INSIDE THIS ISSUE

Methoxyflurane may be returning to the UK

Differential pass rates in the FRCA

Sub-specialty training in pre-hospital emergency medicine (PHEM)

Plastic recycling from the operating theatres, working towards a circular economy

Should the NHS WHO surgical safety checklist be updated?

Stretching the boundaries: London anaesthesia in 1955
The President’s Statement ........................................................ Page 4
Guest Editorial ....................................................................... Page 6
Revalidation for anaesthetists ............................................. Page 9
Patient Perspective ................................................................ Page 10
The Faculty of Intensive Care Medicine (FICM) ............... Page 12
The Faculty of Pain Medicine (FPM) ................................. Page 13
Society for Education in Anaesthesia (SEAUK) ............. Page 14
National Institute of Academic Anaesthesia (NIAA) ...... Page 17
Sprint National Anaesthesia Projects (SNAPs) ................. Page 19
Anaesthesia Clinical Services Accreditation (ACSA) ...... Page 21
Updates to NAP5: Anaesthesia Awareness Support Pack Page 23
Methoxyflurane may be returning to the UK .................. Page 25
Should the NHS WHO surgical safety checklist be updated? Page 26
Differential pass rates in the FRCA ..................................... Page 29
Plastic recycling from the operating theatres, working towards a circular economy ................................ Page 32
Intraoperative handovers: do we have a problem? .......... Page 35
Sub-specialty training in pre-hospital emergency medicine (PHEM) .......................................................... Page 38
Adventures in anaesthesia: the theatre of theatre ............ Page 44
Stretching the boundaries: London anaesthesia in 1955 ... Page 45
As We Were and Letters to the Editor ................................ Page 48
Conserve our Collections scheme – first year’s report .......... Page 49
NIAA Small Grants, Awards and Research Grants .......... Page 51
Report of meetings of Council .............................................. Page 53
Senior Fellows Club Report .................................................. Page 55
Programme of events 2015 ................................................... Page 56
Notices and advertisements .................................................. Page 64

VIEWS AND OPINIONS

expressed in the Bulletin are solely those of the individual authors, and do not necessarily represent the view of The Royal College of Anaesthetists.

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

I intend to start this month with the indulgence of three farewells.

Firstly to Kevin Storey, an innovative and unflappable Chief Executive. He leaves the College in an excellent position. The finances are sound and the staff, support and working environment unrivalled. Kevin actively encouraged me to stand for Council – this may account for his early ‘retirement’!

I have known our President, J-P van Besouw, for many years through the hustlings of programme director and RA. A leader who has not micromanaged, he is only now showing a little fatigue after three years in the traces. His articles for the Bulletin have proven so insightful and thorough that I no longer need to consult The Daily Mail!

And finally to Irene Dalton who comes to the end of her time as Lay Committee Chair. Through irrepressible enthusiasm, energy, insight and knowledge she has cemented the Lay Committee into the College fabric; hard as I have tried I have had no headmistresses’ detention.

I will miss all three of you.

We have a new government and the posturing is starting. All those hollow promises to keep, all that money to be saved and found by 2020. Not actually £30 billion extra for the NHS, but £22 billion to be found from savings!

In this Bulletin, J-P discusses ‘Choosing Wisely’ and NHS England’s revelation that if you are honest with people they might baulk at what’s offered. Irene’s, ‘gloves-off’, tribute to political honesty tells us why there will be little change. There are opportunities though, and perioperative medicine in just the right flavour; more about that in September.

For those of you who wish to know all about pre-hospital emergency medicine but dare not ask, help is at hand. Dr Birks and Major Chinery detail their positive experience in becoming the first anaesthetists to complete PHEM training in the UK. They describe both the structure of the training and importantly the ‘value plus’, the life skills if you like, acquired during their two-year secondment. Helen Hobbiger is the College representative on the PHEM training board and HOS for Anglia. Helen’s guest editorial is essential reading for those considering an application for PHEM training and for those who may need to advise them.

Lucy Grimes and colleagues revisit the WHO checklist, adopted six years in the UK. Originally designed to be short and simple, considerable local modifications have occurred. The value of these changes is unclear given that evaluation after implementation reveals considerable variance and indeed discrepancies between perception and reality. Not withstanding this, the article describes one process and five checks that merit consideration. Hopefully this article will support local debate and change.

An area fraught with risk is intraoperative handover. Sioned Phillip’s outlines the issues here and measures, including the development of an aide memoire to reduce risk.

The College has a public sector equality duty, and this extends to all areas of our work where a public function exists. Differential examination results were the trigger for a case testing compliance at the RCGP. In response to the judgement, we have reviewed our own practice in this and all relevant areas and the examination findings are published here.

Towards the end of the journal, are two articles for amusement. Ellie May has written and published a short book addressing many of the issues and frustrations of anaesthetic life – the ‘red top’ newspaper and Casualty representation. Her article is a brief introduction. Also, Bernard Brandstater, not new to these pages, describes his experience of nitrous oxide, hypoxaemic anaesthesia at the Eastman Dental hospital in 1955; he became an expert!

Methoxyflurane, a potent volatile anaesthetic, was first used clinically in 1960 but withdrawn in the mid 1970s. A licence application has been lodged to reintroduce it, and Les Gordon’s short article is a heads up. Please read.

Tom Pierce was awarded the President’s Commendation at the Spring Symposium. Tom is the College advisor on sustainability, and is our social conscience. He co-authors an article on moves to recycle some high-grade plastics. The article is informative and readable, and the initiative is long overdue for those of us who mourn the demise of the red rubber ET tube and black facemask!
To embed a culture in which patients and clinicians regularly discuss the clinical value and effectiveness of proposed treatments or interventions, with the explicit aim of reducing the amount of inappropriate clinical activity.

To begin the process by supporting Colleges and Specialist Societies to identify those commonly used interventions/treatments within their specialty whose necessity should be questioned and discussed.

To support and spread that work through campaign activity amongst the public, patients and clinicians.

The College’s own program to promote perioperative care closely aligns to these principles and offers a more systematic approach to personalised risk assessment and effective shared decision-making before a patient is formally referred for surgery.

This agenda also aligns with that of NHS England, who in their advice to those commissioning elective surgery have stated that:

Evidence suggests that when patients are given full information about the benefits and potential harms of alternative treatments they tend to opt for the least invasive therapy or for self-management with support.

Learning from others

The National Emergency Laparotomy Audit (NELA) set out to examine the inpatient care and outcomes of patients undergoing emergency abdominal surgery in England and Wales, and to provide comparative information on patterns of care in NHS hospitals. The audit, begun in 2012, was commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government.

The NELA organisational audit report was published in 2014, and investigated the structures and processes in place for emergency abdominal surgery at 190 hospitals in England and Wales. It examined the availability of resources fundamental to the effective care of emergency laparotomy patients, and found wide variations across hospitals. Key findings indicate that:

- Four-fifths of hospitals admitting unscheduled adult general surgical patients provide one or more fully-staffed operating theatres in which emergency laparotomy may be performed at all times.
- Nine out of ten hospitals have 24-hour CT reporting available.
- There are diverse levels of clinical staffing in place, which may have an impact on the delivery of care. Patient-level data will be essential in clarifying this.
- The implementation of clinical pathways for the care of patients undergoing emergency laparotomy varies widely across hospitals.

The first Patient Report of NELA is due to be published on 30 June 2015. Data was provided on over 20,000 patients in England and Wales. NELA compared each hospital’s provision of care against published standards. The standards of care cover the following elements of the care pathway and include:

- Timely review by a senior surgeon following admission.
- Ready availability of diagnostic investigations to aid clinical decision-making.
- A formal assessment of a patient’s risk of death to aid the consent process and identification of high-risk patients who will benefit from targeted care.
- A defined pathway of perioperative care.
- Prompt administration of antibiotics where there is evidence of sepsis.
The President’s Statement

- Timely access to an operating theatre.
- Surgery and anaesthesia performed under the direct care of consultants.
- Admission of patients at high risk of death and complications to a critical care unit after surgery.

The audit results provide each hospital with a breakdown of their own compliance with standards. Best performing centres are identified in order that good practice can be disseminated. It also allows hospitals to highlight those areas locally where improvements can be made.

Some hospitals were able to meet standards in over 80% of patients. Due to differences between hospitals’ service provision and infrastructure, there are unlikely to be generic solutions applicable to all hospitals.

A crisis of care

In 2014, the Lancet Commission on Global Surgery was convened to discuss the case for surgery as an integral component of health care within low- and middle-income countries (LMICS). The report, launched in the late spring, provides stark evidence of the number of people who lack access to basic surgical treatment, and the resultant effect on individuals and upon national economies. The research highlights that to achieve an improvement in access to surgical services, four essential areas must be addressed: health systems, workforce, data management and finance.

The future demands for the global healthcare workforce are just as challenging. Based on UN World Population Prospects, an additional 2.28 million specialist surgical, anaesthetic, and obstetric providers are needed worldwide to reach the optimum specialist surgical workforce density of 40 per 100,000 population by 2030. To meet this target, the present global surgical workforce would need to at least double in just 15 years.

The RCoA, through the work of the International Programmes department, is already active in driving forward change to improve global anaesthesia provision by 2030. The College has a multifaceted approach to this programme of work including:

- The sponsorship of doctors from developing countries who wish to train for two years in the UK via the Medical Training Initiative system, and subsequently take their skills back to their country of origin.
- Offering support for doctors in resource-poor countries in their achievement of postgraduate anaesthetic qualifications, both financially and through provision of training.
- By sharing RCoA educational standards with anaesthetists from developing countries, e.g. the Training the Trainers course for Iraqi Educational Supervisors, and providing on-going support.
- Providing access to sit the Primary FRCA Examination to any anaesthetist worldwide.
- Sharing of on-line educational resources, e.g. e-LA, via e-Integrity and the e-SAFE DVD.
- The development of Fellowships for UK trainees in resource-poor countries, who follow the specially designed unit of training within the anaesthetic CCT curriculum, enhancing the current and longer-term anaesthetic service and training needs for LMICS.

The College will continue to support the goals of the Commission on Global Surgery, and actively promote improved access to safe and effective anaesthesia to facilitate surgical care wherever and whenever it is required.

Because we’re worth it?

As 2015 progresses, there is increased clarity on the path towards delivering some aspects of the Shape of Training agenda. The Academy of Medical Royal Colleges rightly states that the objective of all medical training must be to produce doctors equipped in terms of their knowledge, capability, experience, attitudes and behaviour to meet the changing needs of the patient population, and with the flexibility to continue to meet those needs as they may evolve. We are, after all, training doctors for patients and not doctors for doctors! It is therefore incumbent upon Colleges and those who devise the curricula for postgraduate training to ensure that in reviewing future programmes they are mindful of future service requirements and the requirement for a more generic approach to basic and intermediate training with subspeciality training tailored to service need both in time and location. Over the next few months the Training Committee will be ‘shaping’ our response to the questions posed by the NHS Committee.

Executive summary

As I mentioned in my previous Bulletin statement, the last few months have been occupied by the search for a new CEO following Kevin Storey’s decision to retire after 14 years at the top. The College was pleased to receive over 30 applications for the post. After a three-stage sifting process, we short-listed four outstanding candidates for final interview. The panel recommended the appointment of Tom Grinyer, who I am delighted to welcome as our new CEO. Tom has worked at the Royal College of Physicians since 2010 where he is the Executive Director of Strategy, Communications and Policy. During 2013 he was Deputy and Interim Chief Executive; in this role he delivered the RCP budget for 2014, as well as leading in the development and delivery of a number of key RCP strategic aims. Tom has already been involved in the Council’s 2015 strategy meeting, and we look forward to him taking up post this month to lead our strengthened senior management team and to work with our newly elected President and College Council from September 2015.

Adieu

This will be my final President’s statement, as my term of office comes to an end in September. It has been a great pleasure and an enormous privilege to have served the College as President since 2012, and I offer my thanks to all those who have supported me in the role.
Pre-hospital emergency medicine (PHEM) training – the current scene

The origins of the delivery of UK-based pre-hospital care can be traced back to the 1950s when groups of enthusiastic GPs started to attend to victims of road traffic accidents. Through the 1960s, their endeavours became more formalised with the development of networks, and the introduction of flashing beacons on the roofs of their cars. These schemes were entirely voluntary, but by the 1970s a need for funding was identified and charitable organisations were conceived. Around this time, requests by ambulance crews for experienced doctors to attend an accident scene started to filter into A&E departments. The first national trainee starting in post in August 2012 in The East of England. Recruitment was initially led by the regional deaneries, but moved to a national system for those entering from August 2014. In this edition of the Bulletin, you will read a first-hand account of this new training scheme from Dr Birks and Major Chinery. It is clear they found the experience rewarding and ‘enriching,’ and one which has surely contributed to their professional development. However, for those considering or needing to advise individuals about embarking on a similar training pathway, it is probably timely to reflect on the national picture.

