never be described as a riveting experience. However, these are a small price to pay for the satisfaction and privilege of helping to change your patients’ quality of life.

To all trainees reading this article, I say, don’t be put off by the examination or threats of decommissioning of pain services. Spend your time during your intermediate pain training with a pain consultant passionate about their specialty. Let them become your role model. There will always be a need for doctors in pain medicine. Your reward will be a legacy of patients who will never forget you for the change you bring in their life. I recommend it.
A day in the life of an Advanced Pain Medicine trainee

Dr L Miller, SpR in Anaesthesia and Chronic Pain, North Bristol NHS Trust

I have always chased the adrenaline rush of medicine – starting with accident and emergency and flying doctor in New Zealand before settling with anaesthesia. We often rescue situations when faced with the sickest of all patients that attend hospital. It’s a discipline that is often described as 90% boredom and 10% sheer madness, but isn’t this why it remains so popular? That, and the ability to maintain a work-life balance. It is one of the few specialties that allow you to work in sessions and predict your working-pattern, unlike most other medical and surgical specialties. So why pain? Many were shocked and surprised at my decision to commence advanced pain training. ‘Why on earth would you do that?’ and ‘really? Not you?!’ were among the many comments. My response is simple. I love not only the adrenaline, but also the technical side of medicine. I enjoy investigating, and I enjoy the doctor-patient relationship. Since starting advanced pain training, the suggested 90% boredom has reduced to 10%!

My day as an advanced pain trainee is incredibly varied, which allows for some autonomy in my work. I confess that I greatly enjoy the varied therapeutic and patient-centred interventions that are on offer. I still get a buzz from the technical aspects of procedures, but this is now combined with interprofessional working. My special interest in human factors and non-technical skills is utilised on a daily basis, as we work in a team of specialised nurses, physiotherapists, occupational therapists and psychologists that support each other for the benefit of the patient.

As the trainee representative for the Faculty of Pain Medicine, I have been incredibly impressed by the desire of the Board to listen to trainee feedback and to maintain high standards within this specialist area. This is a continual and ever-changing process which remains up-to-date and in line with the demands of the GMC and DH. There are vacancies for advanced pain trainees across the country, with fantastic opportunities for Out-of-Programme-Experience and inter-hospital working. There is active encouragement to gain experience in allied medical specialties such as rheumatology, orthopaedics, neurosurgery and palliative medicine which makes training varied with a steep learning curve. As to the future, once training is completed, there are regularly consultant positions available in both large teaching and smaller district hospitals. It is a great time to make this positive career choice.

Finally, while completing pain medicine training I have maintained and enhanced my life out of work to include the busy family demands of three young children and sporting pursuits. All in all, it has been a very liberating experience. As I now leave the training scheme to commence my first consultant position in anaesthesia with an interest in chronic pain medicine, I feel strongly able to recommend this career choice to my fellow trainees. Go for it!
This year has started with a bang for the UK ACCP development. The syllabus has been completed and is now out for consultation [www.ficm.ac.uk/news-events/accp-curriculum-consultation-now-open](http://www.ficm.ac.uk/news-events/accp-curriculum-consultation-now-open).

FICM Associate Membership for ACCPs received final approval at the Royal College of Anaesthetists AGM on 11 March 2015. The importance of this to individual Advanced Critical Care Practitioners, and to the development of ACCP practice across the United Kingdom, is enormous. Whilst professional responsibility and registration will remain with the statutory bodies for the individual professions, this alignment with the Faculty creates a clinically relevant partnership between NaACCp and the Faculty, which has responsibility for medical intensive care training, education and assessment, as well as for standard setting and quality assurance in combination with other bodies, most particularly the Royal College of Anaesthetists.

In the light of this, the programme for the third annual ACCP conference has been designed, not only to provide clinical CPD, but also to provide a forum for the discussion of the future of this collaboration. This will involve an interactive panel discussion on ‘what FICM association means for ACCPs’. There will be plenary lectures updating on recent advances in critical care and clinical case presentations from ACCPs from around the UK.

There are two streams of workshops: one of interactive case presentations and another for clinicians, educationalists and managers who are looking to develop an ACCP training programme de novo. This will also involve discussion on succession planning and ongoing CPD for trained ACCPs.

There will be a session exploring the ethical and legal aspects of the ACCP role and how that links with professionalism. And our work involves care. It does what it says on the tin: Advanced Critical Care Practitioner; Intensive Care Medicine; Critical Care. Or does it? Is care always at the forefront of our practice? This difficult and emotive area will be explored.

At the heart of the meeting is the pivotal NaACCp AGM. This allows ACCPs and trainee ACCPs a forum for discussion and debate.

For further information please visit the FICM website at [www.ficm.ac.uk/ficm-events/accp-conference](http://www.ficm.ac.uk/ficm-events/accp-conference).

We look forward to seeing you on Friday, 3 July 2015.
Out of Programme at the Royal College of Anaesthetists

I have just completed a one-year Out-of-Programme Experience (OOPE) post as the Education Fellow based in the RCoA Training Department. During this post, I reviewed the 2010 Curriculum for a CCT in Anaesthetics, and worked on the College’s Perioperative Medicine strategy. I hope that by describing my experience, I can help others decide whether they could benefit from taking time out-of-programme to enhance their training.

Organising an out-of-programme post

Time can be taken out of the training programme for various reasons: research (OOPR); training that is not available in your programme (OOPT), or experience (OOPE), e.g. in management, education or leadership. Usually, some or all of the time taken for OOPR and OOPT will count towards training, so your CCT date is not extended, but taking out-of-programme time for experience (OOPE) extends the trainee’s CCT date.

Organising OOP time can be tricky; my main advice is to keep your Training Programme Director and the College up-to-date with your plans. When you have identified a post that you would like to apply for, you should discuss this with your Training Programme Director. In some areas, there are restrictions on the number of trainees that can be on OOP at any one time and the duration of the post, as this can leave hospitals and rotas under-staffed when you are out of the training programme. There are also likely to be local deadlines with regard to applications. Time out-of-programme may also have implications for slotting back into the training programme and subsequent placements. For these reasons, organising time out-of-programme can be logistically challenging, and approval is not guaranteed. You should bear this in mind when accepting job offers.

When you finish the post, you will need to supply a report for your ARCP and notify the College Training Department that you are returning to training. If you have had a significant break from clinical practice you may need to undertake a ‘Return to work’ programme when you return to training. This would normally be negotiated with the College Tutor at your hospital, and details vary depending on the situation.

If you need further information about OOP, have a look at section 13 of the Curriculum document, or contact training@rcoa.ac.uk.

What did I do?

I was asked to review the anaesthetic training curriculum and given a broad remit. When I started, the Shape of Training report was hot off the press, and I was asked to consider its recommendations in my review. During the year I carried out a large survey, which directed the work of the project for the rest of the year. The issues raised in the survey were then investigated in depth, and I wrote a report for the Training Committee with recommendations...
for improving training and the curriculum. These recommendations are designed to improve the delivery of training, and do not represent a radical departure from the current curriculum. The report is still in discussion, and any changes will be well publicised before they are introduced.

The College has recently launched its Perioperative Medicine programme, and I was also involved in a project to integrate perioperative medicine into training in anaesthesia.

What did I get out of it?

So is it worth it? Undoubtedly, yes! I had the opportunity to manage a major project in the College, attend and contribute to high-level meetings and recommend some improvements to the UK anaesthesia training programme. I couldn’t have had this experience within the training programme.

Working in anaesthesia can shorten the attention span, and I initially found it difficult to sit down and concentrate for long periods of time. As trainees, our work is presented to us and we move from one specialty to another when instructed to do so. This post forced me to take responsibility for managing my own time, weeks and months in advance.

Prior to this post, I had never attended any departmental or hospital meetings, so the decision-making process within organisations was a mystery to me. Attending the Training Committee and various other meetings has allowed me to see how organisations like the College make decisions and get projects off the ground, and has prepared me much better for this kind of role as a Consultant.

Human factors training teaches us to be clear and direct when communicating in clinical situations, and many of my fellow trainees do this well. Having attended many meetings during the year, I realised that being direct can have some disadvantages. I eventually managed to smooth over some of my plain talking, which I hope will pay dividends in the future.

During OOP posts you can often choose how to structure your workload, which may give you the time to undertake external courses and present at conferences. I was able to work towards a Masters in Medical Education at a much faster rate than if I had still been in the training programme.

What is it like to work at the RCoA?

When I told my friends that I was going to work in the College for a year long OOP, there were a few awkward shuffles and inevitable comments about going over to the ‘dark’ side. The mere mention of the College brings most trainees out in a sweat as they recall stressful ARCPs, exams and the e-Portfolio. Before taking up this post my only visits to the College had been for exams and interviews, so I began my first day with a degree of trepidation.

In fact, the College has a warm and inclusive atmosphere, and the staff of the Training department went out of their way to welcome me. Having worked in the NHS for eight years, I was pleasantly surprised to have my own desk, access to a computer that worked, a ready supply of pens and post-its and my own stapler! I also really enjoyed getting to know the people I worked with, something that we often can’t do on 6-monthly rotations working far away from home.

I found an encouraging and supportive environment that acknowledged the challenges faced by trainers and trainees in delivering the curriculum, a willingness to tackle those problems, and openness to new ideas. I had wrongly assumed that members of the Training Committee were staunch supporters of the curriculum and training programme in its entirety; instead I found that they were open and willing to listen to criticism from a relatively junior trainee. Where problems existed they were receptive to suggestions. One of the strengths of the RCoA is that all elected officials are practising anaesthetists, which means that they are in touch with the current problems affecting our specialty.

I would encourage any trainee who is interested to consider an OOP, and to get involved with the College. You could represent your school on the Anaesthesia Trainee Representative Group, consider standing for election to the RCoA Trainee Committee, organise an event, or co-ordinate data collection for a national audit in your hospital. You will get a lot out of it and hopefully realise that it’s not a scary place!
During anaesthetic training the goals change sequentially, from passing the Primary, to obtaining a specialty training post, then passing the Final becomes important, and lastly completing training and receiving your precious CCT dominates your ambitions.

However, the secret angst that many are unaware of until it hits us in the final year of training is the spectre of completing training and looming unemployment after years of secure posts. No matter how much rationality and reassurance is offered, many former trainees confess to having struggled with this but interestingly it only seems to be acknowledged once it is in firmly in the past!

The main post-CCT options are:

- Substantive Consultant job
- Locum Consultant job
- Post CCT Fellow (UK)
- Post CCT Fellow (overseas)
- Grace period

Anecdotally, the destination for UK anaesthetic trainees at completion of training appears to be changing, and there also seems to be a degree of regional variation – perhaps reflecting the different attitudes within schools of anaesthesia to out-of-programme experience. The impression gained is that in regions of the UK where it is hard to get out-of-programme experience, more individuals are opting to go abroad at the end of training than previously. However in regions where there are difficulties recruiting to consultant posts, the majority of trainees complete training and take up a substantive post.

Substantive Consultant Post

Katy Nicholson
Consultant Paediatric Anaesthetist, Evelina London Children’s Hospital

I was appointed to a substantive post at Guy’s and St Thomas’ NHS Foundation Trust in December 2013, and started work in May 2014. I work primarily within the children’s hospital (Evelina London) but do cover some adult lists. Prior to taking up my consultant post, I had never worked within the anaesthetic department here although I had worked on the Paediatric Intensive Care Unit before starting anaesthetic training (so a long time ago!).

Therefore, when I started work the only colleagues I really knew were the paediatric intensivists, and I had to learn my way around a new hospital, colleagues and computer systems all in one go. However, there were advantages – I didn’t have to establish myself in a consultant role – an issue I have watched friends struggle with when appointed to a unit in which they trained.

In addition, being appointed directly to a substantive post meant that I was able to adjust to the increase in clinical responsibility before throwing myself into non-clinical work. If I had been on a short-term contract, aware that applications for a substantive job were looming, I would not have felt able to do this. Instead I had breathing space in which to acclimatize to being ‘the boss’, and have been able to influence the non-clinical role I have within the department.

I am really enjoying my new post and the security it affords me, and am very grateful for all the support my consultant colleagues gave me over the first few weeks and months. Even as a consultant you need to bounce tricky patients off other people!

Locum Consultant Post

Natasha Joshi
Locum Consultant Anaesthetist, University Hospitals Bristol NHS Foundation Trust

I am currently working as a locum consultant in general and thoracic anaesthesia at University Hospitals Bristol. During my training, I undertook two pre-CCT fellowships, in thoracics and obstetrics. When pondering my next step after completion of training, I felt that a locum consultant post would enhance
my professional development more than another fellowship, particularly in terms of the non-technical, leadership and management skills that I could gain.

I accepted an appointment in the trust where I had done the majority of my training, which also offers thoracic and tertiary obstetric services, thereby allowing me to consolidate my subspecialist skills. The locum consultant post is a well-trodden path in this trust and was recommended to me by several former trainees for its supportive colleagues and mentoring system.

Within the post my working week is fixed, although the anaesthetic lists that I do are entirely flexible. This has provided me with a broad exposure to all of the surgical specialties offered. In all honesty, I have found that the jump from registrar to consultant has been significant, especially the weight of responsibility for clinical decisions and leadership. However, this transition has been eased with appropriate support, and I now consider that I have a much better understanding of what the consultant role entails and increased competence and confidence in my own clinical skills. I believe that this will stand me in good stead, and feel fortunate to have had this exposure rather than move straight from a registrar to a substantive consultant post.

Looking ahead, I hope to apply for a substantive post in the same trust. My experiences as a locum have enabled me to form strong working relationships with colleagues, and have also provided an insight into the challenges facing the department. I would be lying if I said that my times as a locum hasn't, at times, felt like a prolonged interview, but it has also given me the opportunity to determine if the department suits my needs as well.

In summary, I would highly recommend undertaking a locum consultant appointment post-CCT. It is worth researching the post thoroughly prior to applying, particularly to ensure that a mentoring scheme and adequate support with respect to professional development are provided.

**Post CCT Fellow (UK)**

**Katrina Bramley**

My current appointment is as a fellow in cardiothoracic anaesthesia at the University Hospital of South Manchester. This centre offers a wealth of experience in theatre and intensive care for local, regional and national cardiothoracic services.

In cardiothoracic anaesthesia, along with other subspecialities such as paediatric anaesthesia, it is common to take a fellowship post between gaining a Certificate of Completion of Training (CCT) and the ultimate goal of consultancy. This is especially true for someone like myself who has joint accreditation in anaesthesia and intensive care medicine. My primary reasons for undertaking such a post were to have more exposure to cardiothoracic theatres, and learn how to perform transoesophageal echocardiography.

I have thoroughly enjoyed my post-CCT fellowship thus far, and, I think that the benefits are:

- **Choice:** post-CCT you are no longer bound to the constraints of training. This might include geographical area or matching potential institutions to expertise required.
- **Continuity:** the benefits of remaining in the same institution for a year should not be underestimated. You’ll be inundated with interesting projects and have time to build up relationships with colleagues.

Colleagues: most post-CCT fellows will be looking for a consultant post, and the fellowship period allows you to experience working in a department prior to consultant applications. The converse is also true – people will be assessing what kind of consultant colleague you are likely to become.

As with any position, there can be a downside too. A post-CCT fellowship needs to have specific goals, otherwise it can be perceived as a tactic for delaying consultant applications. It’s worth investing time to find the right post for you, encompassing the experience/training you wish to gain. However, there is likely to be a service-commitment component too. There are also financial implications; the payscale of a Fellow does not match that of the upper end of the Specialty Registrar. This is something you may wish to negotiate with any potential employer.

In essence undertaking a post-CCT Fellowship is a finishing school for consultancy. When chosen wisely it should be full of experience and opportunities to embrace.

**Post CCT Fellow (Overseas)**

**Shabana Anwar**

Intensive Care Fellow, Toronto General Hospital

I am currently undertaking an intensive care fellowship at the University Hospital Network in Toronto. I came here in August after completing a dual CCT in Anaesthesia and Intensive Care Medicine. I came primarily to gain experience in Extra Corporeal Life Support (ECLS) and organ transplantation. I thought that this would be my only real opportunity to travel abroad and undertake such a programme before becoming a consultant in the UK. I had investigated undertaking such a fellowship during my training, but it proved a rather difficult route to pursue, so I decided to wait until I had completed my training before embarking on the fellowship programme.

The fellowship programme rotates through three University hospitals: Toronto General Hospital, Mount Sinai Hospital and Toronto Western Hospital. During my time here, I have gained a vast amount of experience in managing patients on ECLS and also post-organ transplantation, and seen a fascinating case mix of patients. The education programme is well structured and very organised, and there is a
dedicated half-day of teaching every week, which you are always released for regardless of how busy it is on the unit. There is also ample opportunity to participate in many exciting research projects at each of the three hospitals.

Adjusting to working in a completely different healthcare system was surprisingly easy. The infrastructure enables procedures and investigations to be performed with relative efficiency and ease. The work can be quite demanding and intense, especially the on-calls. The salary is much lower than I received in the UK, however the cost of living is also much lower here in Toronto so it does balance out.

Toronto is a fantastic city to live in. It has all the benefits of a large city like London in terms of the diversity, cuisine and cultural events, but without many of the drawbacks. There is a feeling of spaciousness and freshnes, which would be difficult to match in many other major cities. The city is situated on the edge of the Great Lakes and, in the sweltering summer beaches are easily accessible.

Overall, I have found the experience very rewarding and enjoyable, and I would highly recommend it. However, make sure to pack your thermals, it gets pretty cold here!

Grace Period

Alison Fiorini
Post-CCT Registrar, Nottingham University Hospitals

When I entered my final year of training, the prospect of finding a consultant job became a reality rather than a theoretical sometime-in-the-future event. I was sure for a variety of professional and personal reasons that I wanted to work in the region in which I had trained. While there was the promise of a job on the horizon, there was nothing imminently available to apply for, so I decided instead to enter my grace period and wait. Without this optional extra time, only being eligible for interview in the six months prior to obtaining a CCT, creates a very narrow window to find the ideal job in the ideal hospital, (if such a thing exists!). The grace period gave me the luxury of time to wait for the consultant post I wanted to be advertised, rather than scrabble for the first one I saw and make significant compromises in terms of place and job description.

Luckily, I was looked after very well in my grace period, as I was 28 weeks pregnant when I started it, and this timing coincided with coming off the on-call rota. There was some degree of flexibility in choosing where in the region I went, and I was able to negotiate the theatres I covered with the rota consultant. I aimed for lists that I had a specific interest in, but was all too aware that my main role was service provision at this point. As a result, there was the odd ‘undesirable’ list, but I was still able to keep my hand in with big, interesting cases.

I’ve heard some post-CCT doctors complain that they are ‘used and abused’ and sent to cover all manner of horrendous lists day-to-day, but some I know have used the time to anaesthetise in a particular specialty, such as paediatrics, to consolidate their experience before starting as a consultant. I went off on maternity leave two months into my grace period, and successfully interviewed for a substantive consultant post eight weeks postpartum, but it was comforting to know that the grace period would still be available to bridge the gap until then.
‘Saving Lives in Wales’ with Welsh anaesthetists

In February 2014, an anaesthetic colleague and myself were invited into a high-school in Cardiff to teach a class of 20 students how to perform CPR. Our teaching focused on the science behind resuscitation, along with a simplified approach to basic life-support. This was the beginning of an innovative approach to resuscitation training, and the foundation for this educational project.

In just over a year, we have joined forces with a local charity and recruited over 150 volunteer doctors, nurses and medical students. We have visited 15 secondary schools, 19 rugby clubs, 7 primary schools, 10 remote communities, one golf club, one bowls club and one scout group. In total, we have taught over 3,500 individuals of all ages and from many communities, basic life-support skills.

The project

The inspiration for the project was an amalgamation of witnessing the impact that effective bystander CPR can make to patient survival, recognizing the algorithmic complexity of traditional basic life support teaching, and the lack of any formal training within schools in our local area.

We kick-started our efforts with the help of Julie Morgan, of the Welsh Assembly. Mrs Morgan was inspired by the project, and kindly wrote to local schools on our behalf to highlight the opportunity for such training in schools. This offer was taken up by Cathays High School, Cardiff, and we were soon running a pilot session. We subsequently joined forces with an exciting new charity called Welsh Hearts, which aims to help fund the widespread provision of public access defibrillators (PADs) across Wales.

The project rapidly gained momentum, supported by coverage from local news and media, with many more volunteers keen to help out with the CPR training. In response to increasing demand, we broadened our scope to include local sports clubs and interested community groups. Welsh Hearts has provided support by providing us with the training defibrillators, resuscitation mannequins and administrative support.

Our target audience is mostly school children. Basic life-support is currently not part of the national curriculum in Wales. We believe that by training the pupils, we not only teach them these important skills, but also ingrain a sense of individual responsibility towards themselves and others.

Basic life-support made easy

The emphasis with basic life-support is now on provision of continuous, good quality chest compressions and the maintenance of cerebral perfusion.1 Traditional teaching has an algorithmic structure, incorporating airway manoeuvres and mouth-to-mouth ventilation.2 We feel that for the general public with no medical background, the knowledge retention from this method is limited and can lead to confusion. We have therefore developed a simplistic approach to a patient in cardiac arrest. Our sessions start with a basic physiology lesson, followed by a chest-compression-only approach to resuscitation. This is in keeping with the present guidance from the European Resuscitation Council for the mass training of nonmedical persons.3

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Our science lesson (figure 1) helps with the core understanding of the basic life-support skills and why they are carried out. We believe that our simplistic, rapid assessment of the patient followed by chest-compression-only CPR, promotes a more fail-proof plan when faced with the highly stressful circumstances of an out of hospital cardiac arrest.
The question: ‘why no mouth-to-mouth?’ is often raised. Our explanation focuses on the importance of early, uninterrupted chest compressions and the importance of keeping the management simple and reproducible under when under pressure.

The management of choking and the safe use of public-access defibrillators are also covered. These are all very simple skills and can be taught quickly and efficiently. For the younger, primary school children, greater emphasis is placed on recognizing when someone is not breathing and on calling the emergency services for help.

Feedback and next steps

The courses have received very positive feedback from many who have taken part. A common theme from feedback has been the emphasis on simplicity. The students are often very grateful to be able to open the PADs and incorporate their use into the training. This appears to remove the fear of using these devices in public. Welsh Hearts are striving to get pads into every school, rugby club and remote community in Wales.

We are currently in the process of collecting more formal feedback via a pre- and post-course questionnaire, and aim to share our findings in the near future.

We teach basic skills well, and believe that our clinical experience and enthusiasm towards the training gives the students the confidence to be able to deal with a medical emergency should they be faced with one. With experienced healthcare professionals providing the training, it provides a relaxed and open forum for learning, where all questions can be answered accurately, based on clinical experience and evidence-base principles.

Each session has been incredibly rewarding for all involved. With the help of fellow medics and the charity, we are looking to recruit more volunteers, continue to develop the project, and reach more communities across Wales and beyond.

For more information you can contact me at gareth.roberts@welshhearts.org.

References

‘Mirrors to Windows’: Developing a Masters Programme in Perioperative Medicine

Defining a problem
As a profession we can rightly reflect on our contribution to improved outcomes for surgical patients in modern times. However one group remains elusive to our efforts: a so-called high-risk surgical population, small in number, but accounting for a disproportionate mortality burden. In the last decade we have better characterised deficiencies in care, and are now embarking on wide-scale systems review and a process of quality improvement. It is hoped this will lead to better patient outcomes and satisfaction, and reduced healthcare costs.

Paralleling these activities to improve the science there is a closer look at the education methods required for professional development. In 2012, recognising an increasing call for change, anaesthesia colleagues at University College London (UCL) proposed the development of a new and innovative Masters Programme in Perioperative Medicine.

Institutional buy-in
The process of getting your educational ambitions recognised and fully funded as a course on the UCL postgraduate portfolio is not unlike the submission of a research grant application. What awaits an applicant is a blank eighty-page document, requiring facts and figures to support an argument for institutional investment. Successful courses are able to demonstrate professional justification and to predict market forces, and ultimately the quality of your product design must be assessed for its educational merit.

The professional justification for developing a course in Perioperative Medicine came easily to us. The surgical-patient demographic is changing. Older patients, often presenting with multiple co-morbidities, are now regularly undergoing a wide array of complex major surgeries. A ‘one size fits all’ model of perioperative care is all too often simplistic and reactionary. Failure to adequately identify specific patient needs ‘at the front door’ results at best in ‘catch-up’ interventions, and at worst in a ‘failure to rescue’ and adverse outcomes. This model is recognised as expensive in both human and monetary costs, and a new model of care is considered to be long overdue.

Our application relied strongly on teaching the evidence that supports a proactive, individualised patient-centred model of care. We believed that the profession of anaesthesia was ready to lead the change process, and would actively seek credentials.

Pursuing a novel curriculum
A curriculum may be broadly defined as the totality of student experiences that occur in the educational process, therefore we had big plans! These were:

‘to develop the first online Masters Programme in Perioperative Medicine, delivered by experts, for a multi-disciplinary group of healthcare professionals across the world’

What emerged was a course with no venue or start time beyond that which suited the student, taking place in the best lecture hall available – one’s own home. What we sought was a world-community of learners, not restricted by distance, study leave, professional or other commitments, who might sign in, learn and feel part of a community at a time that suited them.

Of course we recognised the potential drawbacks of online learning, not least from our own institution, who were eager not to see the project fall below its own world-ranked credentials for teaching and research. The question was raised: how would we get around the fact that if a student doesn’t understand something he or she has nobody to ask? In a conventional teaching environment a student would raise his hand and ask a question.
which it might be expected, would be answered by the tutor or one of their classmates. On this course, how might a student in Colombia engage with his/her classmates, seek further tutor help and stay tuned in and interactive with the learning materials?

The answer came in the development of our own unique e-learning environment. UCL, like many other universities, uses a traditional learning management system (LMS) – ‘Moodle’, designed to administer online elements of learning. Moodle is a great way to organise lectures, hold data, administer examinations and provide a platform for learning. Less good however is it’s interactivity capabilities, it’s visual appearance, and it’s ability to have all the learning materials in one place at the click of a button. So we built one, which allowed students to glide between subjects seamlessly, interacting with a rich source of developed multi-media, but importantly still linked by ‘hidden’ interfacing to the UCL LMS. The student would only engage with an eye-catching ‘Perioperative learning page’, while their inputs were being captured and analysed in Moodle, which ran it’s analytical program in the background.

An analogy might be the replacement of Ms DOS by the graphical user interface, Microsoft Windows, easier on the eye, simple and engaging to use and our own design complete with logo! (see figure 1).

**Syllabus design**

Eager not to re-invent the FRCA examination, or any other existing professional examination syllabus, we elected to start our program from the beginning. We wanted to tell a story that a Consultant in Northampton may enjoy as much as the CT2 in Leeds. The former would bring a depth of experience to the course; the latter would not be shackled by old-style paradigms. Together we hoped they would bring a fusion of ideas and enthusiasm.

We enlisted a faculty of expert authors, some from around the world, but many on our own doorstep. We were grateful that each gave their efforts freely and generously. Together, each prepared a ‘chapter,’ and we set about preparing it as a blended piece of learning which included prose, key reading materials, film, podcasts, vodcasts, interviews and much student interactive work.

Eager to develop the course syllabus in line with the emerging professional zeitgeist, we aimed to tackle only broad themes of care, electing not to get bogged down in the minutiae of what we considered inconsequential detail. We were keen to focus on measurement, process and analysis. We began the story by trying to understand the problems associated with major surgery, and moved on to systematically provide solutions, led by the work of international experts and a robust evidence base. The course has revisited old favourites such as risk assessment and surgical outcomes, but through new eyes, and looking beyond the horizon to the evolving themes of shared decision-making, improvement science and clinical leadership.

Central to the learning experience has been ‘interactivity’, where alongside traditional assessment tools such as essays and case-based discussions, we encourage informal group interaction through a blog, a so-called ‘Perioperative Chat’. We extended this interactivity into formal student assessments where it became compulsory to engage discussion on some aspects of the course, students being able to review each other’s contributions. Each student was allocated a group of 15 classmates, with a faculty member mentor with whom to interact. Each chapter would contribute to a discrete themed module, four modules taken over a year to complete a UCL Certificate (see figure 2 on the next page); four more in the second year for the UCL Diploma, culminating in a 10,000 word dissertation project for completion of the MSc.

**Marketing a new course**

We elected to limit our early ambition for the course, agreeing to accept 15-20 students in year one. While course faculty members were all anaesthetists, our course ethos was to broaden the offer of core skills and learning in perioperative medicine to any physician/surgeon – after all, this was a course on perioperative medicine and not anaesthesia. We hoped for a UK audience only in our first year, so that we might learn to provide focus on one healthcare system and a common medical parlance, before broadening the scope of learning to look at other healthcare services. What resulted however was a course that began with 70 students from four continents,
and in hindsight we don’t regret it! Each has brought an enthusiasm and a refreshing personal take on surgical care, with cross-cultural fertilisation of ideas ensuring a vibrant first term. We have regretted having to turn down so many applicants, and will of course be reviewing this in the next academic year.

Going live
When eventually the course went live, it was with a sense of both pride and relief that the faculty were able to watch students interact firstly with the learning materials, then with us and finally with each other. Essays came in, feedback went out and grades were allocated. Suddenly we were up and running with a course we had been dreaming of for almost three years.

Early course reflection
Early days of course! But if we permit ourselves a brief reflection, it would be fair to say that we did not expect the project to be so personally rewarding; 64 chapters, 8 modules, 180 learning hours, and a great sense of achievement. International students, faculty authors from four continents and collaborations with ten internationally renowned institutions will, we hope, make a contribution to an extremely important professional development. Our job now will be to capitalise on a promising start and maintain the high standards already set.

Interested in the UCL Masters Programme in Perioperative Medicine? Find out more at www.ucl.ac.uk/surgery/periopmed and feel free to contact us at periopmed@ucl.ac.uk. Follow us on Twitter @PeriopMedUCL.

Conflicts of interest
Dr Ramai Santhirapala and Dr David Walker are faculty members of the UCL Masters Programme in Perioperative Medicine.

References
The global health landscape is changing. For the first time in history, you’re more likely to be killed by a surgically treatable condition than a communicable disease. But global surgery hasn’t kept pace, and in low-resource countries around the world, surgery can be a challenge to access – and desperately unsafe.

Meet the Lifebox Foundation’s new Fellows

Anaesthetists have a crucial role to play, and trainees can make a difference. In January this year the Lifebox Foundation – a registered charity in the UK and USA, working to make surgery safer in low resource countries – appointed its first fellows. In collaboration with the Association of Anaesthetists of Great Britain and Ireland, the Difficult Airway Society, World Anaesthesia Society and the Royal College of Anaesthetists, two senior anaesthetic trainees have been chosen to make a significant contribution to quality improvement and anaesthesia care in Uganda and Ethiopia.

Dr Nicholas Owen, based at University College Hospital London, will be spending six months in Jimma, Ethiopia from August this year, while Dr Rachel Freedman, at the Imperial School of Anaesthesia, will spend six months in Mbarara, Uganda from January 2016. Half of their time will be spent on clinical duties, and the other half on a quality-improvement project tied to Lifebox’s area of work.

Lifebox is firmly grounded in the principle that safe surgery and anaesthesia is a fundamental right for all, regardless of where they are born. Since its inception in 2011, the charity has distributed more than 8,400 pulse oximeters, as well as training and educational materials, to operating theatres in 90 countries around the world.

Why? Today over 70,000 operating rooms don’t have access to a pulse oximeter, a mandatory device for safe anaesthesia, and the only piece of equipment on the WHO Surgical Safety Checklist. This checklist is the backbone of Lifebox’s work, shown to reduce surgical complications and death rates by more than a third. Advocating for, and facilitating the use of this checklist is a crucial part of Lifebox’s work.

Collaborating with medical professionals is an equally vital part of supporting colleagues in low-resource countries, and the Lifebox Fellowship offers an opportunity to gain valuable practical experience. So, when Lifebox sat down with Nick and Rachel there was a lot to discuss.

What were your motivations for applying for this Fellowship?

Nick: For me there’s two aspects – I lived in Africa and taught in a school there, and from a personal perspective I think it would be a really enjoyable experience to spend more time in that setting – a complete change of scene. From a professional perspective, the quality improvement and patient safety avenue had been one I’d been wanting to get into for a while.

Lifebox is a good example of an active quality improvement that has delivered particularly in a developing-world setting. Going there and learning techniques like halothane and ketamine, which you rarely use in this setting, will be very useful from an educational perspective.

Rachel: I worked with [Lifebox trustee] Iain Wilson in Exeter, so I’ve known about the charity since I started out in anaesthetics. Like Nick, I thought it seemed like one of the only medical organisations that you could see making a difference. I had always wanted to do something with Lifebox, so when the chance to apply came up I was really excited. I attended a course last November – Anaesthesia in Developing Countries, started by Mike Dobson in Oxford – and a lot of that dwelled on whether you could actually do something sustainable. The input that Lifebox has with pulse oximeters and the WHO Checklist, and the emphasis on teaching programmes, seems really sustainable. It actually feels like something I want to do to – and which will stand me in good stead for my CV.

The type of case-load that I think we’ll experience is also something I’m looking forward to. My interests are in paediatrics, obstetrics and trauma, the lion’s share of surgery in low-resource settings.

To find out more about Lifebox Foundation visit www.lifebox.org
You can also follow @saferSurgery on Twitter and Lifebox Foundation on Facebook.
What are the barriers to trainees getting global anaesthesia experience?

Rachel: The difficulty is that you can’t go away too early on in your anaesthetic training, because you would potentially be a liability.

You may well be the ‘best’ provider in a low-resource setting hospital at that point, because nobody else is trained to do complex anaesthetics – but you’re putting yourself under a huge amount of pressure as the senior person, when you’re used to being surrounded by a team of consultants. So I suppose you have to do it later on in your training – and by that point people might be married, have houses and potentially children, and maybe it doesn’t fit so well into training programmes.

This fellowship is supported by the Royal College of Anaesthetists, DAS, WAS and the AAGBI, so you know that it’s a bona fide proper project. You’re going to arrive and it’s a safe and good experience.

Nick: Especially now that they are getting a lot stricter on reducing out-of-programme time. Generally speaking the availability has been lacking, and perhaps publicity as well. On the current curriculum for higher training there are modules in rural anaesthesia and developing-world anaesthesia. They’re optional, but they’re there.

What expectations do you have of this fellowship programme?

Nick: I am deliberately trying to be open-minded, because I don’t really know what to expect! I’ve met up with a group of people who’ve been out to Ethiopia – where I’m going, so I have an idea of the hospital set-up, and the kinds of projects that have begun.

Rachel: I’ve spoken to people who have been to where I’m going to be going – there are consultants there, and I think we will be blown away by how experienced they are, and how well they give anaesthesia with limited provisions.

Do you think this fellowship will have an impact on the way you work in the UK?

Rachel: I’m sure when we first get back we will find it hard to readjust – but I’m hopeful that it will have instilled in us the understanding that there isn’t just one way to do everything; there’s always opportunity to improve things.

I’m hoping that this is the springboard for the rest of my career, linking with developing-world anaesthesia.

What do you think are some of the biggest challenges to providing anaesthesia in low-resource settings?

Rachel: The major problem is that a lot of the new equipment that has been designed simply does not work in the developing world. Historically, anaesthetics hasn’t been a very popular speciality area – doctors have wanted to do surgery, then move out. So they really struggled to train up enough anaesthetists, there’s a huge manpower shortage of doctor anaesthetists.

They’ve done well to fill the gap in a lot of areas with non-doctor anaesthetists – but they have had very minimal training and are left doing their best with limited continuing professional development.

Nick: The biggest obstacle is lack of political will to do anything about it. Relatively recently there has been a general shift in a political view that safety in surgery is an issue. In particular the WHO and UN – they are actually talking about safe surgery – it’s unacceptable that availability of this is based purely on where you happen to be born.