To successfully complete the PHEM sub-specialty training programme the equivalent of 12 months whole-time-equivalent (WTE) training must be completed. Trainees at ST4 level or above and coming from the parent specialties of emergency medicine, anaesthesia, acute and intensive care medicine are eligible to apply via the national recruitment process. For those entering from anaesthesia, there is a requirement to have completed a minimum of six-months emergency medicine prior to application. This can be problematic for those who have not come through the ACCS training pathway. In the East of England we have allowed several of our trainees to gain this requirement by taking an out-of-programme experience (OOPE). This however is not without difficulty, given that back-filling of vacant posts is now virtually impossible. Already extremely pressurised rotas are placed under further strain and this has potential to destabilise the training of peers. Even if this essential criterion is met, there is no guarantee of subsequently gaining a PHEM training place. Some trainees have become dispirited about the extension to their total training time with the only gain being service provision in the EM department.

Recently a suggestion of adding an additional requirement – of six-months acute medicine – has been mooted. This is not essential for those coming from anaesthesia at present, but would a one-year OOPE be acceptable to trainers? Would it not be preferable to at least have the assurance of an allocated PHEM training post prior to the requesting and granting of this ‘additional training’?

Included in the national person specification, in the desirable criteria, is prior clinical experience in PHEM and the completion of the Diploma of Immediate Medical Care, this being the first of the two assessment examinations (see later). Whilst all recruitment processes endeavour to seek out those with a real interest as opposed to those who just want to give it a try it seems strange to ask, as entry criteria, the outputs of the very same. Unique to PHEM, is the requirement to complete a fitness test.

There are currently eight approved training programmes based in England and Wales, which in the last recruitment round offered a total of 24 posts.
Training is delivered via one of three possible schemes:

**Scheme A** – a blending (split) of 12-months PHEM extended over a two-year period, with a proposed 20/80% divide with the parent specialty alternating at six-monthly intervals.

**Scheme B** – alternating six-months of PHEM with six-months of parent specialty training spread over a two-year period.

**Scheme C** – a full 12-months of PHEM.

Trainees who are successful in recruitment are asked to rank their preferences of the above schemes, omitting those they do not wish to consider. Given the complexities of perhaps trying to acquire higher/advanced training in additional subspecialty areas, together with the potential geographical constraints (taking into account the needs of possible partners and children) one can see that choices are limited. From the training programme director’s perspective, Scheme A is almost impossible to ‘sell’ to the receiving Trust. It is difficult to envisage how a department could deliver any real quality of training in 20% of the normal given time, and there is also the added burden of the out-of-hours’ rostering becoming extremely complex. Recent trainee feedback would support this view, and indicates that oscillating between two differing work environments is both difficult and distracting. As a result several programmes have now changed to a 50:50 split, but this only goes part way to addressing the problems. Of the 24 posts available, 14 are of the Scheme A type, but perhaps less widely known is that not all posts have equal access. Some have ‘limitations’ placed on them, and are only open to trainees from an emergency medicine background. Nine posts are badged in this manner with the given reason being the source of funding. So for an anaesthetic trainee wishing to avoid Scheme A this reduces the number of potentially available posts to eight. Thus training in some regions is not an option. Trainees are given 48 hours to accept or decline a post, with no ability to hold. If they respond negatively they are taken out of the process, whilst a positive response offers no opportunity to upgrade should a more suitable placement subsequently become available. One can now perhaps understand why trainers’ email inboxes start to fill around the time of PHEM recruitment with requests from trainees for career guidance.

Once in post, training is divided into three phases. The initial phase lasts for one-month WTE, with the trainee experiencing 100% direct consultant supervision. During this period they attend a one-week national induction course and complete the local induction processes. This is followed by Phase 2 (development) for five months WTE and finally Phase 3 (consolidation) for six-months WTE. The recommended average level of direct consultant supervision during Phases 2 and 3 is 20%. Whilst this appears a rather low supervision level, it is not surprising given that the majority of PHEM trainers are still providing their expertise outside of normal working hours, as few have job plans with allocated time for PHEM. As a consequence levels of supervision can be variable. The PHEM curriculum recommends that over the 12-month period a target number of 110 workplace based assessments (WPBA’s) should be completed. The indicative numbers are for 15 mini-CEXs, 30 ChDs, 30 DOPS, 10 SIM (full case simulations) and 25 ACATs. There is also a need to have completed five teaching observations and two MSF’s. This has proven difficult to achieve with the current supervision. Trainees are reporting a case load of between four to five per week with response to emergencies facilitated via various transport options including helicopters, road ambulances and equipped cars. Supervision levels may not be evenly distributed across these modalities, hence increasing the problem of getting WPBA’s signed off.

There are three formal assessment stages. The first occurs at the end of the first month and is known as Phase 1a. It is the equivalent of the anaesthetic initial assessment of competency, and is assessed locally with the objective of ensuring that the trainee is competent to progress to more comprehensive practice with a reduced level of supervision. After five months, WTE and towards the end of the development phase, the trainee is expected to sit the NSA 1 (National Summative Assessment) taken at the Royal College of Surgeons Edinburgh (RCSEd). If passed, it awards the Diploma in Immediate Medical Care. The NSA 2 is taken after 11 months WTE, towards the end of the consolidation phase. A pass provides the Fellowship in Immediate Medical Care and again is taken at the RCSEd. There are three elements to the fellowship exam: a knowledge test, an Objective Structured Practical Examination (OSPE) comprising 14 exam stations, and two full-immersion high-fidelity human simulations lasting 30 minutes. One can immediately understand the need for extensive manpower to run this assessment process exceeding candidate numbers and with significant cost implications. Limited funding streams are inevitable for new specialties and this can impinge in many areas. In our technology-
Guest Editorial

driven, world another prohibitive cost issue is the setting-up of an e-portfolio system to evidence training achievements. Some of the more senior trainers may however read this with a degree of relief!

With all hurdles successfully crossed, the trainee is conferred with PHEM as a sub-specialty accreditation against their GMC CCT entry. Current workforce estimates suggest the need for 200–250 full-time equivalent consultants in PHEM across the UK. When factoring-in the service needs of the base specialties, a more realistic workforce number is approximately 700. Given the present number of recognised training posts, the inability of current PHEM trainers to be awarded accreditation via a ‘grandfather clause’ and the GMC regulations that equivalence via article 14 does not as yet extend to sub-specialty training, one can see that for the foreseeable future PHEM will continue to be delivered in the main by non-PHEM accredited doctors.

This just leaves a few further issues for senior trainers to consider! From an anaesthetic perspective there may be a need to accommodate an out-of-region trainee who has been accepted onto Scheme A and has therefore been ‘parachuted’ into your training programme. This could include the need for an essentially less than full-time trainee to complete modules in recognised ‘pinch point’ specialties such as neuro and cardiac. Conversely, for trainees going out of region, there could be the requirement to provide an ARCP outcome for somebody who may not be based in your region for two years. The trainee retains the NTN in the region of their parent specialty. A trainee who fails to make satisfactory progress remains a challenge all round. How can further training be provided within the very limited number of training posts, especially if this issue is only identified at a late stage? It is for this reason that the PHEM trainers acknowledge that their preferred route of training is Scheme A. This, of course, provides both trainer and trainee with built-in additional time to correct any problems. As previously alluded to, there are recognised regional variations between the training schemes. This is not surprising given the disparity of the organisations involved and the differing ways in which these have been drawn together. There is a real need to quality-assure the training which they now provide. The problem is how to achieve this. Anonymous trainee feedback is difficult given the small numbers involved, and external review is complex with time and labour implications. The number of anaesthetists accepted onto the scheme is currently small standing at approximately four per year. However, as the majority of us are only too aware, just one trainee with difficulties can generate the same amount of work as ten others. In order to mitigate problems, it is therefore imperative that the requisite training programme directors work closely together, each keeping the other informed of the needs of the trainee.

In concluding, we need to recognise and congratulate the endeavours and progress made by those wanting to ensure a better training pathway for doctors willing to deliver (often voluntarily) care in some of the most challenging conditions. In doing so, however, we should not forget that we have a duty towards our own trainees to become engaged in the future decision-making processes of what is still an evolving sub-specialty.

References

1 British Association of Immediate Care (BASICS) (www.basics.org.uk).
2 Intercollegiate Board for Training in Pre-hospital Emergency Medicine (www.ibtphem.co.uk).
4 A career in pre-hospital emergency medicine. BMJ Careers, April 2013 (http://bmj.co/1RuKjLZ).
Implementing the feedback from the RCoA CPD and Revalidation Survey

Chris Kennedy, CPD and Revalidation Co-ordinator

In the previous edition of the Bulletin we gave an overview of the survey of the CPD and revalidation resources provided by the College which had been held during January and February 2015. The survey generated 718 responses, and the full report is now available in the Revalidation and CPD section of the College website. Many of the suggestions made in the survey responses have now been implemented, and this article provides further information on what has been done.

The majority of respondents to the survey were using the College CPD Online Diary, and 78.5% of them rated the system as ‘Excellent’ or ‘Good’. However, some respondents commented that they felt it was complicated to use, and so the user guidance has now been fully updated, including a special focus on the functionality available to set up and report on a Personal Development Plan within the system.

We receive a number of requests from users wishing to have an amended Cycle 1 start date (the date from which the doctor would like to start recording their CPD activities) in the CPD Online Diary. The system did initially allow for the user to amend this date although this caused some user concerns. For example, if the user had added and reflected upon some CPD activities during July 2013 (with a Cycle 1 start date of April 2013) but then wanted to change this date to August 2013, the system would not let them because of the activities which had already been added. The date can be quickly changed through by emailing cpd@rcoa.ac.uk and it is still possible to run a customised report in the CPD Online Diary over any date range; for example an 18-month period during which the doctor has taken a career break. The updated user guidance explains how this can be done.

At the time of the survey, only about a third of respondents had tried using the College CPD web app – although the majority of these rated it as ‘Excellent’ or ‘Good’. Since then, usage of the web app has increased significantly, and it now receives over 1,500 visits per month (a visit being defined as the next stage beyond selection of the ‘mobile/tablet option’, indicating active use of the system).

We would emphasise that the CPD web app is fully compatible with iPads and iPhones, Android devices and Windows Phones, and we have now further enhanced the user guidance for the system to include, as an example, how it can be accessed: it is not available in sites such as the ‘App Store’ or ‘Play Store,’ but instead should be accessed by the doctor selecting the login screen for the main CPD Online Diary via their mobile device and then saving it as a shortcut.

One section of the survey focused on the CPD Matrix, and 77.7% of respondents felt that there was value in providing information about specialty CPD in one place, and particularly for providing a broad taxonomy to classify and guide individual CPD, and for providing a guide for the doctor’s appraiser to assess their CPD requirements, particularly if the appraiser is from a different specialty. You can read elsewhere in this issue of the Bulletin how a new CPD Framework is going to be developed, in conjunction with the specialist societies and organisations, and further updates will follow in future editions.

Focusing on the Revalidation guidance provided by the College, we have now produced a summary Supporting Information Checklist which emphasises those aspects which need to be demonstrated each year, and those which are required once within the five-year revalidation cycle. This document has proved to be a very popular resource at recent College events, and it is available in the Revalidation and CPD section of the College website. Additional guidance has also been developed on how the deferral process works, and on revalidation for doctors working in different settings, both of which had been requested from a number of respondents to the survey.

The College Revalidation Helpdesk continues to receive a number of enquiries relating to returning to practice after a period of absence, and about collecting patient feedback. These issues are being discussed by two specialist working groups of the Academy of Medical Royal Colleges – a body which comprises the Medical Royal Colleges and Faculties across the UK and Ireland and which speaks on standards of care and medical education. The College is a member of the Academy working groups, and a full report will follow in the next edition of the Bulletin.

With most licensed doctors due to have been revalidated by the end of March 2016, the majority are now going through the process, and we hope that the above resources will assist with this. We would particularly invite you to explore using the CPD web app, and for further information about this, or about any of the CPD and revalidation resources produced by the College, please contact cpd@rcoa.ac.uk.
To hell in a hand cart?
Late score: politicians infinity: reality nil

Irene Dalton, Chair, Lay Committee

By the time this is published, we shall know the results of the general election and the new government will be making pronouncements on the way forward for the NHS. Well, it is done: ‘the people have spoken’, as they say, and it is for those who work in the NHS to get on with it for the next five years at least. Will a change or renewal of government make a difference?

Government?
And therein lies the problem with governments of whatever colour or rainbow coalition: they want to be re-elected, so always have to do something to try to distinguish themselves from the last lot, or move on from where they were the last time. To remain in power they have to get the people on their side, and this leads to at best (?) a bidding culture and at worst to kow-towing to the media, employing spin doctors, and – oh Lord! – ‘listening to the people’. I don’t know about you, but I shall vote (my civic duty and the privilege of living in a democracy), the result will be declared and I then expect whoever takes office to govern in the best interests of the country, not wriggle around to please the public (whoever they are), the press, and a fear of spoilt media darlings like Dimbleby (bossy and arrogant), Neil (sarmy and coy) and Paxman (bullying and blinkered) inter alia. ‘Wee men’, as we say in Scotland!

The health of the nation
The NHS is beyond doubt one of the glories of this country. I was born in 1943, so was five years old when it began. All my life I have benefited from care that I could not possibly have afforded if I had had to pay for it. But 2015 is not 1948. Good medical care has increased life expectancy, made pregnancy, (unless you are very unlucky) a safe and comfortable passage, and improved life greatly for those suffering from problems with joints, while modern diagnostic skills, assisted by technology, allow early and life-saving interventions. But are we a healthier nation when obesity, diabetes and dementia (partly due to increasing longevity) are rising so rapidly?

Intelligent anaesthesia (well done out there!) has made complex surgical procedures, talked of with awe in the fifties, routine. But is surgery always the best way forward, particularly with an ageing population?

If the applied sciences of medicine continue to develop at the current rate, it is conceivable that within fifty years the NHS could absorb almost all of this country’s income. Maybe it is time to call a halt – to determine what proportion of national income can be spent on healthcare, as is the case with the armed services and foreign aid – and for politicians to have the courage to set this out collectively (they probably won’t, though, vide above). Again, it is, in practice, over to you. How will you advise future governments to prioritise and maintain an NHS that we can afford without bankrupting the country?

Pressures
So, the big questions? Well, there is dealing with the morbidly obese and the consequences for them: diabetes, stress on joints, heart disease and other conditions well known to doctors, all these meaning the additional expense to the NHS of specialist equipment, additional risk management and time. There is the prolonging of life beyond any enjoyment of quality of life, including surgical interventions for very frail and elderly, even demented, patients just because it is possible and relatives find it hard to acknowledge when the time has come to call a halt to treatment. GPs are naturally reluctant to initiate discussions on DNR decisions in the aftermath of cases such as the Shipman scandal. The National Health Service has almost become the National Morbidity Service. Then there are ‘fashionable’ conditions, fuelled by very astute pressure groups whose access to politicians, because they are so well funded and therefore noisy, drive the agenda away from taking a balanced look at what should best be done towards what will be popular...
(or at least modify the screams) in the Daily Mail. Dementia was not popular until recently; now it has been added to the agenda but how long can the list be? What is being squeezed out by this populist approach to the overall management of the NHS? If you have too many priorities you have, in reality, no priorities.

**Muddled thinking**

My profession, education, has largely abandoned the debate about the purpose of education: with rare exceptions, it accepts the status quo and attempts to live within the targets, curriculum and organisational structures (strictures?) set from above. We have become rather boring. Worse, we have become the slaves of the system, and the higher the financial rewards and job security for conformity the harder it is for the slave to break free. This is dangerously close in the NHS, especially as top managers are better paid than top doctors and they hold most of the power while you do the work.

Politicians confuse purpose with process, so we can expect further restructuring and rhetoric. Setting targets, for example, can be a good thing, but targets should be aspirational and this is difficult when rival politicians and the newspapers who back one side or another come down in righteous wrath when a target slips, even in the most difficult circumstances. I was close to despair at the air-time given to A&E ‘missed’ targets during the worst winter months – what about all those grateful patients who had been seen within the time expected, and in fact, nobody was actually turned away or bled to death in reception! Most of the patients interviewed seemed to endorse my feelings that we should be grateful for what was done but that didn’t stop the BBC or the red-tops!

**Lets get real**

There has been much talk of poverty during this election campaign, but, despite all the fuss about who is and isn’t using food banks, it is pretty clear that as a nation we spend enough cash to eat and drink ourselves silly as well as significantly rotting our teeth. We are also able to spend a lot of money on activities which keep us tied to the sofa, the mobile phone or the games control. At some point, the question of how to address health education has to be dealt with at a national level, including personal responsibility for healthy living. It is no good just saying schools must do this: schools do and have done for years (rather well actually!) – but adults do not attend schools and external pressures on those of school age are not without significance. Surely HMG can accept some practical responsibility and consider (employ some whizzy IT games people, perhaps?) how health education can begin to reach the population at large – bearing in mind that education and information are two quite different things. But the rights vs responsibilities debate has been ditched in that Slough of Despond called political correctness.

As an old Roman said, (more or less) ‘Whatever madness possesses the generals, it is the poor bloody infantry that get it in the neck.’ Over to you. I wish you good fortune in managing whatever the future brings.

**L’envoi**

As this is my last article for the Bulletin, may I thank those of you who have had the patience to read my pieces. I am grateful to the College for four very interesting years as Chairman of the Lay Committee and for the support of Council, Senior Management and all the admin. staff with whom I have worked so positively. I have learned a lot.

I wish my successor, Rob Thompson, equal pleasure in the role he has accepted.
Guidelines for the Provision of Intensive Care Services (GPICS)

Undoubtedly the highlight of this year so far for FICM has been the publication jointly with ICS in April of the first edition of GPICS – Guidelines for the Provision of Intensive Care Services (GPICS). GPICS includes the Core Standards launched over a year ago and these documents define the standard against which services should be commissioned. The Faculty is indebted not only to the editors Gary Masterson and Simon Baudouin, but also to the authors who gave of their time and produced an impressive product in double quick time. GPICS is endorsed by 18 organisations representing the critical care multidisciplinary team.

Membership

The Faculty continues to grow, and over 2,000 people can now put FFICM after their names. We have welcomed the first ACCPs to associate membership and look forward to this group expanding.

<table>
<thead>
<tr>
<th>Membership category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Fellow (FFICM)</td>
<td>1,493</td>
</tr>
<tr>
<td>Fellow by Assessment (FFICM)</td>
<td>368</td>
</tr>
<tr>
<td>Fellow by Examination (FFICM)</td>
<td>220</td>
</tr>
<tr>
<td>Associate Fellow (AFICM)</td>
<td>50</td>
</tr>
<tr>
<td>Affiliate Fellow</td>
<td>29</td>
</tr>
<tr>
<td>Member (MFICM) (Career Grades)</td>
<td>16</td>
</tr>
<tr>
<td>Associate Members (ACCPs)</td>
<td>6</td>
</tr>
<tr>
<td>Trainee members (CCT)</td>
<td>412</td>
</tr>
<tr>
<td>Affiliate Trainees</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>2,630</td>
</tr>
</tbody>
</table>

FFICM Exam

The fifth sitting of the Fellowship of the Faculty of Intensive Care Medicine Final examination took place in January and March 2015.

During the preparations for the exam, examiners discussed and confirmed the standard for the exam. This was agreed to be ‘a doctor in training who is familiar with the syllabus and has done the necessary bookwork. They would clinically be at the level of a registrar who would be able to formulate a plan of care for a critically ill patient with appropriate consultant backup’. Passing the exam is a requirement of progression to ST7 of the intensive care medicine training programme, and the standard is set to reflect this.

47 candidates out of 74 (63.51%) passed the exam overall and achieved the Fellowship in Intensive Care Medicine. This compares with 65.5% in October 2014.

Recruitment

In April, approximately 230 candidates were interviewed as part of the ICM national recruitment. There are 137 posts, including five from Scotland – who are taking part in the national recruitment process for the first time. Offers have been sent to successful applicants, and fill rates are expected to be available at the end of May. This is a very big jump in training post numbers and is almost at the historical level of recruitment to consultant posts in ICM. Congratulations must go to RAs and TPDs for their efforts in increasing posts.

Shape of Training

The Shape of Training Steering Group statement issued on 17 February 2015 said that ‘Further work will be undertaken to describe how doctors’ training can be more generic, to better meet the current and future needs of patients. This will include a mapping exercise led by the Academy of Medical Royal Colleges and supported by the GMC, to look at the extent to which Colleges have or can develop the generic components of their curricula’.

In April the AoMRC set out the next steps scoping exercise, with each College and Faculty reviewing their curricula for elements that are applicable to more than one CCT programme and looking for potential areas for credentialing.

It is proposed that Colleges are formally invited to begin their internal scoping process in line with the agreed remit. Nominations will also be sought for the Panel to support the scoping exercise.

As set out in the paper, it is proposed to hold a seminar for College education leads as soon as possible and a further meeting at the end of the process.

Advanced Critical Care Practitioners (ACCPs)

The ACCP study day will take place on Friday, 3 July. The first edition of the curriculum for a Postgraduate Diploma/Masters level qualification in Advanced Critical Care Practice has been published. It has been informed by and aligned to the National Education and Competence Framework for Advanced Critical Care Practitioners (Department of Health, March 2008) and the Advanced Practice Toolkit for Scotland (Scottish Government, June 2008).

This curriculum is applicable to trainees entering training from August 2015. The Faculty will seek to approve ACCP curriculum training programmes, and work in collaboration with higher education institutions and clinical training centres.
As I open this report I am delighted to congratulate and welcome our new Board members Dr Ganesan Baranidharan, Dr Carol McCartney, Dr Jon McGhie and Dr Barry Miller. Congratulations also go to Dr Beverly Collett on the award of not only an OBE for her services to pain management, but also the British Pain Society Medal of Distinction. These are richly deserved, a huge accolade to Beverly personally and to pain medicine.

We also welcome Dr Rhian Lewis as a co-opted member of the Board to provide liaison with pain medicine in Wales.

In November we presented our Ask2Questions work (formerly known as the Complex Pain Project) in the House of Lords as an outcome of the Pain Summit of 2011. Ask2Questions identifies two simple, sensitive and specific questions for healthcare professionals to ask at the initial pain consultation which might identify potential long term pain problems, allowing this to be addressed proactively. The work is being piloted.

A major focus for us over recent months has been the Core Standards in Pain Management project. This is led by the Faculty, bringing together all professional organisations involved in pain management to produce standards and recommendation across all domains of delivery from primary to community to specialised to specialist care.

Coming together in this way has demonstrated commitment by all involved to the concept of multidisciplinary pain management. The value of all team members is without doubt, and the value of team members working together is unquestionable. We must however be aware of the unique values and the place of each of the professional groups in the team. To this end the FPM have produced a document: ‘Right patient, right professional, right time,’ which states that although many chronic pain patients can be managed in primary and community care, a complex cohort will need to be managed by pain medicine specialists, and referral to pain medicine specialists and their teams must happen, and happen in a timely way.

The FPM has also overseen ‘Opioid Aware’, again a multiprofessional project, but also strikingly ‘multi-agency’ and including NHS England. This advises on the use of opioids and aims to right the wrongs of the ever growing, worrying trends of opioid mismanagement and improper use.

Again from an educational perspective, work continues with Public Health England on the ‘Pain in Secure Environments’ educational initiative. Through this we are creating ‘transferable’ educational materials, in time to be used for the benefit of carers of other groups.

The FFPMRCA examination continues to build a quality profile. The most recent sitting was in April of this year.

Our undergraduate pain medicine initiative ‘Essential Pain Management-lite’ continues. We have had responses from a number of you involved in undergraduate teaching to which we are responding. The course has now been piloted in Bristol on four occasions, and shortly will be delivered to other medical schools.

The overseas Essential Pain Management courses, which are delivered as a joint project of the Faculty and the British Pain Society, supported by the RCoA, the AAGBI and the Australian and New Zealand College of Anaesthetists, have now run in Uganda, Malawi, Tanzania, Ethiopia and Sierra Leone, with good educational outcomes.

The ePain project is progressing. We now have 57 modules, and have appointed a new clinical lead for the project.