What is your understanding of safe anaesthesia?

Rachel: Surgery is a really common occurrence in an awful lot of people’s lives – and without safe anaesthesia it immediately becomes very risky.

In this country you wouldn’t think twice about somebody coming in for ‘minor’ surgery. But in some developing countries they are terrified when a friend or family member has to have surgery, because they’ve all known people who’ve not survived.

Surgery in this country has benefited so much from the development of safe anaesthetics, and other countries need to be given that same opportunity.

Nick: There are so many guidelines, protocols and checklists, that it’s easier to define what we mean by safe anaesthesia here. These kinds of evidence-based templates give you a driver for political will – they are saying: we know this works, this is what we need and this is how we can implement it.

Rachel: Safe anaesthesia needs a good team, the appropriate equipment and the right ethos.

What advice would you give to other anaesthetists in training looking to apply for this Fellowship programme?

Rachel: I’d say: “go for it, it’s a fantastic opportunity!” I really enjoyed the course (Oxford, Anaesthesia in Developing Countries) I did it in Uganda. It was relatively expensive, but the experience I gained medically – learning how to strip down a ventilator and how to use halothane – was something I never experienced in my training in the UK. But more importantly the people that I met; and the networking that I did, really helped me to know that I definitely want to do something sustainable. I really would recommend that course – the next one is coming up in September this year. There’s also a Bristol version (Developing World Anaesthesia), which is a lot more affordable, I’ve had good feedback from that.

I would say: “be brave and go for it!”.

Nick: There are lots of fellowships and projects you can do, which potentially could be seen as tick-box exercises to maximise our back page. Whereas with this, you genuinely feel there is a real structure, you really feel that there’s a solid template here to actually deliver something sustainable – so it’s a worthwhile-looking fellowship.

Absolutely, go for it, and do it - but also be realistic, because personal circumstances still need to fit into it.
Recording the College Heritage

A new website area is launched
On 1 June the College will launch a new area of its website, College Heritage, primarily as the setting for the launch of the promised ‘Lives of Fellows’ project. However, the area will also present other historical material, some new and some revised, to put the ‘Lives’ project into context and as a focal point for future contributions to this aspect of our activities.

The Lives of Fellows Project
At last, after a very long gestation, the Lives of Fellows project is ready to be launched and will go live with the launch of the College Heritage Site on 1 June.

A brief history of its development
Many of you will be aware that this concept has been around for a long time. Both the Royal College of Surgeons of England (RCSEng) and the Royal College of Physicians, London (RCP) have biographical records of their Fellows. The RCSEng has published 7600 biographies covering those known to have died between 1844 and 2002. The RCP now has a near-complete collection of obituaries for past Fellows from 1518 to the present day. Up until 2005 the RCP published printed volumes. Entries since then are published electronically.

Suggestions that we have our own project were first made during the time of the Faculty, but one of the stumbling blocks was the cost of publication. Even in 2008, when it was proposed that the project be web based, the cost of setting this up, supervising it and populating the data presented a problem. Advances in electronic communication and the updated College website have overcome many of these difficulties, and so at last we are ready to start.

The appointment of Rosemary Sayce as the College Archivist added momentum to the small committee developing the project. With the help of feedback from the Senior Fellows, the History of Anaesthesia Society and the Association of Anaesthetists, a data-collection form has been designed, redesigned, tried and tested. Guidelines have been developed to support the forms, although we feel that the instructions included in the final result are sufficiently straightforward for separate guidelines to be unnecessary, but let us know if you feel otherwise.

Starting the project
The RCSEng sends a form to all new fellows, and another when they retire. Initially, we considered doing the same, but catching up with the very large number of existing fellows from the start was impractical. Thus the immediate focus is on two groups: the original 170 ‘Foundation’ Fellows of the Faculty of Anaesthetists, and the ‘Senior’ (i.e. retired) Fellows. Once these two groups are dealt with we will consider extending the project.

Senior Fellows
We are inviting all retired Fellows to complete their own biography. Please contact Rosemary Sayce (archives@rcoa.ac.uk), who will email you a personalised form complete with your name and College Reference Number already added. Complete this as comprehensively as you wish, and then return it electronically. This will then be archived, but not published or released to anyone without your permission until after your death. The document will not be locked until published so that you can have an opportunity to update or amend it in the future, should you wish to.

Foundation Fellows – Volunteer Authors please
At every stage of the project we have recognised the need to include biographies of Fellows who are no longer with us. This will require third-party authors to do this
for them and we are actively seeking volunteers to help. Offers have been made from both Senior Fellows and members of the History of Anaesthesia Society, but volunteers from all ages are welcomed. We are planning to try and develop a network of interested people, geographically mapped to the schools of anaesthesia, who may be able to act as ‘linkmen’ for those investigating individuals in their area. In this way we hope to engage with individual departments, and interested Fellows and trainees working within them.

If you are interested in helping with this, there are some detailed guidelines on the website where you will find lists of the first 170 Fellows. If you recognise someone that you would like to research then contact Rosemary Sayce, who will not only provide you with a form complete with the important College reference number, but also will know if someone has already begun this and thus avoid duplication of effort. The College may also be able to send you relevant information we already have in the archives. Once a biography has been completed, the name on the list will change to a link so that it is available for all to see.

**Setting a target**
In my last *Bulletin* update in January 2014 I mentioned that the committee had set a target of completing the biographies of the first 170 Foundation Fellows by 2017 to celebrate 25 years as a Royal College. We are still optimistic that we can achieve this, but will need your help. So please do consider volunteering to research the history of at least one of our eminent colleagues and be a part of this exciting project.

**Revising what we had**
Two sections have been updated or rewritten, ‘The History of Anaesthesia’, and the ‘Origins of the Royal College of Anaesthetists and its Fellowship’.

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**An extract from the form for Dr Ernest Gustave Bradbeer**

**EDUCATION AND QUALIFICATIONS**

*General Education*

*School and University information, Academic and Extracurricular*

Hele’s School, Exeter
Bristol Medical School

*Primary Medical qualification, Institution and Date*

MRCS LRCP Bristol 1923

*Initial Fellowship, Type and Year*

FFARCS, FCAnaes or FRCA, By Examination, Election or Honorary
FFARCS by election 1948

*Other qualifications with Date(s) and Awarding Bodies*

Click here to enter text

**PROFESSIONAL LIFE AND CAREER**

*Postgraduate career: appointments with dates (MM/YY)*

*Complete as fully as possible please, including all substantive appointments, salaried and honorary, but not locum appointments unless of three months duration or longer.*

House Officer in Ophthalmics  
Bristol Royal Infirmary  
Casualty Officer  
Bristol Royal Infirmary  
General Practice  
Redland, Bristol  
Honorary Anaesthetist  
Bristol Royal Infirmary, Bristol General Hospital and Bruce Melville Wills Memorial Hospital Bristol 1928  
Consultant Anaesthetist  
Bristol Royal Infirmary, Bristol General Hospital and Bruce Melville Wills Memorial Hospital Bristol 1948

*Professional interests and activities*

*Consider the following: RCoA, AAGBI, Societies, GMC, BMA, Journals and NHS or University administration*

Clinical and Research interests, but detailed list of publications not required
Include Awards, Fellowships by election and eponymous lectureships here
Head of Department of Anaesthesia, University of Bristol
Founder Member and First President of the Society of Anaesthetists of the South West Region 1947

*Other biographical information*

*Consider information on family, sports, hobbies and non-medical interests. A photograph will be welcome, but should be submitted as a separate e-mail attachment*

Served with the Devonshire Regiment in World War I
President of the Society of Devonians in Bristol
A member of the Council of the Bristol Zoological Society
He married Edyth Hetty Chaplin (Joy) at Trinity Chapel, Wesleyan Methodist, Bristol on 05/06/1926
He had two sons, John and Gordon. John becomes a surgeon
His hobbies included caravanning, sailing and gardening
In retirement he acted as Doctor on board a number of Cruise Liners
He died in Poole in 1988
**History of Anaesthesia**

Why, you may ask, does a history of Anaesthesia article need updating, surely history is not changing? The answer is that if you Google ‘History of Anaesthesia’ the Royal College of Anaesthetists’ site is one of the first hits. It was felt that the previous article was a little too brief, but a definitive history would be far too long, and so Professor Tony Wildsmith, the RCoA Honorary Archivist, has written a succinct introduction to the subject with extensive references to the wealth of information that is available elsewhere.

**The origins of the Royal College of Anaesthetists and its Fellowship**

It is fascinating to follow the development of anaesthesia as a specialty, and the metamorphosis from a supportive group of like-minded individuals to the independent and influential College that now exists. This updated article explains the timeline and interrelationship between bodies such as the Society of Anaesthetists, The Royal Society of Medicine, The Association of Anaesthetists and the Royal College of Surgeons of England. Once again this has extensive references and links to previous articles on the subject.

**In a new home**

Three sections have not been changed, but simply been gathered together. Firstly, there is a photographic gallery of past Deans and Presidents that is regularly updated. Secondly there is an article by Dr Tom Boulton about the story behind the College Crest – The Armorial Bearings of the Royal College of Anaesthetists. Finally, there is a film about 65 years of anaesthesia made to celebrate 65 years of the NHS.

**Leaving a legacy**

‘There is a history in all men’s lives.’

Join us by contributing to this exciting project. Be part of our history and leave a footprint for future generations to find and explore.

**References**


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**Consultations**

Consultations the RCoA has responded to in the last two months.

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<td>DH</td>
<td>The Advisory Committee on Clinical Excellence Awards Triennial Review</td>
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<tr>
<td>NICE</td>
<td>Inadvertent perioperative hypothermia: surveillance consultation</td>
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<td>NICE</td>
<td>Draft cardiovascular risk assessment quality standard</td>
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<tr>
<td>NICE</td>
<td>Scope consultation for guideline on management and organisational approaches to safe staffing</td>
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<tr>
<td>NICE</td>
<td>Medical Technologies Evaluation Programme MT238 The 3M Tegaderm CHG IV securement dressing for central venous and arterial catheter insertion sites</td>
</tr>
<tr>
<td>NHS England</td>
<td>Consultation on prioritising specialised services</td>
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BJA Education

Dr J Langton
Editor-in-Chief, BJA Education
Royal College of Anaesthetists
Council Member

Continuing Education in Anaesthesia, Critical Care & Pain (CEACCP) was first published in 2001. Since this time, there have been significant developments and increased usage of the journal both in the UK and worldwide. Within the next few months we will enter the next phase in this development with the launch of BJA Education. BJA Education further strengthens the educational platform provided by the BJA, the aim being to provide greater linkage between BJA reviews and the well-established educational material provided by BJA Education (formerly known as CEACCP).

This will enhance the already broad international appeal, with the latest figures available from Oxford University Press (OUP) showing a bimonthly print circulation of 17,000 and average monthly downloads between January and June 2014 of 219,888, with users in 181 countries. With the launch of BJA Education, we will be aiming to commission articles from an increasing number of international experts; we have also recently added international editors to our Editorial Board.

The online downloads have increased 68% since 2012, and this growth continues year-on-year with recent figures showing an increase in the usage of 11% since 2013. Recently, we have increased the numbers of articles published in the print edition. We also have a number of articles that are published and available online in advance access which are due to appear in the print version over the next few months.

MCQs
Many of you will be familiar with the MCQ tests that accompany every article and what a useful resource for continuing professional development (CPD) they are. Once logged into the OUP learning website, users can complete the MCQ tests on their chosen articles, and obtain a certificate of completion on achieving a pass mark of 80%. The certificate can then be uploaded, into an online CPD logbook/diary, such as the Royal College of Anaesthetists (www.reoa.ac.uk/node/596). In an attempt to provide more space for articles, the Editorial Board recently decided to remove the MCQs from the print edition from April 2015, as they are readily available online. However, to help Fellows and Members access these MCQs online, we have provided clear instructions on how to access these on the OUP website, and I have included these detailed instructions below.

How to access BJA material online
In order to access the MCQs, you will need to register with OUP for online access using your Oxford Journals subscriber number. Members of the Royal College of Anaesthetists can request their subscriber number by e-mailing subs@rcoa.ac.uk or they can find it on the postal label, which accompanies the print version of BJA journals. This has recently been changed by OUP to improve clarity around the subscriber number (Figure 1).

Once you have your subscriber number, you will need to create an account with Oxford Journals at services.oxfordjournals.org/my_account/; you can then read the journals online and access the MCQs by visiting bja.oxfordjournals.org and clicking on the CME links (Figure 2).

Podcasts
In September 2013, we began creating podcasts, consisting of interviews with authors allowing them to expand on the key points in relation to their article, or provide a general overview of the clinical topic. These podcasts are proving popular with readers, with the latest data showing 8,845 downloads between September 2013 and May 2014. There are currently five podcasts available online at http://ceaccp.oxfordjournals.org/.

Additional educational material available online
At http://ceaccp.oxfordjournals.org/, you will also find other useful online resources such as figures and diagrams which, due to limitations of space, we were unable to include in the print version of the article. We are also encouraging authors to supply, where appropriate, supplementary video material to be made available online. For example, articles which lend themselves to this format include those on practical procedures (e.g. nerve blocks) and those with ‘live’ images (e.g. echocardiography).

BJA App
There is now an App available for iPad and iPhone users, where current and previous editions of CEACCP and BJA are available to download, and also advance access articles. There is a helpful link to BJA Education (CEACCP) section of the OUP website where the guide to contributors is available for
those who may be considering writing an article for BJA Education (CEACCP).

The App is free to download and can be accessed via the BJA homepage, or from your App store by searching for ‘BJA’. (You will need to enter your OUP subscriber login details to access the content.)

Compendium issues
We have recently been discussing with OUP the production of specialty collections of related articles, to be made available online, where articles within the same clinical area have been grouped together, for example, articles on obstetric anaesthesia. We know from feedback we receive that this will be welcomed by trainees preparing for examinations, and they will also be useful for trained clinicians wishing to update in a particular area. In combination with the online MCQs and other resources available online, we hope these compendium issues will provide a valuable learning tool. We hope that these will be made available later in 2015.

Updated articles
The Editorial Board has reviewed all articles published in CEACCP (BJA Education) that are more than five years old, and considered whether recent clinical developments warranted a new article; where this was the case, a review of the topic has been commissioned. We have also expanded the scope of articles to be published in BJA Education to encompass non-clinical topics such as Health Services leadership, and Management and Quality Improvement in Healthcare.

Feedback
We recently sought feedback from trainees on CEACCP (BJA Education) using the Royal College of Anaesthetists trainee forum, and we were heartened to receive positive and constructive feedback on how they view the publication, and also some helpful suggestions on how it could develop over the next few years.

The Editorial Board members are always happy to receive feedback on the journal and suggestions on how we can continue to improve this resource for clinicians. If you have any suggestions, please do e-mail them to ceaccp@rcoa.ac.uk.

Finally, I hope that this brief update will help guide your learning and CPD in Anaesthesia, Critical care, and Pain, and that you enjoy the new format BJA Education.

Declaration of interest
None declared.
Macintosh professorships are awarded for one year (normally the College academic year). Recipients are required, within that time or soon after, to give a keynote lecture at a meeting organised by the Royal College of Anaesthetists or its associated Faculties, other related organisations and specialist societies. The lecture is commemorated by the presentation of a certificate.

Applications for Macintosh Professorships are open to Fellows and Members of the Royal College of Anaesthetists and other clinicians and scientists involved in anaesthesia, critical care and pain management within the United Kingdom. Applications will be considered by the Board of the National Institute of Academic Anaesthesia and expert external advisers.

The College welcomes nominations from national and/or specialist societies in anaesthesia within the UK. If successful, the title of the Professorship will reflect a joint award from the College and nominating body.

To apply
Nominations are now invited for the 2015 award, and must be made by a Fellow or Member of the College. The nomination should be in the form of a letter outlining the particular merits of the individual nominated, and should be accompanied by a full curriculum vitae for that individual. Self-nominations are also permitted. Nominations should be sent to the NIAA Administrator at the address below by 5 pm on Friday 28 August 2015.

Maurice P Hudson Prize
Dr Maurice Hudson was a consultant anaesthetist in London, took the DA in 1936, was awarded the FFARCS in...
1948 and had a particular interest in dental anaesthesia. The Hudson Harness was one of his innovations.

The late Dr Maurice Hudson’s daughter generously donated money to the College in memory of her father for an annual prize for the best paper on his favourite subject; resuscitation.

The criteria for this prize has now been extended, and the prize will be awarded to the anaesthetic or intensive care trainee who is the principal author of the best paper relating to the management of acutely ill patients published, or accepted for publication, in a peer-reviewed journal.

To apply
If you are such a trainee and would like to apply for the prize, and have published an article since 1 August 2014, please submit your article by email AND post to the address below, along with a copy of your CV and a covering letter by 5 pm on Friday 28 August 2015. A prize of £500 is available this year.

Please note that only one article may be submitted per applicant.

Applications for the above grants, awards and prizes should be sent to the NIAA Administrator, Miss Clare Bunnell, by post and email at: The Royal College of Anaesthetists, 35 Red Lion Square, London, WC1R 4SG.

Email: cbunnell@rcoa.ac.uk.

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**Education Programme Advisor**

Applications are invited for an Education Programme Advisor to provide clinical advice to support the delivery of the College’s Education Programme. The successful candidate will work closely with the College’s Education Committee and Events Team to maintain the quality of the College’s educational events and to identify additional resources such as e-Learning sessions or journal articles to supplement this learning.

The successful candidate will be expected to attend the College for one day a month (including attendance at the quarterly Education Committee Meetings) and will be available for telephone and email contact.

If you are interested in applying for this post, the job description and person specification and interview date are available through the ‘About the College’ page of our website [www.rcoa.ac.uk](http://www.rcoa.ac.uk).

The closing date for applications is midnight on 30 June. Applicants should submit a short CV with a covering letter and a letter of support from their Clinical Director or Clinical Head of Division to hr@rcoa.ac.uk.

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**Vacancy**

Trainee Representative on NIAA Board

Applications are invited for the role of co-opted Trainee Representative on the Board of the National Institute of Academic Anaesthesia (NIAA). Trainees who hold a National Training Number in Anaesthesia, and are either Academic Clinical Fellows, Academic Clinical Lecturers or are undertaking/have completed an MD(Res) or PhD are eligible to apply.

The appointment will be made for three years or until achievement of CCT in the first instance, with the potential for re-appointment for a second three year term.

The successful applicant will be expected to attend quarterly Board meetings and participate in activities to promote and enhance the work of the NIAA and academic anaesthesia in the UK. The trainee representative will also be invited to attend meetings of the Health Services Research Centre’s Executive Management Board. A job description can be found on the NIAA homepage at: [www.niaa.org.uk](http://www.niaa.org.uk).

If you wish to apply, please provide a covering letter explaining why you are interested in the role, a one page CV, and the names of two referees (one academic and one clinical) to the NIAA Administrator, Clare Bunnell.

The closing date for applications is 5pm on Monday 18 May 2015. Those called for interview will be notified by Tuesday 26 May and interviews are scheduled for the afternoon of Tuesday 9 June.

Further information:


If you require any further information please contact Miss Clare Bunnell, NIAA Administrator, at cbunnell@rcoa.ac.uk.
On Thursday 4 December 2014, the NIAA Grants Committee met to consider the second round of applications for 2014 on behalf of The Association of Anaesthetists of Great Britain & Ireland (AAGBI) and *Anaesthesia*, The British Journal of Anaesthesia (BJA) and The Royal College of Anaesthetists (RCoA), The British Society of Orthopaedic Anaesthetists (BSOA), the Difficult Airway Society (DAS), the Neuroanaesthesia Society of Great Britain & Ireland (NASGBI) and Regional Anaesthesia UK (RA UK).

The committee considered 32 applications over 7 categories for a requested sum of £1,305,588.98, and made a total of 11 awards over four categories to a value of £551,339. Success rate: 34%.

A list of the successful applicants can be found in the following table and abstracts can be viewed at: [www.niaa.org.uk/Round-2-2014](http://www.niaa.org.uk/Round-2-2014).

### Award: AAGBI/Anaesthesia Research Grant

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Dr Sheila Black</td>
<td>Leeds Teaching Hospital NHS Trust</td>
<td>Prospective, open-label, single-site pilot study to assess the effects of spinal cord stimulation on autonomic function in patients with failed back surgery syndrome.</td>
<td>£1,300</td>
</tr>
<tr>
<td>Dr Emma Fitzgerald</td>
<td>Portsmouth Hospital</td>
<td>Cefoxitin resistance as a marker of AmpC beta-lactamase production: clinical significance in the Intensive Care Unit.</td>
<td>£1,100</td>
</tr>
<tr>
<td>Dr Ramani Moonesinghe</td>
<td>University College London</td>
<td>EPICS: EPIdeymology of critical care after surgery: version 2.</td>
<td>£45,354</td>
</tr>
</tbody>
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### BJA/RCoA Project Grant

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Tim Hales</td>
<td>University of Dundee</td>
<td>Improving opioid analgesia by targeting beta-arrestin2 signalling.</td>
<td>£65,000</td>
</tr>
<tr>
<td>Surg Cdr Sam Hutchings</td>
<td>Kings College Hospital</td>
<td>MICROSHOCK: An observational pilot study of the effects of haemorrhagic shock and resuscitation on the microcirculation.</td>
<td>£23,271</td>
</tr>
<tr>
<td>Dr Brijesh Patel</td>
<td>Imperial College London</td>
<td>Death receptor signalling in acute respiratory distress syndrome.</td>
<td>£64,955</td>
</tr>
<tr>
<td>Dr Carole Torsney</td>
<td>The University of Edinburgh</td>
<td>Optimising translational capacity of melatonin administration for chemotherapy induced neuropathic pain.</td>
<td>£65,000</td>
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### BJA/RCoA PhD Studentship

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<tr>
<th>Name</th>
<th>Institution</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Dr Claire Gibson</td>
<td>University of Leicester</td>
<td>Investigating the pharmacology of Nociceptin/OrphaninFQ receptors during cerebral ischaemia.</td>
<td>£72,310</td>
</tr>
<tr>
<td>Dr Graeme McLeod</td>
<td>University of Dundee</td>
<td>Improved patient safety with micro-ultrasound: development of anatomical models for evaluating clinical potential of micro-ultrasound imaging during epidural and regional anaesthesia.</td>
<td>£72,363</td>
</tr>
<tr>
<td>Dr Marie-Anne Shaw</td>
<td>University of Leeds</td>
<td>Identification of genes contributing to malignant hyperthermia and related phenotypes from differential gene expression.</td>
<td>£72,186</td>
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### BSOA Project Grant

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<tr>
<th>Name</th>
<th>Institution</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Anurag Guleria</td>
<td>Royal Manchester Children’s Hospital</td>
<td>To study the effect of tourniquets on tissue oxygen levels using Near Infra Red Spectroscopy (NIRS).</td>
<td>£3,500</td>
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Anaesthesia for austere environments

It is early morning in the field hospital where I have just started working as an Anaesthetist. My team and I are in the resuscitation tent making preparations for the day by performing routine drug and equipment checks. Suddenly, we hear a commotion outside and a man with his pregnant wife explodes into our tent.

The woman collapses onto a stretcher whilst the man is desperately shouting and gesticulating, making hostile gestures towards my male colleague. He speaks no English, but a translator hurriedly informs me that he is armed. It becomes apparent that he is making demands for us to ensure that his unborn child survives. He insists that no men are involved in his wife’s care and wields a gun as I make a rapid initial assessment. The woman is shocked, suffering catastrophic antepartum haemorrhage requiring urgent resuscitation. Her husband remains agitated, is smoking opium, and refuses to consent for his son to be born by caesarean section.

Fortunately, I did not encounter this scenario for the first time in a conflict zone in Afghanistan or during the aftermath of a natural disaster. Rather, this was part of a series of realistic training scenarios conducted in a simulated field hospital set up on the outskirts of Bristol on a sunny weekend in July. It was specifically designed to target issues that may be encountered whilst delivering anaesthesia in ‘austere environments’ with limited resources. Some might argue that cantankerous surgeons occasionally have the ability to turn our NHS operating theatres into places that may be described as austere. However, until now unless we have experienced working in conflict or disaster zones, this has not classically been an area in which it is easy to gain experience or undergo specific training.

The need for a co-ordinated response

Following a haphazard and uncoordinated response amongst many international medical organisations and teams to the large-scale disaster in Haiti in 2010, a need for improved co-ordination, accountability and registration of foreign medical teams (FMTs) was recognised, along with a need to promote implementation of – and adherence to – minimum standards and core principles amongst FMTs. The first guidance on classification and minimum standards for FMTs in sudden-onset disasters was published in November 2013 by the FMT Working Group under the World Health Organisation Global Health Cluster. This document serves as a tool to help improve co-ordination of the FMT response, support the registration of FMTs through a standardised classification system, encourage training and preparation of FMTs before deployment, and promote better standards of medical care.

The UKIETR Anaesthesia Training for Austere Environments (AAE) Course

The UK International Emergency Trauma Register (UKIETR) is hosted by UK-Med and funded by the Department for International Development (DFID). It assembles surgeons, anaesthetists, emergency physicians/nurses and other supporting medical, nursing and paramedical personnel to respond to large-scale emergencies overseas. UKIETR ensures that all its members are highly skilled and appropriately trained to meet international standards. When fully trained and experienced, members are available at 12-24 hours notice to be deployed overseas for 2-3 weeks in response to major international catastrophes. All members undertake compulsory pre-deployment training including specialty-specific training courses. This was the first of these specialty-specific courses in anaesthesia – ‘Anaesthesia for Austere Environments’ (AAE).

The Faculty comprised a hugely experienced team, which had worked in many countries worldwide for a variety of organisations including Médecins Sans Frontières (MSF), and The International Committee of the Red Cross (ICRC). The course was split between...
a simulation centre in Bristol and a scout camp where delegates camped and underwent under-canvas, scenario-based training in a simulated field hospital using the kit and equipment that would be supplied during a UKIETR deployment.

**Tales from Tacloban**

Our first day comprised a series of lectures and workshops. Consultant Anaesthetist Dr Andy Taylor kicked off by providing a fascinating account of his UKIETR deployment last year, highlighting the challenges of providing field anaesthesia in a disaster situation after Typhoon Haiyan. Andy and seven other UKIETR members joined forces with an Australian Medical Assistance Team working in Tacloban where they set up a field hospital and operated on over 100 casualties during a two-week period.

**Practical skills**

Throughout Day One, our learning was targeted on specific anaesthetic techniques and an introduction to new equipment. Whilst this was all familiar to those who have worked in austere environments, many of us had not seen or even heard of it before. Dr Jeanne Frossard gave a wonderful interactive lecture on the wide-ranging uses of ketamine and ‘ketofol’. We soon learned that a great deal can be achieved surgically without administering general anaesthesia as we know it. However, in the event that this is unavoidable, we assembled simple draw-over anaesthesia circuits and learned of the benefits and foibles of oxygen concentrators. The following day the use of these machines was incorporated into a simulation exercise in the Bristol Simulation Suite, which allowed us to set-up, administer and monitor halothane draw-over anaesthesia (Figure 1).

Other skills-based stations included the management of difficult airways with limited resources, discussions surrounding managing paediatric and obstetric emergencies, and the use of a number of commercially available and improvised devices for vascular access. We had an opportunity to use bedside EldonCards to determine our blood groups, and considered how blood transfusion may be managed in a disaster situation. A pig carcass was used for chest drain insertion and two models kindly volunteered for the purposes of FAST scanning and a practical session involving administering regional anaesthesia in a field setting. Whilst the potential benefits in this setting are obvious, this session was particularly useful and has certainly made me consider the value of mastering a handful of nerve blocks that we may not necessarily routinely use in an NHS setting. In a situation where complications would have severe repercussions, certain regional blocks become more or less attractive. In an era where ultrasound is so freely available and actively encouraged, the importance of feeling comfortable performing blocks with and without ultrasound guidance was highlighted.

At the end of a packed first day we were fortunate to be joined by Mr David Nott, who provided a surgical perspective on his extensive work globally with MSF and the ICRC.

**Field hospital**

At mid-day on Day Two we moved to a scout camp on the outskirts of Bristol where team members from the charity Save the Children had been very busy setting up a field hospital. A tour of the field hospital allowed us to see how the tents were carefully laid out. We then split into teams to erect a complete operating theatre, recovery and resuscitation room. My team focused on assembling the operating theatre, and the sense of working in the field setting was wholly brought to life by this exercise (Figure 2). Whilst it rained outside, the tents soon got very warm as everyone worked together to achieve a common goal. After a few minor assembly glitches, we had a functional theatre complete with an operating table, electricity, an oxygen concentrator, draw-over anaesthetic machine, suction, drip stands, operating lights, diathermy and consumables.

**Scenario training**

Soon enough our first patients were arriving into Resus and being transferred to theatre. What followed was a series of extremely realistic scenarios that were run in teams assembled from the skill mix available (Figure 3). This included ED doctors, ODPs, anaesthetists, paramedics, logisticians and an acting surgeon. Together we delivered safe anaesthesia to trauma, obstetric and paediatric emergency casualties (Laerdal SimMan 3G patient simulators) using the equipment and skills that we had been taught. We learnt how to manoeuvre patients onto the canvas operating...
table and work as part of a very newly-constructed team. At times we were forced to make uncomfortable decisions and subjected to pressure from stressed surgical colleagues, testing our non-technical skills.

One of the most striking issues, aside from the obvious medical challenges, was the difficulty encountered with the cultural differences of our simulated patients, and the complexities of constantly working via a translator. Other problems included patients and their families refusing to be treated by members of the opposite sex, difficulties surrounding obtaining consent for surgical procedures, and the security threat posed by armed or aggressive casualties. Many of the ethical dilemmas were addressed in two designated discussion workshops on ethics, which I found very useful and which raised a number of pertinent and complex issues.

The faculty hosted a BBQ in the evening, and everyone had a chance to relax and get to know one another. One of the great things about a course such as this is the fantastic mix of enthusiastic, pro-active and like-minded people that it attracts. The final action-packed day incorporated further simulations, tropical medicine, trauma and neonatal resuscitation. As we dismantled the field hospital, I felt that I had learned a huge amount over the course of three days. Some of it was just as relevant to my NHS practice as to more resource-restricted situations. I had also met some like-minded associates with a common drive to work in some very uncomfortable environments overseas. Importantly, I felt a great deal more prepared for the next time I am required to treat a haemorrhaging mother in a hostile field hospital situation.

Acknowledgements

Many thanks to DFID for funding, and UK-Med, Save the Children, Rachael Craven, Amy Hughes and their faculty for taking the time to organise such an inspiring and forward thinking course.

Photograph credits: Robert Neighbour.

Reference

What is an AAC?

An Advisory Appointments Committee (AAC) is a high-level interview panel for senior appointments established by the employer when appointing senior doctors to NHS posts. The role of the AAC panel is to decide which, if any, short-listed applicants are suitable for local appointment. It is the College’s role to provide, when requested, fully trained AAC assessors to sit on these panels to offer external guidance and recommendations to the employer and to ensure that the job descriptions and plans advertised meet the national standards of appropriateness.

The Department of Health’s (DH) Good Practice Guidance (www.rcoa.ac.uk/node/1445) does not apply to Foundation Trusts; however, the College strongly encourages all NHS employers to make use of the AAC process. This will have a direct impact on boosting individual job satisfaction, patient safety and the integrity of the profession. In recognition of the benefits to employers, the Academy of Medical Royal Colleges and The Foundation Trust Network issued a joint statement encouraging Foundation Trusts to continue using the Good Practice Guide; this was formed into a ‘concordat’ document – http://bit.ly/1Cn3xp0

The National Health Departments of Wales and Northern Ireland also adopted the AAC process, and it is therefore a standard requirement that all NHS employing bodies in England, Wales and Northern Ireland comply with these regulations. From 2009, Scotland developed a different appointments process where a specialist external assessor (SEA) is provided by the Academy of Royal Colleges and Faculties in Scotland. However, the SEAs’ general role and contribution is very similar to those supporting employers in accordance with the DH regulations. For further information please visit our website at www.rcoa.ac.uk/node/367.

Who represents the specialty?

The role of the College Assessor is to ensure the appointment process leads to the selection of an anaesthetist with the appropriate competence and experience to meet the needs of the whole Job Plan. The Assessor provides an impartial, external specialty opinion, with the key aim of placing the right specialist in the role to protect patients, ensure appropriate service delivery and maintain standards of practice in the profession. Each new Assessor will have been personally recommended by his/her Regional Adviser and following confirmation of ‘good standing’ status as a College fellow or member and completion of equality and diversity training, the Assessor’s application will be considered and approved at a President’s meeting in the College. The AAC system provides quality assurance of the recruitment processes in formalising, shortlisting and selection of senior doctors for the benefit of patients and re assurance of NHS employers. By providing an external opinion to the AAC process, the Assessor also offers employers further support in validating their recruitment process – a valuable additional benefit, especially in circumstances leading to appeal by an unsuccessful candidate.

Why continue with AACs

Since the creation of Foundation Trusts and their exemption from mandatory compliance with the DH regulations, the value of AACs has been questioned. However, a current and renewed focus within UK healthcare is on quality improvement (QI) in all areas, and AACs form a fundamental part of getting QI right from the outset. By ensuring that the right doctor is in the right post from the beginning, employers see direct and positive contribution to their service needs. There is a growing level of evidence from the GMC and the National Clinical Assessment Service that poor doctor recruitment methods result in employee dissatisfaction and considerable burden on an employer. Where doctors are placed without due consideration of their general competence and specialty knowledge they are shown to struggle in their post and
become more reliant on colleagues and managers for support – often this only comes to light when assumed competence is shown to be lacking and an untoward incident results. The AAC often marks the beginning of a doctor’s journey through his/her first senior appointment as a consultant, and where the recruitment has been conducted justly and appropriately, but thoroughly, it also contributes to the satisfaction of the individual within their new role. A critical component of the AAC is where there are additional tasks and responsibilities to be performed by the new post-holder beyond direct clinical care, the necessary time and resources made available to support the activity must be evaluated if all responsibilities are to be successfully supported. A College Assessor will have greater clarity on national requirements for each additional responsibility, and will be able to advise the Chair of the AAC directly on what a reasonable time for each task would be.

How can this be improved
To make the AAC process more efficient for the employer and more beneficial for the specialty, the College has revamped the entire engagement process. Through a small, but very experienced, working party, three new guidance documents have been produced by the College specifically addressing particular stakeholders – the Regional Advisers (RAs), HR departments and the AAC Assessors. Each group requires a general knowledge of the whole AAC process, but with focus on slightly different areas of direct importance. Each publication targets the stakeholders specific needs.

The RAs’ guidance (www.rcoa.ac.uk/node/19453) focuses on their role at the very beginning of the process – the approval of the intended job plans and person specifications. It describes in detail what is expected of the RA in the context of AACS and the criteria for analysing and approving job plans. Once a post has been through the College’s RAs’ approval process, the ‘approved post’ logo can be used on advertisements for the role.

The intention is to demonstrate clearly those posts which have gone through a meticulous approval procedure and have been deemed to be an appropriate job opportunity for applicants. We hope that identifying posts with this College approval mark will reassure candidates on the quality of the jobs that they are applying for, specifically those applicants recently progressing from training and entering the career-grade sector for the first time. All RAs should have now received a personal copy of this guidance document. If you have not, please contact aac@rcoa.ac.uk

The guidance specifically for AAC Assessors is tailored towards the candidate shortlisting process, interview structure, NHs fees, personal expenses, and the Assessors’ role as a whole. For further information on this please visit www.rcoa.ac.uk/node/18759.

The document specifically for HR departments has an overall view of the entire process from the employer’s position. The College recognises the particular importance of engaging the employer within the AAC process at all stages in order for it to work successfully. This information can also be found on our website at www.rcoa.ac.uk/node/18698.