As always, I would like to thank the staff of the Faculty and others furthering the work of the Faculty for their ongoing dedication and commitment to pain medicine.
Teaching and training in the workplace – putting theory into practice

Laurence Boss, Anaesthetists as Educators Faculty, St Thomas’ Hospital, London
Alistair May, Educational Co-ordinator, Scottish Centre for Simulation and Clinical Human Factors (www.scschf.org)

This article is designed to help you reflect on past experiences and apply a combination of existing knowledge and new ideas, some of which have already been mentioned in this series of articles on postgraduate medical education.

In order to continue much further, we have to start with some basic assumptions about the motivation of those involved in the learning relationship. The first is that during your list you have the capacity and desire to teach, and correspondingly that the trainee has come to learn.

Learning can be described as a change in behaviour, and it is motivation that directs behaviour. Our role as teacher, is to influence this complex fusion of intrinsic desire and extrinsic incentives and barriers, so that deep learning can occur. As such, this article will attend to: acknowledging core values; considering the learning environment; building on past experiences; clarifying personal goals and matching these to appropriate assessments; and how to offer challenging but supportive deliberate practice.

What someone might say: ‘I teach already, what’s wrong with the way I do it?’

What someone might think after reading this article:
There is probably nothing wrong with what you are doing! Here is a framework that can help you maximise efficiency and the efficacy of the time you spend with trainees in theatre. If we help trainees to learn from more of their experiences, we can mitigate constraints such as reduced training hours and case exposure.

Paradigm shifts
It may be useful to consider the demographics of those who stand before, or sit beside us. Trainees will mainly be from the Generation Y demographic, having been born somewhere between the release of the original Sony Walkman and the launch of Google. Generation Y are linked via social media with a network of friends. Their core values include: free expression, creativity, close relationships with authority figures, work-life flexibility, and of course they use technology extensively.

Many trainers will be from Generation X, born after the post-World War II baby boom. This heterogeneous demographic are often described as highly educated, extremely anxious, family-orientated, materialistic slackers who graduated into a recession. They are tainted with disillusionment and eternal cynicism, struggling with the assumptions about the motivation of others. The challenge here is to utilise each other’s strengths, and identify strategies that support the learning relationship, whilst also accepting certain divergent behavioural characteristics.

Let us now consider the process of teaching and learning. In much the same way as our clinical discipline has evolved over the last century, the traditional views on education have made way for newer learning techniques. The ‘Ether Age’ of learning would advocate the Halsteadian apprenticeship model of ‘see one, do one’, where trainees are viewed as empty vessels to be filled with knowledge; if a trainee did not understand a concept or could not acquire a particular skill, it would be because they had failed to learn it rather than because we had failed to teach it well enough.

Moving into the ‘Desflurane Age’, trainees now demand more control over learning, preferring a self-directed, integrated approach centered around clinically relevant problems. Although this is seemingly at odds with ‘the way we were taught’, current trainees ascribe much less importance to learning pure facts related to the basic medical sciences.

What someone might overhear: ‘They spend a total of three days on basic science at medical school but then expect to be able to put a laparotomy on the table after two weeks of anaesthetics!’

What someone might think after reading this article:
To help our self-directed, problem-based Generation Y trainees, emphasis must be placed on deconstructing the ‘expert performance’. If the component parts of tasks are made explicit, relevant and digestible, they can be understood and applied, rather than just memorised and repeated.

Safe learning environment
With patients to see, drugs to draw up and over-booked lists to start on time,
creation of a physical, intellectual and psychological ‘space’ in which a trainee can learn, is tough. However, without paying some attention to the construction of a safe learning environment, learning will tend to be passive andocketed memorisation of isolated facts, i.e. surface learning; rather than learning that involves understanding, critical analysis, linking to known concepts and long-term retention of new information, i.e. deep learning.

Part of establishing this learning micro-culture involves setting the ‘rules of engagement’ which are all too frequently left implicit and assumed, and although problems are rare, much as in anaesthesia, assumptions can be a costly affair.

Clarifying when and how specific learning events will take place may seem like over-engineering, but it can actually help to reduce the stresses surrounding training expectations, divided responsibilities and clinical list management, not just for trainer and learner but also for other theatre staff, so that allowances can be made and anxieties alleviated.

The morning team briefing is an ideal forum to share your plans with the team, for example, who will be the lead anaesthetist for the second case, for example, who will be the lead anaesthetist for the second case, or which epidural the trainee will be attempting. Leading by example might even engender others to share similar useful organisational information.

**What someone might think:****  
“The trainee was doing slightly strange things and they didn’t seem to have an overall plan of their own”

**What someone might think after reading this article:**  
Trainees will often do things they are personally unfamiliar with because they think you want them to do it ‘your way’. Prior to any observation of clinical performance, clarifying each other’s roles and responsibilities will reduce the chances of confused boundaries. For example: ‘I’ll watch you perform this epidural. I’ll not intervene or comment unless I think there’s a risk to patient safety. Conduct the procedure as we have discussed. If I want you to stop at any point to take over the procedure, I will say ‘thank you for doing your bit, I will do my part of the procedure now’.

**Learning objectives**

This process starts with tailoring specific and achievable goals to meet the learning needs of the trainee and is enhanced by resisting making assumptions about what the trainee wants or needs from the teaching episode.

Although pure knowledge is commonly discussed in theatres, for example during the lead-up to exams, the clinical environment is where trainees can apply their knowledge to practice actually doing the job. Constructing a specific statement of achievement in the future tense at the beginning of a clinical encounter will make it easier to check that this learning has been accomplished at the end of the day. Useful starting phrases include: ‘Which aspects of this case would you find challenging to do for yourself?’ and ‘If this was your own list, what would you feel less confident with?’

**What someone might see:**  
A trainee not using the checklist and then seeing some of the key steps when performing an anaesthetic machine check.

**What someone might think after reading this article:**  
The trainee assumes that they are not allowed to use the checklist while you are watching, however the learning objective is: ‘be able to demonstrate a full anaesthetic machine check.’ For exams the objective includes ‘...without direct reference to the checklist’, but for actually doing the job, the checklist is appropriate and suggestive of a good understanding of safety.

**Facilitated learning**

Learners and teachers often focus attention on doing the practical procedure (Physical Act), however Kolb’s learning cycle’ suggests that learners should also direct time and energy to active reflection (Reflective Observation), focused consideration (Abstract Conceptualisation) and planning how they might do things differently next time (Active Experimentation). It is completing, and indeed repeating, this process that encourages deep learning. The role of the trainer is to facilitate navigation around Kolb’s learning cycle and offer developmental conversations directed towards attainment of expertise.

**What someone might think:**

‘I can’t for the life of me work out why they can’t get the tube in the right place. They are holding the laryngoscope properly and it all looks good, and then it’s in the oesophagus again!’

**What someone might think after reading this article:**

Bobby Robson maintained that ‘practice makes permanent’ and not perfect. Anders Ericsson’s model for Deliberate Practice6 also suggests that it is ‘practice with reflection’ which leads to expert performance or perfection.

**Direct observation**

Only surface learning is encouraged if we allow the trainee to simply regurgitate our technique without understanding the ‘what’ and the ‘why’. A more useful conversation to stimulate deep learning is first based upon ‘what’ the trainee actually did, or more importantly, *would* do if we were not in the room. Progressing on to the ‘why’ then takes you towards the learning opportunities.

Some might argue that being in the coffee-room while the trainee conducts the anaesthetic removes the entrenched behaviour of defaulting on decision-making. Although the true weight of responsibility may well only be felt when one feels solely accountable, so much more can be developed from direct observation.
If you, as trainer, have not actually seen physical events unfold, it’s incredibly difficult to conduct a developmental conversation with your trainee. You can only really know that the patient was anaesthetised and that now the case has finished. Anything in between is a mystery. You will not have witnessed any of the near misses, many of which will have also gone unnoticed by those present in theatre, including by the trainee themselves. All of these learning opportunities will have been lost.

What someone might say:
‘I’m leaving the trainee to learn from their mistakes, I’m not always going to be there when they’re on-call at night’.

What someone might think after reading this article:
Although there will always be some degree of observer bias with the trainer in the room, if you are not physically present during a case, you will have to make multiple assumptions about what happened. This makes it extremely difficult to have a useful conversation.

Frame-based feedback
The discussion you have with your trainee needs to be based upon observed facts and develop from trainee needs to be based upon reasons behind the actions. Teaching is then directed to matching actual learning needs.

Summary
This article is not an all-encompassing textbook on adult learning theory; it is designed to be the catalyst to consider and challenge what underpins teaching and learning in the workplace. In this article we have not separately considered the act of teaching professionalism, partly because professionalism is something primarily delivered by your actions and reactions in real time. It is also part of the ‘hidden curriculum’ for learners and is essentially a side effect of the education we provide. We can display professionalism in education by modelling our teaching and training on foundations that are appropriate for intelligent adult learners.

Summary Box
■ Put theory into practice: consider the way you teach with regard to efficacy and efficiency of learning.
■ Paradigm shift: your learners are intelligent adults like you, but they may be from a different generation.
■ Safe learning environment: learning on the job requires the construction of a ‘virtual classroom’ with its attendant boundaries and expectations.
■ Learning objectives: agreeing specific and explicit learning at the start of the day not only focuses the session but also gives you an opportunity to assess whether you have effectively taught the trainee.
■ Facilitated learning: learning is long lasting when the learner constructs it themselves, as you get more proficient at facilitation, efficiency will develop.
■ Direct observation: if nobody noticed it, no learning can come from it.
■ Frames based feedback: launching conversations based on observation rather than personal interpretation and judgment will lead to true development.

What someone might hear:
‘Sorry, I won’t do it like that again, I’ll do it your way next time’.

What someone might think after reading this article:
If you attach your own interpretation to an observed action, and then try to correct the assumed underlying behaviour, nine times out of ten you will get a defensive apology. If you ask a frames-based question, you should get an accurate diagnosis of the reasons behind the actions. Teaching is then directed to matching actual learning needs.

References
2 Read E. People Management: Myth-Busting Generation Y-Generational Differences at Work; Don’t Understand Your Younger Colleagues. Think They Have Different Work Attitudes to You 2007:63.
Introduction
Research and innovation drive improvements in healthcare and underpin audit and quality improvement. Improving the evidence base for all aspects of perioperative medicine should be a shared goal of healthcare professionals working in this area.

The founding partners of the National Institute of Academic Anaesthesia (NIAA) have recently agreed to support the formation of a UK Perioperative Clinical Trials Group (CTG) to develop and deliver world-class, multi-centre clinical trials in the UK. Core funding is coming from the four NIAA founding partners† and the Rosetrees Trust: a philanthropic family trust that supports medical research.¹

Why do we need better evidence to guide patient care?
The scale of adverse outcome following major surgery is of a magnitude that constitutes a global public health issue, and the care of patients undergoing major surgery is an area of substantial unmet healthcare need. Nearly a quarter of a billion patients undergo surgery worldwide each year. Assuming hospital mortality of 1%, major surgery is associated with around 2.5 million deaths worldwide each year, and complication rates are up to ten times this figure. Improvements in perioperative care may therefore have a substantial impact on public health, and the RCoA has responded to this challenge with the recent launch of the Perioperative Medicine Programme.² However, large-scale changes in healthcare policy and delivery should be underpinned by a robust evidence base, something that is relatively lacking in perioperative care. Comparison with medical specialties such as cardiology and oncology suggest that large clinical effectiveness trials remain the primary source of evidence. At present, very few large randomised controlled trials are conducted in anaesthesia and perioperative medicine, either in the UK or worldwide.

Why do we need a trials group in anaesthesia and perioperative medicine?
The principal obstacle to the successful completion of major trials is patient recruitment. In other specialties, national clinical trials groups have proved the most effective way to organise and coordinate the activities of investigators to ensure patient recruitment targets are met in a timely manner. In any large collaborative trial the skills, experience and contributions of individual investigators vary widely. Clinical trials groups allow the organisation of these many and varied contributors into effective collaborative teams with a shared focus on the wider objectives of the group, and a shared sense of ownership of successful projects. Experience from other clinical areas shows that the high rates of successful trial completion that result from such an approach generate confidence amongst major funding organisations, both in terms of trial design and trial feasibility. Over time, settled relationships with funders lead to high rates of funding success whilst the sense of ownership amongst grassroots clinicians promotes the speedy implementation of findings.

In recent years we have seen a significant increase in patient recruitment to large clinical studies of perioperative care. UK researchers have either led or made major contributions to several major multi-centre studies including POISE, VISION, ENIGMA II, EuSOS, OPTIMISE, ISOS RELIEF and METS. These successes demonstrate an enthusiasm to contribute to large-scale research projects in anaesthesia and perioperative medicine throughout the UK. The time is right to build on these collaborations through a national clinical trials group to ensure the UK plays a leading role in clinical research in our field.

What will the Clinical Trials Group do?
The role of the Director and the Executive Board will be to define the core aims and objectives of the CTG. The vision is to create an environment that allows anyone and everyone with an interest in perioperative care to make a contribution to clinical trials. By creating shared ownership of these projects, the CTG will promote engagement with the research itself and with the research findings. Hopefully, such an approach will also help to drive the implementation of positive findings. To achieve this we will need to be inclusive, creating meaningful...
roles for all members of the group. This will help to ensure that we recognise the role of individual CTG members, even though CTG projects will be large collaborations. The CTG will also build relationships with clinical trials units that have expertise in trial design and management, with major public research funders and with other trials groups in related specialties in the UK and internationally.

**What type of research question will the CTG focus on?**

The scope of the CTG will primarily be to support projects involving the recruitment of patients where the aim is to improve outcomes for patients undergoing surgical treatment. In general, this will not include research into surgical techniques except where there is a clear overlap with perioperative medicine. Similarly, clinical trials that fall clearly under the remit of intensive care medicine are already well served by the Intensive Care Foundation (ICF). It is likely that for such topics, the CTG will only engage when there is a clear perioperative medicine question to answer and, this will probably be undertaken collaboratively with the ICF and other relevant players. It is anticipated that the primary focus will be on large clinical trials enrolling 500+ patients but there will also be opportunities for some smaller studies to gain CTG support, especially if they are likely to translate into subsequent larger Phase II/III trials.

**How can I take part?**

The process of establishing the CTG is under way, and the first major task will be to appoint a Director and Executive Board that will then develop the framework by which the group will operate. Once this is in place, the CTG will begin the process of recruiting individual investigators. Key initiatives are likely to include an accredited local investigators scheme and an accredited principal investigators scheme. These schemes will provide training days and other resources to support and develop investigators in individual hospitals or training schemes. When established, investigators will be able to update their training once every two years in line with Good Clinical Practice for research guidance. We aim to recruit at least one hundred members to each scheme within two years of the CTG launch. In addition, the CTG will run a more intensive chief investigator training and mentorship programme for a small number of talented individuals who wish to lead their own clinical trials.

**When will this happen?**

The role of CTG Director was advertised in February, and will be interviewed for and appointed to in June 2015. This appointment will be followed by recruitment of the CTG Executive Board members. Following this, we will actively seek applications for CTG membership in the various categories, leading up to a formal launch in spring 2016. The selection of the first ‘pathfinder’ studies will begin by the end of 2015. The first job of the Director and Board will be to establish the transparent and open processes and governance that will underpin the identification, selection and development of high quality candidate studies.

**Watch this space**

Regular updates on progress with the CTG will be posted on the NIAA website at: [http://bit.ly/1HKuWKJ](http://bit.ly/1HKuWKJ). Please share your contact details with us if you wish to express interest in joining the CTG. The CTG offers a massive opportunity to transform the clinical trial research landscape within our specialty. Most importantly, it brings the promise of practice changing perioperative research for patient benefit.

---

**References**

1. The Rosetrees Trust ([www.rosetreestrust.co.uk](http://www.rosetreestrust.co.uk)) (accessed 27 April 2015).
3. The Intensive Care Foundation ([www.ics.ac.uk/icf](http://www.ics.ac.uk/icf)) (accessed 27 April 2015).
Many of you will have contributed to the first Sprint National Anaesthesia Project or SNAP-1, which was an observational study of patient reported outcomes from anaesthesia. By a number of different metrics, this has been a great success, so we are now looking forward to SNAP-2 – and hopefully beyond.

What are SNAPs?
The general principle of SNAPs is that they are short ‘snap-shot’ studies of a common, patient-centred issue, which are firmly focused on improving the quality of patient care. They are research studies (rather than audits or service evaluations) and are delivered under the governance of the National Institute of Academic Anaesthesia’s Health Services Research Centre (NIAA HSRC) and are sponsored by the chief investigator’s own NHS Trust or University. A critical enabler of the SNAPs is the Quality Audit and Research Coordinator (QuARC) network, which was established to help engage local clinicians across the UK in health services research and quality improvement. A key principle of SNAPs is the facilitation of trainee-led and delivered research: thus SNAP-1 had a trainee lead (Ellie Walker) and we actively sought the participation of trainees across the UK as local investigators. SNAP-1 used validated measures to understand the epidemiology of patient-centred outcomes: anaesthesia related discomfort, patient satisfaction with anaesthesia care, and accidental awareness under general anaesthesia (AAGA). These topics were chosen as they provided the latest chapters in two programmes of work carried out under the auspices of the NIAA’s HSRC: a patient satisfaction measures programme, which began with a systematic review of all available patient satisfaction measures, and the 5th National Audit Project (NAP5) programme of work on advancing knowledge around AAGA.

SNAP-1: the story so far
We were overwhelmed by the engagement of the profession in SNAP-1. The study recruited adult patients undergoing non-obstetric procedures on 13 and 14 May 2014. Participation came from 171 separate NHS Trusts and Health Boards covering over 220 hospitals in all four devolved nations. Over 1,400 investigators were registered, of whom nearly 900 were trainees or medical students. The study collected demographic data on over 16,000 patients and postoperative outcome data on over 15,000: this is considerably larger than any previously published study of patient reported outcomes from anaesthesia. We are hugely grateful to the patients who took the time to complete the questionnaires; the response rate of over 92% is testimony to them and to the extraordinary efforts which local investigators went to in order to collect as much data as possible. The level of engagement was tangible to those of us on the central delivery team. We really enjoyed making contact with our colleagues all the way from NHS Orkney (total number of hospital beds: 48) and Shetland (78 beds), through to the behemoths of the capital cities, and all the way out to Truro in Cornwall. There was huge positivity amongst the local and lead investigators at each site all the way through the conduct of the study, which was reflected in the feedback given through our post-study investigator survey.

As the study was supported by a grant administered by the NIAA, provided by the RCoA, and by the University College London Hospital’s National Institute for Health Research (NIHR) Biomedical Research Centre, SNAP-1 was adopted onto the NIHR portfolio. Furthermore, as it was a consenting research study (patient consent assumed on the basis of completing postoperative questionnaires), each patient recruited into SNAP-1 counted towards each participating trust’s target for patient accruals into research studies, established with the NIHR. This meant that each participating trust was able to use the patient recruitment rates into this study to support its case for future funding from the NIHR to support delivering national research at local level. SNAP-1 was, to our knowledge, the highest recruiting anaesthesia study requiring patient consent in the history of the NIHR portfolio. As it was such a high recruiting study, we hope that it will have made a significant contribution to local research capability for other future studies. This level of patient recruitment was only possible due to the huge effort put in at local level by each and every investigator, and also to the great co-ordination led centrally by Ellie Walker and Maddy Bell (née Humphrey).
The first manuscript (the study protocol) was published by the journal, Perioperative Medicine in April, and all collaborators were listed in an appendix; the collaborators’ names will be added to Pubmed, although this may take a little time owing to the number of contributors. Ellie is working hard on the main manuscripts, and an initial results paper will hopefully be submitted to journals for peer review in July; our hope is that some results manuscripts will be published before the end of 2015, but we will have to wait and see how the reviewers respond! Our preliminary look at the results (shared with some QuARCs at their annual meeting in March) demonstrates the value of these data: we now have important (and sometimes surprising) information about the prevalence of different types of anaesthesia-related discomfort in different types of surgery, which will generate important benchmarking targets, and contribute to the literature which we provide to patients about what to expect in the perioperative period.

SNAP-2: EPIdemiology of Critical Care after Surgery (EPICCS)

So, now to start planning for SNAP-2. This study is again being supported by the NIAA, RCoA and specifically by the AAGBI through a project grant awarded in December 2014. EPICCS will focus on decision-making regarding postoperative critical care admission. We already know from a number of high-profile epidemiological studies that many patients who die soon after surgery do not receive critical care support during their surgical episode. However, the reasons for this are unclear: is it lack of resources, lack of appropriate risk-stratification by clinicians, or the fact that there may still be equipoise over the benefit of immediate postoperative critical care admission in some settings? Despite this possible equipoise, there may also be uncertainty over the ethics and feasibility of undertaking a randomised controlled trial of postoperative critical care admission as a treatment strategy; therefore, a major part of EPICCS will also be an attempt to determine the benefit (or otherwise) of postoperative critical care admission, by using two relatively novel statistical methods which can be applied to cohort studies: Instrumental Variable Analysis and Propensity Score Matching. This will be an exciting study and one which we hope will substantially contribute to the debate over perioperative resource utilisation and how we can provide best care for our high-risk patients. We are currently seeking a trainee-lead for this study and they should be appointed by the time this article is published. We look forward to working with them and with the wider anaesthetic community on delivering another SNAP.

SNAP-3 and beyond…?

On some levels, SNAP-1 may already be viewed as a success in terms of supporting research endeavours in a large number of hospitals (many of which do not consider themselves to be ‘academic’) and in terms of professional engagement and patient recruitment. The hard work of getting manuscripts published is far from over, and successful publication in a good quality journal remains an important goal. However, our aspiration is that the SNAPs should continue, and will hopefully become a ‘brand’ which is as recognisable as the ‘NAPs’. Importantly, we hope that SNAP-3 and beyond will open up further opportunities for the profession: for example, through enabling open invitations to suggest future topics, and through supporting new chief investigators and new trainee-leads for every successive SNAP. We hope
2015 and ACSA

Carly Melbourne, RCoA Quality and Safety Manager

The College’s Anaesthesia Clinical Services Accreditation (ACSA) scheme was launched in June 2013, and since then we have jumped ahead by leaps and bounds. Firstly, for those who have not come across ACSA before, it is a voluntary peer-review scheme to enhance quality improvement. It has been developed by the College’s Quality Management of Service Group (QMSG) and the Clinical Quality Directorate. It is not an ‘inspection’, but a national benchmarking process to enable anaesthetic departments to self-assess against the ACSA standards and apply quality improvement measures.

I encourage you to visit our new ACSA website, which offers a user friendly insight into everything ACSA! Including the new 2015 ACSA standards (www.rcoa.ac.uk/acsa).

The process begins with a local department collectively deciding to partake in the ACSA scheme. This is usually initiated by a few enthusiasts, but ultimately requires broad buy-in. Once contact is made with the College and engagement with the process established, the self-assessment and gap-analysis begin. During this time the department will have access to a College-appointed Guide, as well as regular contact with the ACSA team to discuss specific ACSA standards. During their gap-analysis, a department may find it useful to contact other accredited departments regarding particular areas of good practice, and the College will assist with this by referring to our Good Practice Library.

The Good Practice Library is a resource available to all ACSA-engaged departments, which highlights particular areas where exceptional processes, procedures or techniques have been successfully applied elsewhere in the UK. It is a resource that will improve communication and sharing of information nationally will be a benefit to departments signed up to ACSA. Once the department has confirmed they are ready for a review, a visit will be organised and carried out by an ACSA-Review Team. A report will be produced, with QMSG making the final decision for accreditation.

In October 2014, ACSA accredited our first anaesthetic department at the Homerton Hospital, quickly followed by Harrogate Hospital and West Suffolk Hospital in April 2015. For 2015 so far we have confirmed dates for 12 other departments to be visited with a total of 56 departments engaged in the process. The College is pleased with the uptake.

ACSA standards are born from the Guidelines for the Provision of Anaesthetic Services (GPAS) document which is reviewed yearly. ACSA standards are therefore also updated annually following the revised GPAS version. ACSA standards 2015 were published on 20th April 2015. No new standard will become a Priority One (essential) but will be introduced as a Priority Two for the first year, with the possibility of moving up into a Priority One the following year. This is to ensure accredited departments are not left unable to meet the year’s revised standards.

Upcoming events

ACSA will be exhibiting at the following meeting(s):

Annual Scientific Meeting – NASGBI 50th Anniversary
Date: 7–8 May 2015
Location: Manchester

College Tutors Meeting
Date: 11–12 June 2015
Location: Nottingham

Steps of ACSA
ACSA Engaged Departments
Date: 21 September 2015
Location: RCoA, London

ACSA/ART Reviewers Training Day
Date: 29 October 2015
Location: RCoA, London

Patient Safety Conference
Date: 4 November 2015
Location: Thinktank, Birmingham

Please contact our ACSA office via acsa@rcoa.ac.uk or 020 7092 1697 for further information.