What next
With this new series of documentation, the College has taken the lead in identifying the significance of improving the communication with all involved in running successful AACS. In addition to improving those the process, the College has responded to a request from RAs and AAC Assessors by establishing a new formal position – Lead AAC Assessor. This individual will work in a representative role for College committees and events, but also drive the evolution of AACS forward. Recruitment of this individual is currently underway and we hope to announce the successful candidate shortly. The role of Lead AAC Assessor will set a precedent for future AAC developments, specifically taking a leadership part in the College AAC Assessors’ Days, representing the College on AAC matters to external organisations and engaging with wider AAC stakeholder groups.

In conclusion, the world of AACS is continuously improving as we strive to work more closely with external stakeholders such as the HR departments and employers, as well as refining internal activities to ensure a smooth, beneficial experience for all those involved.

The College is always looking to refresh and expand its list of AAC Assessors. Applications are very welcome, and anaesthetists with an interest in this rewarding role are asked to contact the AAC team at – aac@rcoa.ac.uk or on 020 7092 1571.
Attending and preparing for a Coroner’s Inquest

Preparing for and presenting evidence to the Coroner’s Court is one of the most stressful experiences in the life of a doctor. Hopefully, the majority of you will never have to undertake this, but for those of you who do, the following will hopefully ‘debunk’ some of the myths surrounding it, and provide a template for how you are expected to prepare for the inquest and behave during it.

The nature of a Coroner’s Inquest means that potentially you will have already gone through a fairly stressful experience – involvement in the death of an individual that is deemed to require further investigation and explanation. Firstly, it is useful to understand the purpose, remit and limitations of a coroner’s inquest:

- It is essentially a fact-finding exercise where the coroner is required to make findings about who died, when, where and how the death occurred, and thereafter to reach a conclusion (previously called the verdict) about the death as a whole.
- Matters of fault or blame, guilt or innocence together with issues of criminal or civil liability form no part of the coroner’s inquest.
- However it can sometimes be difficult not to think that your actions and care of the deceased are being called into question, particularly where lawyers are involved and are seeking litigation in the future.
- Deciding whether the acts or omissions of clinicians caused or contributed to the death does form part of the fact-finding process, and your acts (or omissions) will come under close scrutiny in the course of the inquest.

The Preparation

There is almost universally a substantial time period between the death of an individual, and the commencement of an Inquest (due to the extensive and wide-reaching workload of the Coroner, their Officers and the potential need to gather specialist evidence in certain cases). However, be aware that the Coroners and Justice Act makes it a mandatory requirement that inquests are held within six months of the date of death, unless it is not possible for this to happen. Coroners are under increasing pressure to deal with inquests expeditiously and this can mean that the coroner will refuse to adjourn or to change the date simply to accommodate you.

You should make a point of obtaining copies of the notes that you have made to remind yourself of what you said. Furthermore, take the opportunity to read as much of the file as is necessary to give yourself a background to the case as a whole. Whilst you should never be asked about matters in which you were not involved or about which you know nothing, it is often advantageous to have an overall ‘feel’ for the case.

For the majority, the fine details of any case will not be fresh in the mind, and this point emphasises the absolute requirement for high quality, contemporaneous note keeping, at all times. A quick search of any of the examples of assistance provided by the MDU or MPS will demonstrate that doctors come unstuck due to inadequate record keeping more often than any other cause. This is especially important given the time delay between the events and the Inquest, as it is highly likely that any notes made at the time will form the main evidence-base of any statement you are asked to prepare.

The purpose of the above point is not to instil a sense of paranoia or pessimism in the reader, or to provide a lecture on note-keeping, but when tired in the middle of the night, it is worth asking yourself whether the notes you are making would stand up to a robust examination by the Coroner in any future Inquest, and to make any necessary
adjustments in your style then, before they have to come under potentially embarrassing scrutiny in an open court.

Depending on the particulars of the individual case and your involvement, you may or may not be offered representation by the responsible NHS Trust. If you are not offered representation, then it is imperative that you contact your defence organisation to arrange for your statement to be checked and to obtain representation at the Inquest. Even if you are represented by the trust, we would still advise contacting your defence organisation to have them check over any statements you are required to submit, as their skills in refining statements often prove invaluable. They will require an anonymised copy of your case notes in order to do this, so make sure that you obtain the permission of the trust before sending them to your defence organisation.

The Statement
Many trusts will have sample statement templates for you to use if required.

The single most important point to remember when compiling a statement for an Inquest is to be purely factual. The statement is intended to ascertain your recollection of events and your direct involvement in the individual’s care, but without any ambiguity – if you are uncertain of something or cannot remember the exact events, or what exactly was said to whom, then don’t include it in the statement. Where numbers are included (such as patient observations or blood results), double check that they are correct – it draws into question the credibility of all of your evidence if objective measurements that you have included in your statement do not exactly match those in the notes.

While your statement should contain only facts, you should, if necessary, explain why you took a certain course of action, or made certain decisions. This, clearly, will include some element of setting out your professional judgement, and will help the Coroner to understand why you did what you did and to frame the appropriate questions to allow you to be able to explain this in your evidence.

The Inquest
As soon as you are told the dates of the Inquest (usually by the responsible trust rather than the Coroner’s Office) inform your employing trust. Given the time delay in most Inquests, and given the nature of modern medical training, it may well be that the Inquest is scheduled to take place during a future placement or course. One of the reasons for the time delay when scheduling Inquests is to ensure that every individual whose presence has been requested by the Coroner can be free to attend.

The dates that are given originally are the expected dates for the whole Inquest, and it is unusual for a single witness to be required to attend every day. Closer to the dates, you are likely to be told on which specific days you are required, although from experience this can be very fluid, with the order of witnesses changing even whilst the Inquest is underway, depending on the evidence being heard.

Furthermore, you may well be called earlier than scheduled if the Inquest is progressing more speedily than expected, or not at all if it is deemed that your evidence is no longer required. Finally, it is possible (although unusual) for you to be called back to the Inquest even after you have attended on your scheduled day. For this reason, our advice would be to ensure that you are available for all of the days that the Inquest is taking place (i.e. not have any on-call commitments). Bear in mind that attending an Inquest after being summoned is a legal requirement, and you will be prosecuted if you do not attend.

On the day of your summons, it almost goes without saying that you should make sure that you arrive in plenty of time. At the risk of stating the obvious, dress as you would for an interview (in a way, giving evidence is a bit like an interview). Many people will have heard tales of individuals being sent home to change attire by the Coroner for turning up in jeans and a T-shirt, but unfortunately such tales are true.

Take the opportunity to read through your statement before going into court so that it is fresh in your mind. If the medical file is available take the opportunity to look at that in like fashion.

Ask the court staff to show you the courtroom before you go in (familiarity with the surroundings is a good way of putting yourself at ease).

The number of people present at an Inquest varies substantially, but as a minimum there will usually be members of the deceased’s family and their legal representatives, as well as representatives from the trust and their legal team. A Coroner’s Court is classed as an open court, and any member of the public and/or press is free to attend. That said, it is unusual for members of the press to attend, unless the case is particularly high profile or emotive. It is of course possible that if members of the press are present, they may attempt to ask you questions at the end of the day following adjournment. The best generic advice to give is for you to politely decline to comment.

Giving evidence in front of the court is a daunting and nerve-wracking experience, and it is very difficult to adequately prepare for it. The initial questions will probably be asked by the Coroner. Prior to questioning, you will be required to take an Oath, which can have a religious emphasis or not, depending upon your personal preferences and beliefs. You will be asked to confirm your full name and
your professional qualifications. You are likely to then be asked to talk through your version of events to the court. This does not usually mean reading your statement out by rote, but rather that you give a brief synopsis of your version of events. The Coroner may interrupt you fairly frequently to clarify something you have said – this does not mean that you have said something controversial or incorrect. For instance, any medical terminology that you may have mentioned will require clarification for the lay members of the court. Try to speak as clearly as you can, and keep to a steady, even pace. All of the concerned parties at the Inquest, including the Coroner, will be making their own notes whilst you talk, and speaking too quickly or too softly will result in you being interrupted for clarification more frequently.

Following your description of events, the Coroner may ask you further questions him/herself. Each of the parties then present will be given the opportunity to ask you further questions. It is plausible that if some area of care is being called into question, you may be asked to comment on it. The golden rule should such a situation arise is to steer well clear of commenting on the practice of others. If the actions of another are being scrutinised then it is likely that an expert witness (usually a senior and well-respected consultant in the specialty being scrutinised) will have been summoned to the Inquest – you should leave such comments to them. Needless to say, your approach to any questions from individuals other than the Coroner should follow the same approach as your initial written statement and your verbal evidence in Court. Remember that your natural inclination will be to want to answer every question – your professional life revolves around helping and assisting others, and it can feel akin to a failure if you are asked about something you cannot recall.

The only questions which you may legally refuse to answer are those to which the answer may result in you incriminating yourself in a crime. Hopefully none of us should be faced with such questions given our involvement in a healthcare setting. After all the parties have had an opportunity to question you, the Coroner will formally ask all parties if you may be released from questioning. After you have been released, you are free to leave the court should you so wish, but there is the potential for you to be recalled for further questioning or to clarify your evidence further (this may rarely occur if another witness gives a juxtaposed viewpoint) at any point whilst the inquest is active.

After the Inquest
As we have pointed out several times, giving evidence can be a disproportionately stressful experience in your career. Many trust legal teams will be happy to provide support following the inquest – at the very least you should be offered a ‘debrief’ at the end of the day that you attend, and follow-up at the end of the Inquest as to the eventual conclusion and findings.

There are no set classifications as to the conclusion that can be reached by a Coroner, although by far the majority of cases fall under the categories of natural causes, industrial disease, accident or misadventure, suicide, or unlawful killing. A growing number of cases now reach a ‘Narrative Conclusion’, which is simply a factual statement of the events that eventually led to the individual’s death.

Finally, it is important to mention that emotions are often running high during an Inquest, not only amongst relatives and friends of the deceased, but also in all of those attending to give evidence. We all cope with stress in different ways, and it is beyond the scope of this article to detail possible mechanisms for dealing with it, but a suitable end-point is to remind you not to neglect your own health and wellbeing when involved with preparing for and giving evidence at a Coroner’s Inquest.

Conflicts of interest
None declared.
Advocates of Total Intravenous Anaesthesia (TIVA) claim many and varied advantages over inhalational anaesthesia, and there are circumstances when no realistic alternatives exist, malignant hyperpyrexia susceptibility being the obvious example.

The College recognises TIVA as an essential competency, as do anaesthesia colleges across the world. However, regional surveys have reported patchy training and limited exposure to TIVA, and called for TIVA specific competencies and advice about course content from the Society for Intravenous Anaesthesia (SIVA). As of 2015, there appears to have been insufficient progress towards adequate TIVA training.

The first algorithm for a propofol infusion, used to induce and maintain anaesthesia, was introduced in 1988, and required the user to calculate a bolus dose and a reducing infusion rate based on weight and elapsed time following the bolus. This was superseded in 1996 with a Target Controlled Infusion (TCI) system requiring ‘chipped’ propofol syringes. A more complex computer-driven algorithm was implemented and allowed the user to set a target plasma concentration, while the pump determined the precise dose needed to achieve the target. User uptake was limited for a variety of reasons. Over the past ten years a number of manufacturers have produced a range of TCI pumps that contain algorithms for more than one drug and can be described as ‘open source’. Coupled with a reduction in drug cost, TIVA given as a TCI (most commonly using propofol and remifentanil) has become more widely used although these currently makes up less than 10% of UK anaesthetics. However TCI is not always the preferred means of drug delivery, some preferring infusions based on mg/kg/hr or simply ml/hr. This variation is confusing for all, and for trainees it inhibits learning and understanding.

The authors feel the time has come to define a set of TIVA competencies. The survey reported here confirms suspicions that trainees are not using TIVA competencies as part of their training.

Current state of TIVA training in the UK
We conducted a survey through the RCoA asking college tutors if their department used any formal TIVA competencies to facilitate training, defining a competency as a training tool that required sign-offs to cover aspects of knowledge and practice.

Results
There were 83 replies from 327 emails covering 285 hospitals (some having more than one college tutor). The email and hospital response rate was 25.4% and 29.1% respectively. There were three positive replies but when these were followed up it was agreed that TIVA competencies as defined in the question were not in use. It is possible that TIVA competencies are used in hospitals that did not reply but we expected these hospitals to be keen to be recorded as ‘users’. The overall signal is that TIVA competencies do not formally exist.

Discussion
New techniques are not always fast to catch on and TIVA has been no exception. Initially, equipment was scarce, techniques rudimentary and importantly, experience was very limited. Today some departments (or sub specialities within larger departments) have gained a critical mass of equipment, experience and appropriate case-mix for trainees to be TIVA trained as opposed to being attached to a consultant list in which TIVA is being used. Harnessing this critical mass will be pivotal in moving forward.

NAP5 indicated an approximate two-fold over-representation of accidental awareness during general anaesthesia (AAGA) when using TIVA compared with inhalation anaesthesia. Preventability was assessed in 25 of the 28 certain/probable, and possible reports, and
19 (75%) were considered to have been preventable. The commonest contributory factor identified was (lack of) education and training. They recommended that all anaesthetists should be trained in the maintenance of anaesthesia with intravenous infusions and that the relevant anaesthesia organisations should establish a set of standards and recommendations for best practice in the use of TIVA. This recommendation follows a pass rate of only 17.5% for a question on propofol TCI in the March 2014 SAQ of the FRCA examination. The Chairman’s report for this examination describes a ‘... “black-box mentality” from the majority of candidates, with little real understanding of how infusion devices work or of the underlying pharmacokinetics... Given that the administration of TCI propofol is used nationwide, the poor performance observed must reflect a paucity of formal teaching of the subject within Schools of Anaesthesia.’ Perhaps in the light of this, one deanery has decreed that Core Trainees must not be left unsupervised for any part of a TIVA anaesthetic. Given that a steady stream of senior trainees rotating through our hospital claim to ‘have done plenty of TIVA’, but are then unable to recall which variables are used for the Marsh Model and how they affect the dose given, one can only despair at their over-confidence.

The RCoA Syllabus for basic (Annex B) and intermediate-level training (Annex C) (combined total of 170 pages) makes only four references to TiVa and or TCi. Annex B (Basic Level Training)

- Context-sensitive half-life comparison of drugs e.g. propofol, fentanyl and remifentanil. Target-controlled infusions [TCI].

Annex C (Intermediate Level Training)

- TiVa and TCI: Demonstrate how a TCI system is set-up and used to deliver both induction and

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### Rule 1
**Equipment**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Ensure enough drug reaches the patient</th>
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<tbody>
<tr>
<td>Drugs</td>
<td>Matching syringe to correct algorithm</td>
</tr>
<tr>
<td></td>
<td>Matching drug concentration to concentration in algorithm</td>
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<tr>
<td></td>
<td>Accurate preparation of remifentanil concentration (20 or 50 mcg/ml)</td>
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<tr>
<td></td>
<td>Avoid mixing drugs</td>
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<tr>
<td>Syringe</td>
<td>Match syringe type (size and manufacturer)</td>
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<td></td>
<td>Scale markings visible</td>
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<td></td>
<td>Correct pump (see above)</td>
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<td></td>
<td>Luer lock</td>
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<td></td>
<td>High pressure alarm</td>
</tr>
<tr>
<td>Giving set</td>
<td>RCoA guidance (Oct 2009)</td>
</tr>
<tr>
<td></td>
<td>Avoid 3-way taps</td>
</tr>
<tr>
<td></td>
<td>Integrity</td>
</tr>
<tr>
<td></td>
<td>Mandatory use of fluid infusion</td>
</tr>
<tr>
<td>Cannula</td>
<td>Perfection</td>
</tr>
<tr>
<td></td>
<td>Dressing</td>
</tr>
<tr>
<td></td>
<td>BP cuff not on TIVA limb</td>
</tr>
<tr>
<td></td>
<td>Visibility/accessibility</td>
</tr>
<tr>
<td>TCI pump</td>
<td>Syringe Order (Propofol above, Remifentanil below)</td>
</tr>
<tr>
<td></td>
<td>Different manufacturers</td>
</tr>
<tr>
<td></td>
<td>Combination pumps</td>
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<td></td>
<td>Power (failure)</td>
</tr>
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### Rule 2
**Kinetics**

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<thead>
<tr>
<th>Kinetics</th>
<th>Stick to one model but understand the differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Single compartment model</td>
</tr>
<tr>
<td></td>
<td>Multi-compartment model</td>
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<tr>
<td></td>
<td>Context-sensitive half-time</td>
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<td></td>
<td>Half-life</td>
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<td></td>
<td>Rate constants including Keo</td>
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<tr>
<td></td>
<td>Plasma site vs effect site targeting</td>
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<tr>
<td></td>
<td>Decrement time</td>
</tr>
<tr>
<td></td>
<td>James Formula</td>
</tr>
<tr>
<td>TCI Models</td>
<td>Marsh, Modified Marsh, Schnider, Minto</td>
</tr>
<tr>
<td></td>
<td>Compare V1, Keo &amp; targeting options</td>
</tr>
<tr>
<td></td>
<td>Input variables (age, weight, height, sex) and pump limits</td>
</tr>
<tr>
<td></td>
<td>Extremes of weight</td>
</tr>
</tbody>
</table>

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### Rule 3
**Pharmacodynamics**

<table>
<thead>
<tr>
<th>Pharmacodynamics</th>
<th>It’s not all about kinetics!</th>
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</thead>
<tbody>
<tr>
<td>Drug synergy</td>
<td>Isobologram – propofol and remifentanil</td>
</tr>
<tr>
<td>Patient Factors</td>
<td>Cp50 optimal</td>
</tr>
<tr>
<td>Age</td>
<td>Co-morbidities</td>
</tr>
</tbody>
</table>

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### Rule 4
**Comfort**

<table>
<thead>
<tr>
<th>Comfort</th>
<th>Have a post-op pain plan</th>
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<tr>
<td>Options</td>
<td>Local anaesthetic</td>
</tr>
<tr>
<td></td>
<td>NSAIDs</td>
</tr>
<tr>
<td></td>
<td>Opioids (short and long acting)</td>
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</table>
maintenance levels of intravenous agents. Discuss the advantages and disadvantages of such a technique.

Discusses the place of infusions compared to bolus doses as well as target-controlled infusions [TCI], and the pharmacological models and pump technology relevant to their use.

Annex C certainly points in the right direction, but lacks the detail required to form a set of comprehensive competencies, and thus provides the expectation gap between the FRCA candidate and examiner.

However, while we need to ensure that trainees receive adequate TIVA training, we should also note that less than 15% of anaesthetics in the UK are delivered by unsupervised trainees. Although junior anaesthetic staff were associated with AAGA in NAP5, it would be wrong to assume that the recommended training and education should be directed solely at trainees, when the vast bulk of anaesthetics are delivered by consultants and non-training grades.

Over the past 5-10 years our department has steadily increased its use of TIVA, and we have centred our teaching around four golden rules, which have also formed the basis of a regional TIVA Training Course. This has now been further refined into a set of TIVA competencies that we believe may prove useful for others as a basis from which to teach the necessary knowledge and skills.

**Winchester TIVA Competencies**

These are based on knowledge and skills (assessed practice) for specialist trainees.

The knowledge is based around four topics, each with a golden rule:

- **Equipment** – ensure sufficient drug reaches the patient.
- **Kinetics** – stick to one model but understand the differences.
- **Pharmacodynamics** – it’s not all about kinetics!
- **Comfort** – have a post-op pain plan.

All aspects of the knowledge component are discussed by one of a group of (self-certified) TIVA trainers. When complete the trainee progresses to assessed TIVA practice (propofol and remifentanil) for ten cases over at least three separate operating lists with different TIVA trainers. Each stage is signed off. Once all the knowledge and practice sections are signed off, the specialist trainee is deemed competent to provide TIVA without immediate supervision, in a way similar to their provision of a standard volatile anaesthetic.

These competencies are designed to enable basic, safe TIVA practice. There are other areas (rapid sequence induction, paediatrics, propofol as a single-agent sedative and the use of other opiates) that have deliberately been left out in order to make this achievable in a six-month trainee post.

**Summary**

TIVA training has lacked adequate central direction, with no published competencies that cover the relevant knowledge and skills required to deliver TIVA safely. We believe that our competencies are a first step towards covering these basics.

A curriculum review is currently underway. Surely this area should be expanded and clarified to satisfy the deficiencies identified by the poor exam performance.

**References**

8. Personal communication.
A post-FRCA teaching programme should encompass the clinical and non-clinical areas necessary for all aspects of Consultant work. An article in the *Bulletin* in January 2014 outlined the OxDAT (Oxford Deanery Anaesthetic Trainees) approach: a trainee-led post-fellowship teaching programme. This inspired us to develop an initiative along similar lines in the North West School of Anaesthesia. The ‘Countdown to CCT’ (Certificate of Completion of Training) programme commenced in September 2014, and offers trainees the opportunity to organise, as well as attend, monthly teaching days. It has so far been successful in delivering well-rounded teaching, in line with the principles of the RCoA Advanced curriculum.

**Background**

The importance to the National Health Service of an effective consultant workforce cannot be overstated. In its 2012 report *The Benefits of Consultant Delivered Care*, the Academy of Medical Royal Colleges outlined the key role of consultants in effective resource allocation, as well as in raising clinical standards. The *Shape of Training review* is one of the latest in a series of reviews recognising the need to complement clinical skills and knowledge with developing broad, generic capabilities in areas such as management, leadership and patient safety, both during and following specialty training. This principle is already addressed within the Royal College of Anaesthetists’ curriculum, which specifies six ‘domains’ of outcomes to be achieved during advanced training: clinical practice, team working, leadership, innovation, management, and education. Addressing these aspects within a training programme is a challenge faced by each school of anaesthesia.

The North West School of Anaesthesia has well-established Primary and Final FRCA teaching programmes. In the post-fellowship period, although there were occasional regional study days, simulation training dates and governance opportunities, there was until recently no formal teaching programme to complement higher and advanced training. Stand-alone teaching days had been organised by trainees and had been successful, but had never been incorporated into an ongoing programme, and there were often long periods of time with no such events.

After reading an article in the January 2014 *Bulletin* about the trainee-organised OxDAT programme in the Thames Valley Local Education and Training Board, we proposed to implement a similar programme for the North West. The ‘Countdown to CCT’ post-fellowship programme, named to convey the dawning realisation of impending independent practice, was launched in September 2014.

**Concept**

The Countdown to CCT programme consists of monthly full-day teaching sessions for post-fellowship trainees in the North West School of Anaesthesia, held at various hospitals around the region. Each day is themed, with the major subspecialties covered over a two-year rolling schedule. Rather than lectures being dedicated purely to clinical aspects of the day’s theme, approximately a third of each Countdown day is allocated to management topics, and a third to education and training. Each day is therefore relevant to consultant practice beyond that subspecialty, which helps to maintain the attention (and attendance) of those post-fellowship trainees who plan to subspecialise. For example, a lecture on a quality improvement project in orthopaedics will have many cross-over learning points applicable to other subspecialties, such as outlining stages of project design and formulating a business case. Also incorporated were the existing bi-annual trainee Morbidity and Mortality meetings, which continue to be coordinated by a separate group of trainees.
Consultants keen to speak. Talks given by out-of-region experts have been very well received, as have non-anaesthetist speakers from surgical, emergency medicine and medico-legal backgrounds. Many of the best-rated talks have been on management subjects, such as turning around a loss-making directorate, and organisational changes to improve decision to delivery times in Category 1 Caesarean sections. This suggests a real appetite for those subjects beyond the purely clinical sphere, and perhaps reflects the lack of such teaching previously.

Analysis of feedback suggests that the programme has so far delivered a well-rounded spread of talks: Figure 1 shows the mean overall rating for each of the five days which have taken place against each of the six advanced domains. The results reflect the different emphasis of each Countdown day, each focusing on some advanced domains more than others. Overall, the results show that the Countdown programme is delivering well-balanced teaching in both clinical and non-clinical areas, in line with RCoA curriculum principles.

A few aspects of the programme, however, have not proved as successful. Initially, hoping to replicate the OxDAT trainee forum, time was allocated for meetings chaired by the STC trainee representatives. However these have concentrated on putting together an innovative programme and liaising with speakers. At the same time, the delegation of responsibility for individual teaching days means that the Countdown Committee’s workload is not overly arduous.

Assessment
The programme has had a successful start. Attendance has ranged between 30 and 50 trainees at each meeting, representing approximately one third of the post-FRCA trainees in the region. A number of these trainees even attended on zero-days, off-days, or breaks from training, which we regard as an endorsement of the programme. There has been no shortage of consultants keen to speak. Talks given by out-of-region experts have been very well received, as have non-anaesthetist speakers from surgical, emergency medicine and medico-legal backgrounds. Many of the best-rated talks have been on management subjects, such as turning around a loss-making directorate, and organisational changes to improve decision to delivery times in Category 1 Caesarean sections. This suggests a real appetite for those subjects beyond the purely clinical sphere, and perhaps reflects the lack of such teaching previously.

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**Figure 1** mean feedback score for each advanced domain, by Countdown study day (1=low relevance, 5=high relevance)
been discontinued due to a lack of demand, although there is always an STC trainee representative in attendance at each Countdown day to allow trainees the opportunity to raise issues informally. Similarly, the social after-events described in the OxDAT article have yet to materialise (or if they have, the Committee has not been invited!)

Overall, it has been a very positive start, well received by consultants and trainees alike, and further supports the concept of senior-trainee-organised teaching for those approaching completion of specialty training.

**Future**

Two additional trainees have been appointed by the North West STC to join the Countdown Committee, bringing the total to four members. In order to ensure the programme is sustainable, the plan is that each Committee member serves two years, with two members replaced every year. The aim of this staggered succession is to ensure that the organisational ‘know-how’ on the Committee is not lost, whilst passing the torch to new trainees. We hope to see the teaching programme grow as an established part of regional anaesthetic education.

**Acknowledgements**

We would like to thank the Head of School, Training Programme Director and the STC for their support, and to particularly thank the trainees and College Tutors who have been involved in organising a Countdown to CCT day.

We are also very grateful to Laura Vincent, formerly of the OxDAT committee, who provided invaluable tips and advice on the potential pitfalls of organising post-fellowship teaching.

**References**

The most remarkable characteristic of the work of the modern criminal is its preparation. Skilled criminals elaborate a plan with extraordinary patience. A diamond robbery that attracted much attention in its day was a striking illustration.

A feeble old diamond merchant kept in his home a stock of diamonds of many thousand pounds value. This became known to two diamond dealers, respectable men, but in financial difficulties. They conceived the idea of robbing him of his hoard. Through a young man employed at one of the hospitals, a close friend of the daughter of one of them, they were introduced to an Italian. He was a unique personage, a man of good education and great cunning; said to be the brother of a distinguished Italian minister, he led a life of persistent crime. His favourite pursuit was sleight-of-hand whereby valuable jewels were abstracted from jewellers’ trays by a pretended purchaser. Often successful, but not always, while serving eight years penal servitude he had made the acquaintance of one Black, who was completing a seven year term.

To the Italian the two dealers broached the idea of robbing the merchant. It was not quite his line, but the size of the booty, some £30,000, tempted him. He sent his daughter, a handsome young woman, to visit the merchant and reconnoitre the premises. Her report was satisfactory. The plan was to chloroform the diamond merchant, make off with his diamonds, and deliver them to the diamond dealers. The hospital employee procured some chloroform and, to satisfy the Italian, experiments were made with it. At the Italian’s lodgings it was tried on a kitten, but as the Italian described it, it only made the kitten ‘sneeze a lot.’ He insisted that if the liquor failed he would be caught like a ‘rat in a box.’ A second experiment was made on a live rabbit purchased for the purpose, equally to the dissatisfaction of the Italian, who was apprehensive, as he stated, of ruining himself by another conviction. A final and unsatisfactory experiment was made on a woman in Hyde Park. Then violence was suggested instead of chloroform. Thereupon the hospital employee, who had been the apostle of chloroform, withdrew from the plot. The Italian told the diamond dealers he knew two brothers who were ‘very crafty,’ who might be able to supply the necessary violence. It was decided that the diamond merchant must have a ‘tap on the head,’ but only sufficient to stun him. The Italian had scruples about committing murder.

The Italian and the two dealers ran over to Paris, and at a well-known jewellers secured an invoice for 2,000 francs for a purchase they promised to complete the following day. The 2,000 was soon converted to 20,000, and the affixing of a receipt stamp gave the document the appearance of a receipt for a substantial transaction. En passant the Italian lifted a pair of earrings as a gift for his devoted daughter, which she was able to pledge for £20.

Returning, the Italian and Black visited a stick shop, where they purchased a life-preserver for ninepence. Having provided themselves with a very powerful weapon, their next step, in deference to the Italian’s scruples, was to moderate its force. They purchased some gutta percha and, at the Italian’s lodgings, it was heated and fastened on the knob of the weapon.

Next day, while the Italian was seated next to the merchant, sorting some larger diamonds, Black, standing behind the merchant, dealt him two blows on the head, and as he in his half-stunned state, grasped his precious stones, a third blow finally disabled him. The design had been to stun him so completely that the two conspirators would be able to seize the diamonds and ransack the safe, but either Black’s blows were too light or the weapon was too thickly padded, for the victim, instead of being stunned into silence, shrieked and groaned so loudly as to make immediate flight necessary.

The Italian met the wife face-to-face running up the stairs. He could have escaped, he declared, by pushing against her, but rather than throw a woman downstairs he stood aside, and Black unfairly seized the opportunity of brushing by and getting out of the house. The Italian followed as best he could, followed by the servant girl crying ‘Stop thief!’ Black, younger and more agile, got away. The Italian, as he piteously explained, being old and feeble, was soon in the grasp of a constable; and his daughter was in communication with the police. The Italian was enraged that the two dealers had neglected to provide for his daughter, and he also wanted to earn a remission of sentence.

Black had escaped to America, but was arrested on his return. He was sentenced to ten years penal servitude, the two dealers likewise. The Italian received a substantial remission of his sentence, but was soon in the hands of the law again, and did not survive his final sentence of four years.


Moral: Certainly test your chloroform, but test your cosh as well.
13 May 2015
FPM EXAM TUTORIAL
RCoA, London
£90

RCoA SPRING SYMPOSIUM: PERIOPERATIVE MEDICINE
Royal College of Physicians, Edinburgh
£390 (£295 for RCoA registered trainees)

FICM: CRITICAL WORKS
RCoA, London
£295 (£155 for trainees and nurses)

3 June 2015
ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
FULLY BOOKED
RCoA, London
£220 (£165 for RCoA registered trainees)

3–5 June 2015
RECENT ADVANCES RELEVANT TO ANAESTHESIA, INTENSIVE CARE AND PAIN
Hilton Hotel, Newcastle Gateshead
£490

4 June 2015
AIRWAY MANAGEMENT: TRAINING THE TRAINERS
RCoA, London
£260 (£195 for RCoA registered trainees)

5 June 2015
FPM STUDY DAY: MEDICO-LEGAL ISSUES IN PAIN MEDICINE
RCoA, London
£170 (£140 for trainees)

9 June 2015
CPD STUDY DAY: ORTHOPAEDICS
RCoA, London
£200 (£150 for RCoA registered trainees)

9 June 2015
TRACHEOSTOMY MASTERCLASS
RCoA, London
£260 (£195 for RCoA registered trainees)

10 June 2015
ETHICS AND LAW FOR ANAESTHETISTS
FULLY BOOKED
RCoA, London
£200 (£150 for RCoA registered trainees)

17 June 2015
AIRWAY WORKSHOP
Hilton Brighton Metropole Hotel
£260 (£195 for RCoA registered trainees)

29–30 June 2015
UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE
Solihull Hospital, Birmingham
£450

29 June–2 July 2015
PRIMARY FRCA MASTERCLASS
RCoA, London
£305

30 June 2015
BJA/NIAA RESEARCH METHODOLOGY WORKSHOP
RCoA, London
£150

1 July 2015
GASAGAIN (GIVING ANAESTHESIA SAFELY AGAIN) COURSE
Bradford Teaching Hospital
£240

3 July 2015
FICM ADVANCED CRITICAL CARE PRACTITIONERS CONFERENCE
RCoA, London
£40

6–10 July 2015
FINAL FRCA REVISION COURSE
RCoA, London
£395

16 July 2015
JOINT RCoA/LSORA REGIONAL ANAESTHESIA SYMPOSIUM
RCoA, London
£200 (£150 for RCoA registered trainees)

17 July 2015
JOINT RCoA/LSORA REGIONAL ANAESTHESIA PRACTICAL WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)

REDUCED RATE
A reduced rate of £360 (£270 for RCoA registered trainees) is available for those attending both the Joint RCoA/LSORA Regional Anaesthesia Symposium and the Joint RCoA/LSORA Regional Anaesthesia Practical Workshop.

4 September 2015
ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS
RCoA, London
£240 (£180 for RCoA registered trainees)

9 September 2015
ULTRASOUND WORKSHOP
RCoA, London
£240 (£180 for RCoA registered trainees)

11 September 2015
FPM EXAM TUTORIAL
RCoA, London
£95

14 September 2015
PAEDIATRIC EMERGENCY MANAGEMENT FOR THE ANAESTHETIC TEAM
RCoA, London
£260 (£195 for RCoA registered trainees)

15 September 2015
LEADERSHIP AND MANAGEMENT: PERSONAL EFFECTIVENESS
RCoA, London
£220

16 September 2015
ADVANCED AIRWAY WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)

21–22 September 2015
CPD STUDY DAYS
RCoA, London
£355 (£270 for RCoA registered trainees)

22 September 2015
GASAGAIN (GIVING ANAESTHESIA SAFELY AGAIN) COURSE
Royal Bournemouth Hospital
£240

23–24 September 2015
UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE
RCoA, London
£450

28–29 September 2015
ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
RCoA, London
£425 (£320 for RCoA registered trainees)
AIRWAY MANAGEMENT: TRAINING THE TRAINERS

Thursday, 4 June 2015
RCOA, London
£260 (£195 for RCoA registered trainees)
Event organiser: Dr F Mir
CPD Matrix codes: 1F05, 2A01, 3A01

Airway training – What do they need to know?
The future of airway training/teaching – methods and strategies
Simulation in airway training
Airway Training Workshops
Workstations on how to organise and deliver airway training:
- Teaching fibreoptic intubation skills
- Teaching supraglottic assisted intubation
- Teaching trans tracheal ventilation
- Case based discussions
- Simulation in airway training
Ethico-legal considerations for airway training
How to teach awake fibreoptic intubation?
Supported by Freelance Surgical and Karl Storz
Wednesday, 3 June to Friday, 5 June 2015
Hilton Hotel, Gateshead, Newcastle
£490
Event organiser: Dr M Tremlett

DAY 1
SESSION 1: MORTALITY AND MORBIDITY
Mortality figures and what they really tell you about your hospital (1I0J, 3J00)
Dr M Allan and Mr T Roberts, Middlesbrough
Neurocognitive deficit in infants and the young child associated with anaesthesia. What should we tell the parents? (3D00, 3J00)
Dr G Bell, Glasgow

SESSION 2: MEDICAL UPDATE 1
Modern stroke management (2A12, 3J00)
Professor A Rudd, London
Management of seizures (2A12, 3J00)
Dr N Archibald, Middlesbrough

SESSION 3: OBSTETRICS
Lessons from MBRRACE and obstetric sepsis (2B06, 2C03)
Dr N Lucas, London
Obstetric changing practices for the next decade (2A06, 2B05)
Dr A Quinn, Middlesbrough

DAY 2
SESSION 5: APPLYING PHYSIOLOGY. FUNDAMENTALS OF ANAESTHETIC CARE
Artificial ventilation in theatre – the same as in ICU? (2C02, 3C00, 3I00)
Dr A Lumb, Leeds
General anaesthesia, sleep and coma (1A01, 3I00)
Professor E Brown, Boston, USA