The Clinical Quality Directorate (CQD) at the College encompasses all aspects relating to professional standards, quality improvement and safety in anaesthesia.

ACSA
Anaesthesia Clinical Services Accreditation
ACSA is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review. It is recognised by the Care Quality Commission.

To become a ACSA Reviewer, please contact:
020 7092 1697
ACSA@rcoa.ac.uk
www.rcoa.ac.uk/acsa

AAC
Advisory Appointments Committee
- An AAC is a legally constituted interview panel used when appointing consultants. Its remit is to make a recommendation to the employing body.
- We receive approximately 300–400 AAC requests a year.

To become an AAC Assessor, please contact:
020 7092 1571
AAC@rcoa.ac.uk
www.rcoa.ac.uk/aac

ART
(Anaesthesia Review Team) Invited Reviews
- The ART is offered to trusts/boards who would benefit from an independent professional opinion and recommendations to improve their anaesthesia services or to assist doctors in trouble.
- We welcome anaesthetists who feel they can provide their expert professional help to these trusts/boards.

To become an ART Reviewer, please contact:
020 7092 1571
ART@rcoa.ac.uk
www.rcoa.ac.uk/art

CPD
Continuing Professional Development
- The College expects doctors to complete at least 50 hours of CPD per year. This can include attending meetings organised by national bodies and specialist societies.
- We receive over 700 applications for CPD event approval each year and welcome doctors interested in acting as a CPD Assessor to review these events.

To become a CPD Assessor, please contact:
020 7092 1729
CPD@rcoa.ac.uk
www.rcoa.ac.uk/revalidation-cpd

If you would like further information on the department in general, please contact: clinicalquality@rcoa.ac.uk or visit www.rcoa.ac.uk/clinical-standards-quality.
Updates to NAP5: Anaesthesia Awareness Support Pack

As readers will by now know, the 5th National Audit Project (NAP5) was completed and launched in September 2014. There were two core meetings held at the Royal Society of Medicine: a launch to the profession followed by a public meeting that was coupled with a public engagement exercise funded by the Wellcome Trust. Dr Andrew Morley, a consultant at Guy’s and St Thomas’ NHS Trust, led a collaboration with musicians and the poet Ruth Padel to create an artistic piece on ‘consciousness’ that has since also been performed at the Oxford Science Festival and the University of Birmingham.

Jaideep J Pandit
Consultant Anaesthetist, Oxford, Fellow of St John’s College, Associate Professor Oxford University, Clinical Lead, NAP5 2011–2014

Tim Cook
Consultant Anaesthetist, Bath, Director of National Audit Projects, RCoA

The report itself was summarised in three key papers, jointly published in *Anaesthesia* and the *British Journal of Anaesthesia*, and in close proximity were the related papers from Ireland and the Activity Survey. In the same month, the AAGBI Annual General Meeting devoted a session to NAP5, and subsequent RCoA CPD days have aired the topic. Internationally, the NAP5 panel has delivered lectures in Europe, Japan, Australia and the United States. Media interest has been impressive with almost 500 articles and broadcasts, encompassing all the major UK newspapers, BBC and regional radio, radio interviews in Ireland, Germany and the US, and international papers such as the New York Times and Le Figaro.

Yet there is much work to do. The report made 64 recommendations for practice and over 100 suggestions for research. We anticipate that many departments will already have made a start on implementing those recommendations which are locally relevant. To supplement local action the Safe Anaesthesia Liaison Group (SALG) are soon to produce additional advice on implementation. The research recommendations have been noted by national bodies, and some have become a research priority for grants offered by the AAGBI via the NIAA. The purpose of this article is to highlight an aspect of NAP5 of which readers might be unaware, namely the resources available on the website (www.nationalauditprojects.org.uk/NAP5home).

For anyone planning further audits or studies, these resources include all the questionnaires used in the Baseline Surveys, the templates for data collection forms for both the prospective phase of NAP5 and the Activity Survey, and the supporting information provided to Local Co-ordinators. We have also added a section for patients and carers to the NAP5 website (www.nap5.org.uk/for-patients) which includes patient-specific summaries and updated patient information about awareness. Perhaps most importantly is the development of the self-contained ‘Anaesthesia Awareness Support Pack’. Although the information contained in this pack was already embedded in the NAP5 Report, this document brings together the key items in easy-to-download formats. It addresses the particular need (identified in the Baseline Survey) that few if any UK hospitals had a specific policy to manage a case of Accidental Awareness during General Anaesthesia (AAGA). Furthermore, a standardised pathway to offer psychological support to patients who had experienced AAGA was lacking. The key ingredients of psychological support include listening to the patient at the Meeting stage, and accepting the patient story as a genuine experience. Analysis involves seeking the cause of awareness, including checking the patient story with staff and medical records, describing the episode according to the templates developed by NAP5, and ideally obtaining an independent opinion. This last can be obtained from any source (ideally external to the hospital), and NAP5 panellists are prepared (albeit not exclusively) to assist if necessary. Then, follow-up and early support are recommended, with psychological/psychiatric input where the symptoms meet...
NAP5 Awareness Support Pathway for AAGA (more detail available on the NAP5 website at: www.nationalauditprojects.org.uk/NAP5-anaesthesia-awareness-pathway)

Screenshots from the NAP5 app which will soon be released

certain criteria. At all stages, results and outputs of the process can be documented in a standardised manner as outlined in the pack.

Another item is the soon-to-be released ‘NAP5 app’, which will be available on both Apple and android formats. This app will provide a ‘pocket size’ summary of NAP5 and links to more detailed information. We hope to launch the app later in 2015.

For those who have not yet had the chance to read the NAP5 Report or papers, we urge them to do so soon. There is much within them that will help – and even change – the current routine practice of many. We anticipate that in the coming months there will be further articles highlighting issues addressed by NAP5. We anticipate that other articles will focus on areas perhaps overshadowed by the main aspect of interest (i.e. awareness and its impact). These include issues related to sedation, consent and medico-legal issues (for example, in the light of the recent Montgomery ruling).8 Watch this space – and watch the NAP5 website!

References

1 Cook TM et al. 5th National Audit Project (NAP5) on accidental awareness during general anaesthesia: patient experiences, human factors, sedation, consent, and medico-legal issues. BJA 2014;113:560–574.

2 Pandit JJ et al. 5th National Audit Project (NAP5) on accidental awareness during general anaesthesia: summary of main findings and risk factors. BJA 2014;113:549–559.

3 Pandit JJ et al. 5th National Audit Project (NAP5) on accidental awareness during general anaesthesia: protocol, methods, and analysis of data. BJA 2014;113:540–548.


5 Jonker WR et al. A national survey (NAP5-Ireland Baseline) to estimate an annual incidence of accidental awareness during general anaesthesia as known to anaesthetists. Anaesth 2014;69:969–976.


Methoxyflurane may be returning to the UK

Les Gordon, Consultant Anaesthetist, University Hospitals of Morecambe Bay Trust; Team Doctor, Langdale Ambleside Mountain Rescue Team

Methoxyflurane has a very low SVP (23 mm Hg at 20°C) and high blood and lipid solubility. Although potent (MAC 0.16% in a 40-year-old), induction of anaesthesia was extremely slow, even with a vaporiser delivering ten-times MAC. The large tissue reservoir led to prolonged recovery. Methoxyflurane has analgesic properties and was used during labour and other painful procedures. By today’s standards, it is not a clean drug; 50–70% undergoes hepatic biotransformation. Because of the large tissue reservoir, metabolites may be detectable >1 week after exposure. The drug can be hepatotoxic if used repeatedly, even in analgesic doses, and trigger malignant hyperpyrexia (MH). If present in sufficient quantities, the combination of two metabolites, fluoride and dichloroacetic acid, can cause potentially irreversible renal failure in adults. Anaesthetists were therefore advised to restrict exposure to ≤2 MAC-Hours to ensure metabolite levels remained below the nephrotoxic threshold. By about 1980, the more favourable profiles of enflurane and isoflurane led to methoxyflurane being abandoned except in Australia and New Zealand where it is still used as an inhalational analgesic in military and prehospital care and in hospital and dental practice for procedural sedation.

Methoxyflurane may soon be given a UK license for inhalational analgesia. There are potential ethical issues about using a non-essential drug that persists in tissues and undergoes extensive biotransformation. Nevertheless, there is pressure to reinstate it. This appears to be coming from doctors in Emergency and Prehospital Medicine seeking an alternative to Entonox, and from commercial interests. Methoxyflurane is manufactured by Medical Developments International, Australia. The Company intends to introduce the drug (trade name: Penthrox) to new international markets, facilitated by developing a ‘world class Regulatory Dossier’. By 2013, the drug had been registered in 12 countries and applications made in several more including the UK. Application to the USA will follow after European approval has been granted. Galen Ltd (Northern Ireland) now has exclusive marketing and distribution rights in the UK and Ireland, thereby providing access to the Western European market.

Penthrox is supplied in 3 ml bottles and self-administered by the patient from a single-use inhaler in concentrations from 0.2–0.7%. Drug vaporisation occurs on inhalation. An activated charcoal filter can be attached to reduce environmental contamination from exhaled breath. This will be effective so long as the patient exhales through the device. Current prescribing information limits daily and weekly usage. Nevertheless, a case of hepatitis has occurred after repeated exposure. Official literature lists about a dozen contraindications and cautions including history of MH or hepatitis, renal disease, concurrent use of hepatic enzyme-inducing drugs (risk of increased metabolite levels) or drugs like tetracyclines (nephrotoxic combination), head injury and the elderly. Additional contraindications should include children under five years (risk of excessive sedation) and renal transplant. Several adverse reactions to Penthrox are listed on the Australian Database of Adverse Event Notifications. Methoxyflurane has some advantages over Entonox. The small light-weight equipment can be used in some situations where Entonox cannot e.g. pneumothorax or when ambient temperature is <0°C, although at that temperature, the SVP is ≤6 mm Hg so it is unclear whether there will be sufficient vapour.

Anaesthetists may encounter Penthrox in prehospital situations or the Emergency Department. Hospital anaesthetists need to know whether, given the tissue reservoir, there are any anaesthetic implications if a patient who has received methoxyflurane presents for surgery later the same day. For example, as fluoride levels are much higher after sevoflurane than isoflurane, it might be preferable to use the latter in such patients. If the patient is subsequently admitted to intensive care, it would be appropriate to monitor renal function and apply greater caution before administering nephrotoxic drugs. Finally, data is needed on any potential interactions between methoxyflurane and drugs, particularly those that were not available 30 years ago – www.drugs.com lists 291; 42 are categorised as major.
Should the NHS WHO surgical safety checklist be updated?

Lisa Grimes
CT3 ACCS Anaesthesia, West Suffolk Hospital, Bury St Edmunds

Daniel Stubbs
CT3 ACCS Anaesthesia, West Suffolk Hospital, Bury St Edmunds

Nicholas Levy
Consultant in Anaesthesia and Acute Pain Medicine, West Suffolk Hospital, Bury St Edmunds
nicholas.levy@wsh.nhs.uk

Surgery forms a key part of the management of various conditions, with millions of people worldwide undergoing surgical procedures each year. However, as well as delivering benefit, surgery may cause harm, and the World Health Organisation (WHO) estimates that, each year, half a million preventable deaths related to surgery occur globally. In England and Wales, over 100,000 incidents relating to surgery, including 271 deaths, were reported to the National Reporting and Learning Service in 2007.

It is now recognised that human factors and system failures play a key role in errors in surgery and anaesthesia. Thus, the WHO launched the ‘Surgical Safety Checklist’ as part of the ‘Safe Surgery Saves Lives’ campaign in 2008. The checklist itself was developed by an international team of experts led by Dr Atul Gawande at Harvard medical school. Checklists had been developed by the aviation industry to help standardize procedures and mitigate human error on the safe operation of aircraft. The Harvard team drew lessons from the aviation industry in the development of the Surgical Safety Checklist.

Pilot studies in eight centres across the globe, including those in high-income settings and low-to-middle income settings, demonstrated that correct implementation of the checklist reduced the complications and mortality associated with a variety of surgical procedures, with the death rate falling from 1.5% to 0.8% (p=0.003), and the inpatient complication rate falling from 11% to 7% (p<0.001).

The WHO surgical safety checklist implemented simple evidence-based interventions in an attempt to improve patient care. These interventions included positive identification of patient and correct site of surgery, specific anaesthetic and surgical concerns and procedures designed to improve communication.