SESSION 6
Delirium, pathophysiology and perioperative management
Professor A MacLullich, Edinburgh
Lecture title to be confirmed
Professor E Brown, Boston, USA

SESSION 7: INTENSIVE CARE MEDICINE
Not for intensive care. Which ones? (2C01, 3C00)
Dr C Bartley, Gateshead
Muscle weakness in critical illness (3C00, 3I00)
Dr N Hart, London

SESSION 8
Goal directed therapy. What is the evidence in surgical patients? (2F01, 3A10, 3F00)
Dr G Minto, Devon

DAY 3
SESSION 9: ASPECTS OF TRAUMA CARE
Scientific management of penetrating trauma (2A02, 3A10)
Mr T Konig, London

SESSION 10: MEDICINE RELEVANT TO ANAESTHESIA
Changing diabetic care in the perioperative period (2A12, 3I00)
Speaker to be confirmed

SESSION 11: ANAESTHESIA AND THE OLDER PATIENT
Anaesthesia for the elderly for planned colorectal surgery (3A03)
Dr I Foo, Edinburgh
Dementia aetiology, differential diagnosis and management (2A12, 3I00)
Dr J Holmes, Leeds

DEBATE
Granny has not been the same since her operation. I blame the anaesthetic (3I00)
■ PRO: Dr J Steinmetz, Denmark
■ CON: Professor A Gordon, Nottingham
TRACHEOSTOMY MASTERCLASS

Tuesday, 9 June 2015
RCoA, London
£260 (£195 for RCoA registered trainees)
Event organisers: Dr L Barrass and Dr H Drewery
CPD codes covered: 1I01, 3A02, 2A01, 2A12, 1B02

- Review of the critical incidents/lessons from NCEPOD
- The surgical tracheostomy and complications
- Tracheostomy equipment
- Communication, swallowing and weaning
- The percutaneous tracheostomy
- Algorithms
- Simulation work
- Emergency stations workshops to include:
  - Small group discussions
  - Presentations
  - Part task demonstrations

CPD STUDY DAY ORTHOPAEDICS

Tuesday, 9 June 2015
RCoA, London
£200 (£150 for RCoA registered trainees)
Event organisers: Dr R Verma and Dr N Narula

09.10 am – Registration

- Regional anaesthesia for day-case upper limb surgery (2G02, 3A06, 3A09)
  Dr T Moll, Sheffield
- Recent trends in spinal surgery (3A08, 3F00)
  Dr R Krishnan, Middlesex
- Thromboprophylaxis and orthopaedic surgery (1E05, 3A08)
  Dr A Kidd, Epsom
- Peripheral regional anaesthesia – practical pitfalls (2G02, 3A09)
  Dr J Picard, London
- Anaesthesia for foot and ankle surgery (2G03, 3A08, 3A09)
  Dr J Barcroft, Stanmore
- Anaesthetic considerations for shoulder surgery (2G03, 3A08, 3A09)
  Dr Z Sheikh, Derby
- Hip Replacement Surgery (3A08, 3A09)
  Dr J John, Shropshire
- Bone cement – perioperative implications (3A08)
  Dr J Cernovsky, London

4.30 pm – Close

RCoA WEBCASTS

The Royal College of Anaesthetists uses a webcasting platform to provide a range of the College’s educational programme. RCoA Webcasts are free video recordings of lectures (including lecture slides) from selected RCoA Events. To assist with your revalidation needs, you can record CPD credits for viewing RCoA Webcasts.

HOW TO ACCESS RCoA WEBCASTS

- **Step 1**
  Visit [www.rcoa.ac.uk/webcasts](http://www.rcoa.ac.uk/webcasts) on your internet browser.

- **Step 2**
  Select the Webcast you’d like to watch from our Catalogue of Webcasts.

- **Step 3**
  Watch the Webcast and earn your CPD Credits.

- **Step 4**
  Log your CPD Credits earned by logging a Personal Activity on the CPD System/e-Learning/e-Portfolio.
AIRWAY WORKSHOP

Wednesday, 17 June 2015
Hilton Brighton Metropole Hotel
Wednesday, 7 October 2015
The Teacher Building, Glasgow
Thursday 15 October 2015
RCoA, London
£260 (£195 for RCoA registered trainees)
Event organisers: Drs R Bhagrath, S Sudan and C Urquhart

9.00 am – Registration
Rotational group workshops include:
■ Fibreoptic handling skills (2A01)
■ Supraglottic airways (1C02)
■ Rescue techniques (2B02)
■ Awake fibreoptic intubation (2A01)
■ Video laryngoscopy (1C01, 1C02, 2A01)
■ Extubation (1C01, 1C02)
Please note that stations may be subject to change.

4.00 pm – Close
Supported by: Cook Medical, Fannin UK, Freelance Surgical, Karl Storz, Teleflex and Verathon

UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT

29–30 June 2015, Solihull Hospital, Birmingham
23–24 September 2015, RCoA London
5–6 November 2015, Edinburgh Royal Infirmary
£450

The UK TEAM Course is a two day simulator-based course designed to teach the foundations of the knowledge, skills and attitudes required to safely manage the airway in an emergency situation outside the operating theatre (for example, the Emergency Department resuscitation room). The course is taught by an experienced faculty using small groups and high fidelity patient simulators. The course is aimed at doctors 3–4 years after qualification and those attending should have had at least six months experience in anaesthesia and three months experience in intensive care. It is particularly relevant for doctors intending to pursue a career in anaesthesia, critical care, emergency medicine or acute medicine.

BJA/NIAA RESEARCH METHODOLOGY WORKSHOP

Tuesday, 30 June 2015, Monday, 5 October 2015
Monday, 21 March 2016, Tuesday, 7 June 2016
RCoA, London
£150
Event organiser: Professor P Hopkins
CPD Matrix code covered: 3J03

9.00 am – Registration
DEVELOPING AN IDEA
■ Research question
■ Literature searches
■ Critique of published work

GROUP SESSION ONE
■ Critique of published research paper (previously circulated)

STUDY DESIGN
■ Hypotheses
■ Data capture
■ Analytical versus interventional research
■ Bias, sampling controls, confounding variables
■ Power
■ Significance, hypothesis testing, estimation (CI)

GROUP SESSION TWO
■ Design a clinical trial (outline given on day)

GETTING YOUR STUDY STARTED
■ Ethics committees
■ Sponsorship
■ Clinical trials authorisation and registration
■ Funding

GROUP SESSION THREE
■ Common pitfalls in analysis, presentation and interpretation of data

DISSEMINATION OF RESULTS
■ Presenting abstracts and posters
■ Writing a paper
■ Getting it published

4.30 pm – Close
JOINT RCoA/LSORA REGIONAL ANAESTHESIA SYMPOSIUM

Thursday, 16 July 2015
RCoA, London
£200 (£150 for RCoA registered trainees)
Event organisers: Dr S Patel and Dr B Madhavan

8.30 am – Registration

SESSION 1: ADVANCES IN REGIONAL ANAESTHESIA
Best for breast?...Serratus Plane vs PECS vs Paravertebral
Dr R Blanco, Spain
Quadratus lumborum...the new TAP
Dr J McDonnell, Ireland
Adductor canal...the perfect block?
Dr T Bendtsen, Denmark

SESSION 2: INNOVATION IN REGIONAL ANAESTHESIA
Using catheters in regional anaesthesia
Professor B Tsui, Canada
New drugs...liposomal bupivacaine, the panacea
Dr A Hadzic, Croatia
Ultrasound and MRI for needle placement
Dr T Bendtsen, Denmark

SESSION 3: UPDATES IN REGIONAL ANAESTHESIA
Outcomes in regional anaesthesia...what should we measure?
Dr C McCartney, Canada
Most influential papers in the last 24 months
Professor D Buggy, Dublin

SESSION 4: EDUCATION
Where are we now with education in regional anaesthesia?
Dr C McCartney, Canada
A license to practice regional anaesthesia?
Dr B Nicholls, Taunton
Maximising safety with nerve blocks
Dr A Hadzic, Croatia

5.20 pm – Close

DRINKS RECEPTION FOR ALL

JOINT RCoA/LSORA REGIONAL ANAESTHESIA PRACTICAL WORKSHOP

Friday, 17 July 2015
RCoA, London
£260 (£195 for RCoA registered trainees)
Event organisers: Dr S Patel and Dr B Madhavan

Candidates will be asked skill level and streamlined into appropriate groups. There will be plenty of opportunity to discuss novel blocks with international experts during the stations and more comprehensively during the Ask the Experts session.

During the day, there will be parallel needle scanning stations using blue phantoms. Each group will comprise of 4 candidates to enhance the learning experience.

8.30 am – Registration

SCANNING STATION 1: UPPER LIMB
Interscalene, supraclavicular, infraclavicular, axilliary

SCANNING STATION 2: LOWER LIMB
Femoral, fascia iliaca, obturator, adductor canal, sciatic, popliteal

SCANNING STATION 3: TRUNK
Lumbar plexus, TAP, PECS, serratus plane, peripheral blocks of the forearm

SCANNING STATION 4: NEURAXIAL
Spinal, epidural, PVB

SCANNING STATION 5: ASK THE EXPERTS

5.00 pm – Close

REDUCED RATE
A reduced rate of £360 (£270 for RCoA registered trainees) is available for those attending both the Joint RCoA/LSORA Regional Anaesthesia Symposium and the Joint RCoA/LSORA Regional Practical Workshop. Places for the events will be offered on a first come, first served basis.
ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS (HICKMANS, PICCS AND PORTS)

Friday, 4 September 2015
RCoA, London
£240 (£180 for RCoA registered trainees)
CPD Matrix codes covered: 2D03, 3100
Event organisers: Dr A Bodenham and Dr A Johnston

10.00 am – Registration
- Choice of devices, patient assessment, sedation/LA/GA?
- Insertion of PICC’s, Hickmans, Ports. Introduction, how we do it – three short videos
- Catheter tip positioning
- Central venous access in the very small child
- Common problems
  Blocked catheter management
  Fibrin sleeves, mechanical blockage, fibrinolytics
- Rotational Workshops:
  Ultrasound/X-ray/surgical skills/radiology/trade stands
- Radiology to the rescue! Ask the expert, interactive session faculty with worked examples; e.g. blocked central veins, great vessel damage, management of thrombosis

4.30 pm – Close

ULTRASOUND WORKSHOP

Wednesday, 9 September 2015
Tuesday, 23 February 2016
RCoA, London
£240 (£180 for RCoA registered trainees)
Event organiser: Dr A Gaur
CPD Matrix codes covered: 3A08, 3A09, 3B00

8.45 am – Registration
Workshop stations (delegates will be split into small groups to rotate through eight workstations, 40 minutes each).
- Upper limb – above clavicle
- Upper limb – below clavicle
- Lower limb – femoral and LFCN
- Probe and needling
- Lower limb – sciatic popliteal
- Epidural/spinal
- Abdominal
- Lumbar plexus
5.00 pm – Close

PAEDIATRIC EMERGENCY MANAGEMENT FOR THE ANAESTHETIC TEAM

Monday, 14 September 2015
RCoA, London
£260 (£195 for RCoA registered trainees)
Event organiser: Dr P James

8.40 am – Registration
- Anaesthesia for upper airway obstruction
- Anaesthesia for children with heart disease (congenital or acquired)
- Workshops (45 minutes each)
  – Paediatric airway management
  – Collapsed neonate
  – Time critical transfer
  – Anaesthesia and haemodynamic compromise
- Neurosurgical emergencies
4.15 pm – Close
LEADERSHIP AND MANAGEMENT
PERSONAL EFFECTIVENESS

Tuesday, 15 September 2015
RCoA, London
£220
Event organiser: Dr C Ralston

9.30 am – Registration

■ What are the key ingredients of personal effectiveness?
■ Emotional intelligence
■ When things don’t run smoothly
■ Exercising personal influence in a politicised world
■ Personal reflections

4.00 pm – Close

ADVANCED AIRWAY WORKSHOP

Wednesday, 16 September 2015
RCoA, London
£260 (£195 for RCoA registered trainees)
Event organiser: Dr R Bhagrath

Aimed at consultants and senior trainees wishing to gain advanced airway skills using experienced small group teaching and hands-on practice.

9.00 am – Registration

Attendees will be split into three groups – all groups rotate through each station (50 minutes per station)

■ Awake FOI (2A01)
■ Front of neck access (2B02)
■ Exubation (1C02)
■ The paediatric airway (3A01)
■ Jet ventilation (3A01)
■ Human factors (1L03)

4.00 pm – Close

Please note that programme stations are subject to change.

Sponsors: Fannin UK, Freelance Surgical, Karl Storz, Verathon, Cook Medical, Inspirational Healthcare

CPD STUDY DAYS

Monday 21 and Tuesday 22 September 2015
RCoA, London
£355 (£270 for RCoA registered trainees)
Event organiser: Dr P Groom and Dr M Goulden

Day 1

9.00 am – Registration

■ EPOCH trial (2A03, 2A06)
■ Airway management (3A01)
■ Goal directed therapy (2A04, 2A05)
■ Transfer medicine (3A10, 3A11)
■ Obstetrics (2B05, 3B00)
■ Duty of candour and wilful neglect (1F01, 1F03, 1F05)
■ Echocardiography for anaesthetists (3G00)
■ Bridging antithrombotic medication (1A02, 1E05)

5.20 pm – Close

Day 2

8.40 am – Registration

■ Acute pain (1D01, 1D02)
■ Lung protective ventilatory strategies (2C02, 2C01)
■ Perioperative medicine (2A03, 2A07)
■ Is oxygen a dangerous thing? (2A07, 3J03)
■ Enhanced recovery
■ Ebola (3C00)
■ NAP5 results and conclusions (1E06)
■ Managing a patient with pulmonary hypertension (1A01)

4.30 pm – Close
ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE

Monday, 28 and Tuesday 29 September 2015
Tuesday, 10 and Wednesday 11 November 2015
Wednesday, 10 and Thursday 11 February 2016
RCoA, London
£425 (£320 for RCoA registered trainees)
CPD Matrix codes covered: 1H01, 1H02, 2H01, 2H02
Event organiser: Dr S Williamson

JOINT RCoA/RSM EMERGENCIES IN ANAESTHETIC PRACTICE

Friday, 6 November 2015
RSM, London
Please visit the website for event fee
Event organiser: Professor R Mirakhur

Day 1
9.45 am – Registration
■ Personal learning objectives
■ Learning theories
■ Learning styles
■ Planning learning

Day 2
8.00 am – Registration
■ Workplace teaching
■ Assessment of professionals
■ Practice teaching and feedback
■ Practice teaching debrief

ANAEHSTHETISTS AS EDUCATORS: EDUCATIONAL SUPERVISION

Tuesday 6 October 2015
RCoA, London
£220
CPD Matrix codes: 2H01, 2H02
Event organisers: Dr A Cooper and Dr T Dorman

JOINT RCoA/RCEM STUDY DAY: MAJOR TRAUMA

Tuesday, 24 November 2015
RCoA, London
Fee: £200 (£150 for registered trainees)
Event organisers: Dr S Reid and Dr J Nolan

9.00 am – Registration
■ C spine immobilisation – are we treating the patient or our own instability?
■ The trauma airway and the trauma anaesthetic
■ Pelvic fracture management
■ Trauma team leadership
■ The role of the trauma consultant
■ Management of traumatic bleeding
■ Has ATLS had its day?
■ Training in prehospital emergency medicine

PROGRAMME SUBJECT TO CHANGE
WINTER SYMPOSIUM

Thursday 19 and Friday 20 November 2015
RCoA, London
£395 (£295 for RCoA registered trainees)
Event organiser: Dr R Alladi

DAY 1
9.00 am – Registration

SESSION 1: CARDIOVASCULAR
■ Perioperative hypertension – when to treat, how to treat and implications to the anaesthetist
■ Cardiology update – new drugs – a review
■ Anaesthesia in the cardiac catheter lab – new challenges

SESSION 2: REGIONAL ANAESTHESIA
■ Anaesthesia for shoulder surgery
■ Role of epidurals in modern anaesthesia and postop analgesia – are they still gold standard?
■ Regional anaesthesia for trauma-update and controversies

SESSION 3: DILEMMAS AND DISASTERS
■ Avoiding and dealing with medico-legal issues
■ Strategies for handling the aftermath of intraoperative death
■ Disciplinary proceedings – and how to cope with them

SESSION 4: NEW CHALLENGES
■ Improving outcomes after emergency laparotomy
■ Older patients – how best to deal with them?
■ Tackling high BMI – tips to deal with this area

5.25 pm – Close

DRINKS RECEPTION FOR ALL

DAY 2
08.30 am – Registration

SESSION 5: OUTSIDE THEATRES
■ Safe sedation – best practice from a patients’ perspective
■ Anaesthetic management for procedures outside the operating theatres

SESSION 6: MANAGEMENT ISSUES
■ How to maintain a good image in your department?
■ Quality and outcomes – what is best practice?

FREDDIE HEWITT LECTURE

AWARDS SESSION

SESSION 7: CRITICAL ISSUES
■ Case of awareness – what to do? Results and recommendations from NAP5
■ Extubation stridor – options for management and prevention
■ Difficult acute postoperative pain-management strategies

SESSION 8: REVIEW OF ROUTINE PRACTICE
■ TIVA – advantages and downsides
■ Ketamine usage in modern anaesthesia – a review of evidence
■ RSI and preoxygenation – pro’s and con’s – clinical evidence

4.50 pm – Close

PLEASE NOTE PROGRAMME IS SUBJECT TO CHANGE
Dear Editor

I read with interest the President’s Statement in the last Bulletin, and in particular the section ‘All part of the bigger picture?’. I would agree that ‘the provision of anaesthesia by non-medically qualified practitioners’ has been a point of debate over the years. I would like to suggest that the debate is over and moves on from whether there is a need to have non-physician anaesthetic providers to how many we actually need in our departments to support the existing medical anaesthetic workforce.