Pilot studies in eight centres across the globe, including those in high-income settings and low-to-middle income settings, demonstrated that correct implementation of the checklist reduced the complications and mortality associated with a variety of surgical procedures, with the death rate falling from 1.5% to 0.8% (p=0.003), and the inpatient complication rate falling from 11% to 7% (p<0.001). The improvement is likely to be multifactorial, however, ensuing studies have confirmed the improvement in patient safety since introducing the checklist. Furthermore, subsequent retrospective studies (thereby mitigating any Hawthorne effect) have also demonstrated a significant reduction in mortality after introduction of the WHO checklist.

In January 2009 the National Patient Safety Agency (NPSA) in England and Wales issued a Patient Safety Alert requiring all NHS organisations to implement the WHO Surgical Safety Checklist for every patient undergoing a surgical procedure.

The existing checklist

The current NHS WHO surgical safety checklist incorporates three sections; ‘sign in’, ‘time out’ and ‘sign out’ (http://bit.ly/1DPIb7j). The ‘sign in’ is done upon arrival of the patient in the anaesthetic room/theatre prior to induction of anaesthesia. The ‘time out’ is done just prior to the start of surgery, and the ‘sign out’ is done before any member of the team leaves the operating room.

Adapting the current checklist following new national recommendations

Trusts and hospitals can adapt and modify the checklist via local clinical governance procedures. The implementation of the national checklist published in 2009 has contributed to an increase in awareness of patient safety, and there are a number of new recommendations and safety alerts which should now be considered for national inclusion. These include:

- The use of a preoperative team briefing.
- Ensuring that the blood transfusion laboratory has at least two group and screen samples to ensure that ABO compatible blood can be issued.
- Prevention of accidental awareness under anaesthesia.
- Reducing surgical site infection and prevention of intraoperative hypoglycaemia by maintenance of optimal glycaemic control.

CONFLICT OF INTEREST

Dr N Levy is an author of the NHS Diabetes guidelines on the perioperative management of the surgical patient with diabetes, as well as the RCoA representative to the VTE prevention board of NHS England.
■ Prevention of wrong-site block.
■ Flushing of residual anaesthetic drugs from intravenous cannulae.

By subtle modification, rearrangement of, and some minor additions to the current questions within the WHO checklist, many of these concepts and others could be incorporated into the checklist without arduously extending the length of current checks, and thus helping to guard against ‘checklist fatigue’.7

This article will now discuss these potential alterations.

The use of preoperative team briefing (‘the huddle’)

In 2010 the National Patient Safety Agency (NPSA) produced a guide on the effective implementation of the WHO NHS checklist, adding a team briefing prior to the use of the checklist. Studies have shown that when a briefing is used alongside the checklist, there is an improvement in patient safety and team performance, as well as a reduction in delays and a smoother running of lists.8,9 The team briefing should occur prior to commencing the theatre list, and enables the theatre team to discuss potential and actual safety issues as well as key concerns. Availability of the right equipment is also confirmed.

Prevention of ABO incompatibility and Prevention of inappropriate use of O negative blood products

In 2012, the British Committee for Standards in Haematology (BCSH) stated that it is a requirement for all blood transfusion laboratories to compare the ABO group obtained with a historical ‘Group and Screen’ sample to reduce the risk posed by blood bottle labeling errors.10 A local audit at our institution in elective and emergency patients showed that over 25% of patients at risk of requiring cross-matched blood did not have two valid Group and Screen samples prior to their surgery, and thus the laboratory would be unable to release cross matched blood if required.11 It is therefore argued that the theatre team should ensure that the laboratory has both the necessary samples prior to induction, and that the most logical time to check this is at the preoperative team briefing.

Discussing potential for major blood loss at team briefing, and agreeing appropriate strategies

In order to minimise the need for homologous blood transfusion, many guidelines suggest the use of cell salvage.11 It is argued that the need for cell salvage is best discussed at the team briefing rather than ‘sign in’, to ensure that the necessary personnel and equipment are available.

Discussing venous thromboembolism (VTE) prophylaxis at the ‘sign in’, instead of at ‘time out’

NICE guidelines suggest that VTE prophylaxis (both chemical and mechanical) should be offered to patients at risk of VTE9 and who do not have contraindications. In the present NHS WHO checklist this is discussed at ‘time out’, once the patient is anaesthetized and fully draped and positioned. It can be argued that this is too late to assess VTE risk and apply mechanical prophylaxis if indicated. Likewise, if the anaesthetist is considering central neuro-axial blockade, it would be useful for the anaesthetist to know whether chemical prophylaxis has been recently administered. Thus, we believe that VTE prophylaxis should be discussed at ‘sign in’.

Prevention of accidental awareness under general anaesthesia (AAGA)

In 2014, the 5th National Audit Project of the RCoA and AAGBI (NAP5) was published. The report recommended that key questions to help minimise the risk of awareness should be incorporated into the WHO checklist.14 The report highlighted two potential causes of awareness that could be minimised. Firstly by ensuring that adequate anaesthesia/amnesia was being administered after transfer from the anaesthetic room, and secondly by ensuring that adequate surgical anaesthesia was being provided before ‘knife to skin’.

The authors of NAP5 propose an ‘Anaesthetic (sub)checklist’ as part of the WHO checklist which would aim to ensure, not only prior to the start of surgery but after transfers and the end of cases, that there was an ongoing anaesthetic plan, available anaesthetic and emergency drugs and effective team communication.15

Reducing surgical site infection caused by hyperglycaemia and prevention of intraoperative hypoglycaemia by maintenance of optimal glycaemic control

The initial NHS checklist just asked whether glycaemic control had been undertaken to minimise surgical site infection. In the light of national guidelines16 and the results of trials such as ‘NICE-SUGAR’17 this is potentially too vague and, instead, a target blood-sugar range should be incorporated into the ‘sign in’ section to encourage measurement of blood sugar in the immediate preoperative period, and to prioritise its intraoperative control. The ‘NICE-SUGAR’ trial demonstrated that a target range of 6–10mmol/L in surgical and medical ICU patients minimized episodes of hypoglycemia with no significant decline in outcome when a target of <10mmol/L was compared against a target of 4–6mmol/L. It therefore seems logical to adopt a similar target intraoperatively.18

Prevention of wrong-site block

Wrong-site block is an ongoing issue. Following a trigger incident, the National Reporting and Learning Service searched their data base for wrong-site block. They identified 67 further reports of wrong site block in a period of 15 months. Subsequently the RCoA began their ‘Stop before you Block’19 campaign in November 2010. More recently, NHS England has incorporated ‘wrong-site block’ into the 2015–2016 list of ‘Never Events’ under the heading of ‘wrong site surgery’.20 The repercussions of a ‘never event’ include the Department of Health, Monitor and the General Medical Council all being notified of the event, as well as the names of the individuals involved.
We propose that the WHO checklist should be modified and utilised in an effort to reduce the incidence of wrong site block. We would recommend that the block site is marked prior to ‘sign in’, and the block mark is verified at ‘sign in’, at the same time as checking the surgical mark. This is especially important for regional blocks that are performed away from the operative site, e.g. paravertebral block for breast surgery/intercostal block for shoulder surgery.

Prevention of Residual Anaesthetic Drugs in Intravenous Cannulae

In April 2014, NHS England issued a Stage One Warning notice alerting practitioners to six cases of cardio-respiratory arrest due to residual anaesthetic drugs present in IV cannulae being flushed into the patient in the postoperative period. This built upon an alert issued by the now disbanded NPSA in 2009. Guidance from the AAGBI in 2013 already dictates, ‘All lines should be flushed to remove any residual anaesthetic drugs if necessary and checked to be patent, adequately secured and protected’. This could easily be verified and incorporated into the ‘Sign Out’ section.

Conclusions

In last year’s Reith Lectures, Atul Gawande discussed how the wealth of medical knowledge gained over the years could overwhelm any one mind, and thus it is important to have systems in place to ensure that knowledge is utilized effectively. He subsequently labelled the 21st century as the century of the system. Although the WHO Surgical checklist has helped to make surgery safer, and has been widely adopted to help maintain local standards, we feel that the time has come for changes with a direct bearing on patient safety. Improved patient outcome is likely to come from improving the system, rather than a focus on developing knowledge and technical skills alone, as was perhaps the case in the past. An updated checklist with the selective inclusion of new safety critical questions combined with reorganization of the current list (Box 1) should be nationally implemented to improve patient safety by strengthening the systems already in place.

Box 1

Summary of suggested modifications to NHS WHO checklist

<table>
<thead>
<tr>
<th>The use of preoperative team briefing to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Decide on the risk of major blood loss and the strategies to manage it (e.g. cell salvage).</td>
</tr>
<tr>
<td>▪ Guarantee that ABO compatible blood can be issued if required (i.e. laboratory has at least two valid ‘group and screen’ samples on record).</td>
</tr>
</tbody>
</table>

The use of ‘sign in’ to:

- Aid in the prevention of ‘wrong-site block’.
- Ensure VTE risk assessment has been performed, which will guide appropriate intraoperative prophylaxis (rather than at ‘time out’).
- Check the blood glucose in patients with diabetes mellitus is in the target range of 6–10 mmol/L to reduce the risk of wound infection and intraoperative hypoglycaemia.

The use of ‘time out’ to:

- Reduce Accidental Awareness under General Anaesthesia.

The use of ‘sign out’ to:

- Ensure flushing of residual anaesthetic drugs from intravenous cannulae.

References

**Differential pass rates in the FRCA**

Any large-scale assessment system inevitably produces differential attainment, with some groups performing better than others. In UK education this is first seen as a ‘gender gap’ in Key Stage 1 assessments at age 7, the gap becoming maximal at GCSE when 10% more girls than boys achieve five or more A*–C grades. Even more stark differential attainment is seen with social class (however measured) and ethnicity, with some ethnic groups performing better (Chinese, Indian) or worse (Black Caribbean) than White British, though ethnicity and social class are closely linked in the UK making interpretation of raw pass rates difficult. The same factors also influence entry to higher education and student performance on undergraduate courses. At medical school white students and women consistently out perform non-white ethnic groups and males, irrespective of whether this is in clinical or non-clinical assessments. These trends are maintained for postgraduates with several UK Medical Royal Colleges (RCGP, RCPsych, RCR, RCPL) publishing differential pass rates according to ethnicity and gender. These trends are also found worldwide with similar data from Australia and the USA. The situation is further complicated by international medical graduates (IMGs), as this candidate group has also been found to be less successful in UK postgraduate exams. A recent publication about IMG pass rates in the RCGP examinations led to that College being accused of racial discrimination, though a High Court judgement did not find this to be the case.

**FRCA pass rates**

So how does the FRCA perform in this respect? It is a regulatory requirement by the GMC that demographic and outcome data is collected from all candidates entering the exam. A summary of the pass rates for different candidate groups from College data is shown in Table 1. For 2014 the GMC requested this raw data from all UK medical Colleges and Faculties, and an interactive report of examination outcomes is available on the GMC website. The table shows differences in pass rates between the groups, irrespective of the exam component. The ethnicity effects seen elsewhere in education are clearly seen, though gender gaps are minimal. However this single table cannot convey the complexity of the data. First, description of ethnicity in this binary fashion, although widely done, misrepresents many groups. College ethnicity data-capture involves several options, but without combining the data the numbers for individual groups are too small to be meaningful. Secondly, many factors that may impact on these pass rates are not included, for example the first language of candidates, training region, exempting qualifications etc. Thirdly, these data include all candidates, irrespective of how many previous attempts they have made at exam components, so may include poorly performing candidates more than once, exaggerating any differences seen. Finally, there are many interactions between the factors shown, the most obvious being IMGs and black and minority ethnicity (BME), with more BME candidates having received their primary medical qualification abroad. This interaction is also highly pertinent when looking at the source of the differential attainment between BME and white candidates. Lower pass rates are also found amongst UK graduate BME candidates mirroring the trends seen in educational attainment outwith medicine. The summative data from the recent GMC report found that BME doctors from a UK medical school were less likely to pass than white doctors from a UK medical school. Pass rates were 63.5% and 76% respectively. Similar trends are found for anaesthesia but...
Table 1
Pass rates in FRCA exams by candidate groups. Data show all candidates who attempted any of the exams between September 2013 and June 2014

<table>
<thead>
<tr>
<th>Candidate group</th>
<th>Primary</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MCQ</td>
<td>OSCE</td>
</tr>
<tr>
<td>All candidates</td>
<td>765</td>
<td>56</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>385</td>
<td>59</td>
</tr>
<tr>
<td>F</td>
<td>380</td>
<td>53</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>492</td>
<td>61</td>
</tr>
<tr>
<td>BME</td>
<td>238</td>
<td>48</td>
</tr>
<tr>
<td>Current post:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>659</td>
<td>59</td>
</tr>
<tr>
<td>Non-training</td>
<td>96</td>
<td>32</td>
</tr>
<tr>
<td>Medical degree:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>633</td>
<td>59</td>
</tr>
<tr>
<td>Europe</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Rest of world</td>
<td>57</td>
<td>37</td>
</tr>
<tr>
<td>Unknown</td>
<td>66</td>
<td>41</td>
</tr>
</tbody>
</table>

BME, black and minority ethnicity

the FRCA is not an outlier in respect of this aspect of differential attainment. This aspect of differential attainment is the most difficult to account for, and is likely to involve complex sociological, behavioural and cultural issues that will need detailed study to unravel. The GMC are currently conducting a literature review covering the UK and other countries including the USA, Canada and New Zealand over the last decade, which will help in understanding what is currently known about differential attainment, including the relatively poor performance of indigenous BME medical graduates.