Non-physician delivery of anaesthesia by Physicians’ Assistants (Anaesthesia) (PA(A)s) is consultant-led care and should not be seen as a compromise in the quality of anaesthesia care that is delivered. The PA(A) Scope of Practice is already established in many hospitals. Several organisations have locally agreed guidelines to enable the PA(A) group to consistently deliver the service provision workload of the department. The recognised training is a Post-Graduate Diploma: Physicians’ Assistant (Anaesthesia) (or previously Anaesthesia Practice/Anaesthesia Studies) developed by the University of Birmingham and NHS partners. Career development requirements are similar to all other health professionals in the NHS.

The Heart of England NHS Foundation Trust (HEFT) has done the groundwork in establishing a PA(A) workforce. These bridges have been built and crossed. The wheel does not need reinventing. The model is in use in other hospitals and can be transferred and adapted to any other hospital setting. At HEFT we frequently have visiting clinical directors, consultants, service managers and other interested parties inquiring first hand information. We support them with the ‘paper work’ and provide assistance as needed in setting up a PA(A) workforce in their departments.

The debate of the past is over and the reality of the future is already here. On discussion with colleagues in other departments it is obvious a shortage does exist in our workforce. PA(A)s have a defined position in the answer to this shortage and can be fully utilised in the service provision aspect of anaesthesia.

Kind regards

Phillip Cawkwell MSc
Physician Assistant (Anaesthesia)
Heart of England NHS Foundation Trust

Reference

1. Rimmer, Abi (2014) Will physician associates be replacing doctors?
   http://careers.bmj.com/careers/advice/view-article.html?id=20019162

Dear Editor

The Gas Ceiling

It is important to discuss this topic and the authors are quite right in at least 2 of their assertions-lots more women in the emerging medical workforce, and Anaesthesia is a great career for those who wish to be part of a busy ‘hands on’ speciality. Anaesthesia also has a wonderfully diverse choice of areas to get involved in, but is there really evidence that sexism in our speciality is ‘everywhere’?

Additional thoughts...

1. Some more statistics (supplied by this College)

   (From the last 2 census reports) There was a slight increase in the proportion of female consultants between 2007 and 2010 from just below 30% (28.46) of the workforce to just over 30% (30.28) - approximately a 2% increase. In real terms this was 2,074 female consultants from a total of 6,849 for the UK in 2010. Projecting this to today (unscientifically) it is reasonable to assume the figure is around 33 – 35%. The 2015 Census will offer greater clarity on this.

   In Training-membership data reveals 3425 Female Fellows and Members registered with the college, 6944 male Members and Fellows (does not include senior fellows) – so similar to the above 33% female proportion.

   This demonstrates that the proportion of RAs is actually considerably higher than the proportion of women in the speciality (46% as quoted by Nigel Penfold in the Editors commentary). Whilst there are just 27% of examiners, again this is not far off the one third mark. So keep going?

   2. There is a dearth of female anaesthetists in academic posts and publishing actively, but there are many others in equally valuable
Report of a meeting of Council

At a meeting of Council held on Wednesday, 11 February 2015 the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**
Council considered making the following re-appointments:

- **Northern Ireland**
  - Dr D W Lowry

- **Nottingham & Mid Trent**
  - Dr C A O’Dwyer

**Deputy Regional Advisers**
Council considered making the following re-appointments:

- **North Thames West**
  - Dr S Jaggar
  - Dr R Bacon

**College Tutors**

- **Mersey**
  - *Dr K E Brodbelt (Arrowe Park Hospitals, Wirral)*
  - *Dr A O Ohusunmade (Liverpool Women’s Hospital)*

- **Wessex**
  - Dr M Pearson (St Mary’s Hospital, Isle of Wight) in succession to Dr I Rice
  - *Dr P Mackie (Southampton University Hospital)*

- **South West Peninsula**
  - Dr N J Hollister (North Devon District Hospital) in succession to Dr G Rousseau
  - Dr S M K Nash (Royal Cornwall Hospital, Truro) in succession to Dr R Langford
  - Dr N B Marshall (Royal Cornwall Hospital, Truro) vacant post
  - *Dr P Thomas (Royal Devon and Exeter Hospital)*

**South Thames East**

- Dr V Ponnaiah (Guy’s & St Thomas’ NHS Foundation Trust) in succession to Dr M P Rao

- Dr M Kurup (Kings College Hospital) in succession to Dr S A Leonard

**Nottingham & Mid Trent**

- *Dr T Shah (Derby Hospitals NHS Foundation Trust)*

**Sheffield & North Trent**

- Dr R Dobson (Doncaster Royal Infirmary) in succession to Dr M Denton

**Head of Schools**

- There were no appointments to note.

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.

**December 2014**

- **Anglia**
  - Dr Suhas Santhosh Kumar*
  - Dr Natasha Louise Lawrence*

- **KSS**
  - Dr Paul Douglas Everett Smith
  - Dr Sinan Adnan Bahlooil*

- **North Central**
  - Dr Jamie Gross*
  - Dr Pradeep Rajkumar Madhivathanan*
  - Dr Selvakumar Panchatsharam*

- **Barts and the London**
  - Dr Peter Brendan Sherren*

- **Mersey**
  - Dr Deepa Bansi Jumani

- **North West**
  - Dr Papari Deka
  - Dr Redmond Paul Tully*
  - Dr James John Leadham
South East Scotland
Dr Alastair James Morgan*

Severn
Dr Emma Margaret Bennett Clow

Sheffield
Dr Sireesha Aluri

Wales
Dr Ausama Hassan Mohammed*

Stoke
Dr R Anil Kumar
Dr Rajkumar Thangaiah

Birmingham
Dr Radhu Pandrangi
Dr Ramy Adel Same Labib

West of Scotland
Dr Ryan Laurie Campbell

Hull, York & East Coast
Dr James Edward Stevenson

Leeds and Bradford
Dr Hayley Victoria Kemp
Dr Saravanan Varadhahren Prakasam

January 2015

Anglia
Dr Abigail Louise Hallett

Nottingham
Dr Anna Louise Davey

South East
Dr Chima Alexander Oti
Dr David Nicholas Oliver
Dr Abigail Jane Medniuk
Dr Shaima Elmour
Dr Claire Louise Barker
Dr Syed Moshin Qureshi
Dr Edwardina Mary Mae Alexandra Lillie

Mersey
Dr Edwin Crossley Clitheroe
Dr Tanja Beaumont
Dr Jessica Brown Griffith

North of Scotland
Dr Douglas Andrew Coventry*
Dr Ian William Scott*

North West
Dr Helen Ruth Simmons

Oxford
Dr Andrew Skog
Dr Prabir Patel*
Dr Diane Hue Dung Tran

South West Peninsula
Dr James Cockroft

South East Scotland
Dr Rachel Louise Smith
Dr Edward Alexander Mellanby

Severn
Dr Izreen Rozana Mohamed Iqbal
Dr Lucy Ann Miller

Sheffield
Dr Julie Lucy Hui

Wales
Dr Robert Jonathan Dawes
Dr Lowri Bowen
Dr Asha Anil Naik
Dr Benjamin Holst

Birmingham
Dr Bhadraj Kumar Basu
Dr Nicholas John Cowley*

Hull, York & East Coast
Dr Pumali Nisha Gunasekera*

At a meeting of Council held on Tuesday, 10 March 2015 Fellowship ad eundem of the Royal College of Anaesthetists was awarded to:

- Dr Syed Muhammad Ali
- Dr Alastair John Dorman
- Dr Valasubramaniam Mahadevan
- Dr Douglas Robert Alexander McKendrick
- Dr Sreekanth Rayalu Uppugonduri

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

Regional Advisers

South Thames West
Dr R Suite in succession to Dr P Quinton

Deputy Regional Advisers

Oxford
Dr D Choi

South Thames East
Dr Helen Scott

Head of Schools
There were no appointments to note.

College Tutors

North Thames Central
Dr K Hunt (National Hospital for Neurology and Neurosurgery) in succession to Dr Y K Amin
Dr C J Taylor (National Hospital for Neurology and Neurosurgery) vacant post
Dr M Simpson (Lister Hospital) in succession to Dr O W Boomers

South West Peninsula
Dr H E J Pugh (Royal Devon and Exeter Hospital) in succession to Dr P Thomas

Wales
Dr E Curtis (Nevill Hall Hospital) in succession to Dr B John

Oxford
Dr J M Chantler (John Radcliffe Hospital) Acting Tutor for Dr M W Speirs

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.

February 2015

Anglia
Dr Siddharth Sadanand Adyanthaya
Dr Andrew Michael Hettred*  
Dr Peter James Featherstone*

Leicester
Dr Abigail Fell
Dr Amy Rebecca Needham*
Dr Amit Saxena

Nottingham
Dr Hasankhan Sherkhan Pathan
Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

- Dr S Aluri
  Barnsley Hospital
- Dr S Bahloo
  William Harvey Hospital, Ashford
- Dr C F Baylis
  Salford Royal Foundation NHS Trust
- Dr A Beckingsale
  Wansbeck General Hospital
- Dr L Bowes
  Birmingham Children’s Hospital
- Dr N R Burri
  Castle Hill Hospital, Cottingham
- Dr S Cross
  St John’s Hospital, West Lothian
- Dr R P Curtis
  Royal Derby Hospital
- Dr M Ings
  Sheffield Teaching Hospitals NHS Foundation Trust
- Dr B Ittzes
  North Devon District Hospital
- Dr H Langrick
  Mid Cheshire Hospitals NHS Trust
- Dr P Madhivathanan
  King’s College London
- Dr O Ojo
  Basildon University Hospital
- Dr S M Qureshi
  Broomfield Hospital
- Dr A Ranjan
  Bristol Royal Infirmary
- Dr T J Scarratt
  Bradford Teaching Hospital Foundation Trust
- Dr R L Smith
  Chelsea and Westminster Hospital
- Dr A Trimmings
  East Sussex Healthcare Trust

To note recommendations approved by the GMC, that CESRs be awarded to those set out below:

- Dr Hussain Karim
- Dr Malka Liyanage
- Dr Abdulaziz Refaet

KSS
Dr Debamoy Chatterjee

Imperial
Dr Vijay Purushottam Kale
Dr Angus Rivers

North Central
Dr Melanie Ee-Leng Tan
Dr Ramanathan Kasivisvanathan

Barts and the London
Dr Nathan James Borgeaud

South East
Dr Audrey Tan
Dr Ziyad Narsay Yousif Rassam
Dr William Alexander Eyer Birts
Dr Dragos Petrut Dragnea
Dr Thomas Alexander Williams*
Dr Charles Yan Kit Ho
Dr Daniel Barry Moult*
Dr Sheela Badiger

St George’s
Dr Sarah Lucie Millams*
Dr Rebecca-Lea Smith
Dr Carlos Mauricio Corredor*
Dr Nicholas Mark Courtenay-Evans

Northern
Dr Eleanor Clare Ripley
Dr Steven Lobaz*
Dr Kaled Sa El-Nagar
Dr Madhu Babu Balasa (CESR CP)
Dr Oana Maria Cole
Dr Mika Hamilton*
Dr Thomas William Angus Mackie
Dr Sarah Christian Gibb
Dr Ahmed Mazen Elwishi

North West
Dr Alexander Momen Bonner
Dr Simon William Coleman
Dr Elizabeth Claire Allison
Dr Toby Charles Thomas*

Severn
Dr Clare Louise Newton Dunn
Dr Alexander George Middleditch*
Dr Shailendra Deep

Tri Services
Dr Victoria Clare Pribul

Wales
Dr Sonia Arun Sathe*
Deaths

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

Dr Janie Morrison McIntyre, Glasgow
Dr Andrzej Maciejewski
Dr Bashir Misgar, Kent
Dr Archibald Cousland Milne, Edinburgh
Professor James Payne, London
Dr Vivek Sivaraman, London
Dr John Ainley-Walker, Cumbria
Dr Clifford Franklin, 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).

Honours, Awards and Prizes

The following awards were presented at the Anniversary Dinner and Meeting on the 11-12 March 2015.

Dudley Buxton Prize
This endowed trust fund was established in 1967 to provide for an annual award of a prize for ‘meritorious work in anaesthesia or in a science contributing to the progress of anaesthesia.’

■ Professor Michael Grocott

Humphry Davy Award
Awarded for sustained contributions to the Royal College, usually in a specific area of activity. This is national activity but may include successfully completed commissioned activity. The project or activity has to be significant for the Royal College and involve high levels of commitment and delivery over some years, although usually less than the ten years criteria for the higher awards.

■ Dr Kerri Jones
■ Dr Martin Kuper
■ Dr Michael Swart

College Medal
This is awarded to those who have made a clear and significant contribution to the Royal College. This is normally related to a defined major project and is considered on successful completion or delivery of that project.

■ Mr Martin Bromiley
■ Dr Lucy White

President’s Commendation
Introduced in 2011, this is awarded to those who have provided sustained or specific contribution to the Royal College.

■ Mrs Clare Kennedy
■ Dr Katy Nicholson
■ Dr Platon Razis
■ Dr Paul Spargo

The John Snow Oration
This eponymous lectureship is the highest lectureship awarded by the RCoA on behalf of the NIAA Health Services Research Centre. The orations are delivered at appropriate national meetings. They are awarded to established senior clinicians, academic experts, policy makers or pioneers in the field who have made a significant contribution to advancing the field of Health Services Research in relation to Anaesthesia, Perioperative Medicine, Pain, or Critical Care Medicine. Academic nominees would normally be senior post holders at professorial level with an international reputation in Health Services Research.

■ Professor Nick Black

Macintosh Professor
This prestigious lecture and title is awarded on the recommendation of the Board of the National Institute for Academic Anaesthesia (NIAA). It is in recognition of outstanding contributions to the wider field of anaesthesia in a senior academic or clinician. In the case of an academic, it would normally be at a senior lecturer level. The delivery of the lecture will be at a suitable scientific meeting and the title of ‘Macintosh Professor’ is bestowed for one year from the date of Council’s approval of the award.

■ Professor Daqing Ma

Appointment of Members, Associate Members and Associate Fellows

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

Member
Dr Edward Colin Todd
Dr Partha Sarathy Annamalai
Dr Jeanie Clare Worthington

Associate Members
Dr Ioana Doina Sintie
Dr Cameron Cairns Smith
Dr Lubomir Gavula
Dr Manpreet Singh

Affiliate – Physicians’ Assistant
Ms Lynn Alison Maxwell
DIFFICULT AIRWAY SOCIETY

Airway Revalidation Course

at The Royal College of Anaesthetists, Red Lion Square, London WC1
Friday, 19 June 2015

WHAT YOU NEED TO KNOW ABOUT SAFE AIRWAY MANAGEMENT

Following on from the very successful NAP4, Airway Leads Day, and several new ‘Airway’ guidelines, Difficult Airway Society is pleased to announce the launch of the first of a series of Airway Revalidation Courses to be held on 19 June 2015. The Course is specifically designed to meet the airway CPD requirements of UK Anaesthetists.

It benefits from DAS standardisation, peer review and quality control. It is based on latest evidence and draws upon the experience and consensus of experts in airway management.

DAS experts and high profile airway trainers have developed the full-day course consisting of up-to-date lectures on various aspects of airway management which include:

- Airway assessment.
- Decision making in airway management.
- Choosing the right equipment.
- Managing the correct technique.
- Extubation.
- Human factors/non-technical skills.
- Airway management outside the theatre environment.

DAS-RCoA Airway leads are strongly encouraged to attend this course as DAS intends to spread these courses across the country with their active involvement.

For more information and booking details please visit: www.das.uk.com.
### Intensive Care Society

**Care when it matters**

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<tr>
<td>12</td>
<td>FICE Echocardiography</td>
<td>Churchill House, London</td>
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<tr>
<td>28-29</td>
<td>Radiology</td>
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<td>11</td>
<td>Law &amp; Intensive Care Medicine <strong>NEW</strong></td>
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<td>Core Topics for Training &amp; Revalidation in ICM</td>
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<td>27</td>
<td>Snowdon Xtreme 3 Fundraising Challenge</td>
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<td>7</td>
<td>Nurse &amp; AHP Rehabilitation in Critical Care <strong>NEW</strong></td>
<td>Churchill House, London</td>
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<td>25</td>
<td>Core Topics for Training &amp; Revalidation in ICM</td>
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<td>Chest Ultrasound</td>
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<td>9</td>
<td>Core Topics for Training &amp; Revalidation in ICM</td>
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<td>16</td>
<td>ICM Career Day</td>
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<th>DECEMBER</th>
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<tr>
<td>7-9</td>
<td>State of the Art Meeting</td>
<td>The ICC, East ExCeL, London</td>
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For further information and details of events please visit [www.ics.ac.uk](http://www.ics.ac.uk) or email events@ics.ac.uk

Search: Intensive Care Society  Follow us @icsmeetings
THE MSA SAQ WRITERS CLUB

The Writers Club has seen more than 450 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
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Join now 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>October 2015</td>
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<td>1–3 May</td>
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<td>Final SBA/MCQ</td>
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<td>Final SBA Only</td>
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<tr>
<td>Final MCQ Only</td>
<td>17–20 August</td>
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<td>Final Written ‘Booker’</td>
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<td>Final Viva Revision</td>
<td>16–21 May</td>
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<tr>
<td>Final Viva Weekend</td>
<td>12–14 June</td>
<td>November 2015</td>
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‘I DID IT, I PASSED! I honestly don’t know how to express in words how deeply grateful and appreciative I am for all your help. From my written Primary until now, signing the book of Fellows at the Royal College of Anaesthetists, I am 100% sure that is has been the strength of your courses that have got me through it. Although Liverpool and MSA has always been connected to feelings of dread, revision and exams, I believe I will look back with fond memories. Seriously, thank you, your words are like gold, I couldn’t have done this without you and the MSA.’ (Feedback Final Candidate 2014)

To see details of all of our courses please visit: www.msoa.org.uk or contact us at: enquiries@msoa.org.uk
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Anaesthesia Review Teams (ART)
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Bulletin
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020 7092 1692/1693

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