**Why might different candidate groups have different pass rates?**

Gender and ethnicity effects in school-age children can be explained mostly by differences in early language acquisition and behavioural differences between the sexes at adolescence, which are unlikely to contribute in post-graduate exams. The factors that determine success in an examination are too numerous to list here, but may be broadly divided into those determined by the examiner, the questions and the candidate. Within these categories, potential contributors to differential pass rates include:

**Examiner bias.** Conscious bias against a candidate based on their race or gender is possible but in reality is unlikely in modern examinations. The College’s examiner selection process strives to ensure that the Board of Examiners includes appropriate representation of both gender and ethnicity groups. The BME and gender balance is increasingly being achieved with 50% of new examiners appointed this year being female and 43% of BME origin. All potential candidates for examinership must have completed equality and diversity (E&D) training as a prerequisite. Once appointed as an examiner, the initial training package includes bespoke E&D training followed by mandatory annual updates for all examiners. Examining in pairs in SOEs means overt bias should be quickly detected by the co-examiner and the plethora of visitors to the examinations who are actively encouraged to provide feedback on the conduct of the examinations provides an added safeguard.

Unconscious bias is a well-recognized phenomenon which is more subtle and harder to detect. Does this occur in practice? A study in the MRCP PACES exam used the paired examiner format to specifically look for racial or gender bias in individual examiners, and from a dataset including 2084 examiners,
found only a single examiner who displayed significant ethnic bias. A different approach to detect examiner bias has recently been used in the Final FRCA. An exploratory ‘snapshot’ study as part of the 2014 triennial Examinations Review looked at the differential pass rates of various groups between the final FRCA exam components on the premise that the amount of examiner involvement in awarding marks varies widely in these, from almost none (MCQ) to substantial (SOE). In this project, involving around 1,000 first attempt candidates, there were no significant differences in the relative performance of different groups between the exam components, suggesting examiner bias is not a major contributor.

Question material. All questions in the FRCA are linked to the relevant parts of the CCT curriculum, which is primarily designed to meet the training requirements for UK practice. One possible explanation for the better performance of UK graduates is greater familiarity with the disease patterns seen in the UK and the approach to medical practice in this country. Greater exposure to basic medical sciences teaching at undergraduate level and their application to clinical medicine may also be a contributing factor. Emphasis on different pathologies and varied formats for teaching medicine elsewhere in the world, such as less integrated medical courses, may disadvantage IMG candidates. In a study of the RCGP examination outcomes and the legal ruling following this it was stated that exams in the UK cannot be ‘culturally neutral’ and that they may legitimately be designed specifically to ‘ensure that doctors are safe to practise in UK general practice’. In other words it is acceptable if material tested in an exam is ‘country specific’ even if this disadvantages some candidates.

Communication skills. These may differ between the various candidate groups, and may affect performance in any part of the exam, but particularly in oral components. This is believed to explain some of the differential pass rate between IMG and UK graduates in the clinical skills component of MRCGP, despite IMG doctors having passed assessments of English language proficiency. This difference however cannot explain the differential pass rate between BME UK graduates (who have English as their first language) and their white peers.

Exam preparation strategy. How candidates prepare for examinations may differ between the groups. Individual trainees all have their own personal approach to preparing for exams, with widely different learning styles, propensity to attend exam-based courses, and engagement with local examination preparation activities with trainers or peers. The low pass rate seen in non-trainees (in which group BME candidates are over represented) may be partly attributable to being unable to access many of these activities, a situation which most examiners and trainers would agree make a successful outcome less likely. Cultural differences may therefore affect exam preparation strategy and hence exam outcomes, and this is one possible explanation for the difference between BME and white candidates from UK medical schools.

What is the College doing to address these findings?
The Board of Examiners and College Council take the issue of differential attainment very seriously and are committed to delivering the fairest examinations possible, providing equality of opportunity regardless of gender, ethnicity or country of origin. However, important caveats are that our examinations are embedded within the CCT curriculum to reflect UK practice and that quality and patient safety have to be the first consideration in any medical examination process.

Our triennial review of the FRCA examinations which is about to be published at the time of writing has included a section focusing on differential attainment. With regards to examiner bias, they recommend investigating the issue further with a detailed study using the same methodology of the MRCP PACES study discussed previously. In addition we will continue to actively encourage female and BME examiner applicants so that the Board of Examiners better reflects the demography of the examination candidates. With regard to the examinations, a longitudinal analysis to analyse which sub-sections of all our exams show the largest differential performances, which would then allow teaching and exam preparation to focus on those areas for the relevant candidate groups. Finally, we need to know if there are any differences in the BME and gender profile and other protected characteristics before sitting the examinations with regards to important variables, e.g. clinical modules completed, ARCP outcomes, attendance at courses and trainer input and peer support (remembering that the majority of LTFT trainees are female). This aspect of the work will require close co-operation with the schools of anaesthesia.

Rest assured, we will commit the necessary resources, including input from experts external to the College, to answer these important questions and publish our findings and the actions arising in due course.

References
2 BAPIO v RCP and GMC (2014) EWHC 1416.
Plastic recycling from the operating theatres, working towards a circular economy

Discard an empty carbonated drinks bottle into the mixed recycling and the handler will refer to the resin identification code, (RIC) embossed in the bottle identifying the bottle as PET (polyethylene terephthalate, Figure 1) to direct the bottle into the appropriate recycling stream. Similarly an empty milk carton will be directed into facilities for HDPE (high density polyethylene, Figure 2). Both PET and HDPE can be recycled back into food-grade plastic containers.

The most widely used plastic in healthcare is polyvinylchloride (PVC, Figure 4), frequently used to form fluid administration sets, tubing and face masks but rather than being recycled this enters the clinical waste stream. Inspired by the Vinyl Council of Australia, a recycling programme called RecoMed has been established in the UK to examine the feasibility of collecting and recycling this high quality PVC in the UK. RecoMed is funded by Vinyl Plus, the voluntary sustainable development programme of the European PVC industry, and is managed by resource efficiency specialists Axion Consulting and the British Plastics Federation.

Wider use of PVC and PVC recycling
The EU sells 4M tonnes of PVC annually and it is used widely in the construction, fashion and automotive industries. The likelihood is that, within one’s home, flooring, guttering, water pipes and cable insulation are all made from PVC. By changing the relative proportions of PVC to plasticiser the functional characteristics of the product can be changed to suit the desired need. Recycling processes are well established, and upwards of 470,000 tonnes of PVC is recycled annually in Europe and nearly 100,000 tonnes in the UK in 2014. PVC manufacture is a highly energy dependent process requiring 60 megajoules per kg (16kWh) to make a kilogram of new PVC granules. Using recycled PVC reduces the energy requirements by 85%.

Plastics in anaesthesia and critical care
Only 1% of all PVC manufactured is made into medical devices; however, PVC is used to make 40% of all plastic disposable medical devices. Other commonly used plastics include polypropylene for some ventilator breathing circuits and thermoplastic elastomers for certain anaesthetic face masks. Some devices are made of different plastics in different parts – certain corrugated breathing circuits for example. Endobronchial and endotracheal tubes, whilst entirely made of PVC, are made of different types of PVC in different parts, and of course they are contaminated once used. Some intravenous fluid bags are composite laminate materials made to improve their chemical resistance and cannot be recycled.

Ideal characteristics of recyclable medical device PVC
The following characteristics are considered ideal for a PVC device to be recycled:
- High quality PVC item.
- Uniformly made of only PVC.
- Uniform plasticiser content.
- Single type of PVC within the device.
- Ideally clear but coloured PVC is possible.
- Not contaminated with blood or tissue fluids.
- Minimal risk of cross infection.
- Free of metal and other components.
nearly 100% and cross contamination of the recycling bins with other waste was zero. In its present form, the outlay for the hospitals is in staff time only.

Hotel and environmental services worked together to ensure that the daily waste collection schedule included the RecoMed bags which were then taken to a central waste hold before collection by the RecoMed team and subsequent delivery of the PVC from the hospital to the recycler.

The end product of recycled medical grade PVC

Whilst the PVC that goes to make ones windows and facias can be recycled into new windows and facias up to eight times, recycling medical devices, including face masks, into new face masks is not permitted under the regulations. EU medical directive 93/42/EEC4 ensures that devices will not harm or pose a health risk and EN/ISO 109935 covers biological testing. Since the recycled product has an uncertain pedigree, a used face mask cannot be recycled into another face mask. The specialist recycler shreds the PVC and produces 100% recycled horticultural products such as tree ties.6 The temperature of the process ensures the denaturing of all biological residues. There remains the possibility that, in time, recycled PVC could be used to manufacture products that serve as collection devices, such as urine collection bags, nasogastric collection bags and dialysis effluent collection bags.

Financial and carbon savings

Yellow bagged clinical waste is incinerated at a cost of about £630 a tonne and orange bagged clinical waste is steam or microwaved treated at a cost of about £200–300 per tonne. The financial saving of recycling depends on the local waste stream management and any additional costs incurred in the recycling process. With the process in its infancy, the carbon saving is complex and has yet to be calculated.
The next steps

Once the financial and carbon savings are defined the case can be made for wider roll-out of recycling PVC and possibly other plastics. Working with The Environment Agency and other regulators to ensure safety is vital. It would aid identification if recyclable PVC could be embossed with the RIC (Figure 4). In the longer term, other plastic devices may be worth recycling, especially if made of a single type of plastic.

The linear and circular economies

The linear ‘take, make and dispose’ model relies on large quantities of non-sustainable resources, in the case of PVC, petrochemicals, energy and salt. The circular economy,7 involves the continual flow of technical and biological materials through the value circle. This pilot has demonstrated the practical feasibility of recycling, high-quality, medical-grade PVC albeit into lower-value products. Multinational organisations are working towards circular economies in car and food manufacture, then why not the healthcare industry too? From face mask to face mask.

References

Intraoperative handovers are a practical necessity, but may lead to increased morbidity and mortality.\(^1\) Nationally there has been a drive to improve patient handover during all aspects of the hospital journey.\(^2\) The World Health Organisation’s ‘High Five’ patient safety initiative states that communication during handover is a top priority.\(^3\) High quality handover is necessary to provide safe patient care, with poor handovers significantly increasing the risk to patient safety.\(^4\) Currently there is no national guidance regarding intraoperative handover in the UK.

Locally we have had several serious incidents (SI) and episodes of patient harm related to intraoperative handover. Although not reported, we believe this is a problem that occurs nationally. These incidents seem to follow a trend of relevant information being omitted during handover. Indeed, communication failure has been highlighted as the most common cause of adverse patient event.\(^5\) There are few studies looking at information transfer specifically during the intraoperative period,\(^6\) however is has been well documented that handovers in the post-anaesthetic care area are often incomplete.\(^7,8\) A recent retrospective study in the US showed that, as the number of intraoperative handovers increased, the likelihood of having an adverse event whilst in hospital also rises.\(^9\) The study looked at 138,932 anaesthetics in one center, and found that with each handover there was an increased risk of morbidity or mortality of 8%.

The 2015 Anaesthesia Clinical Services Accreditation (ACSA) standards state that there should be ‘documented and agreed policies and documentation for the handover of care of patients from one team to another throughout the perioperative pathway’.\(^9\) The RCoA and AAGBI document ‘The Good Anaesthetist’ states: ‘an anaesthetist must pass on information to colleagues involved in, or taking over the care of your patient’.\(^10\) Additionally, the AAGBI, in the 2004 document ‘Fatigue and Anaesthetists’ has suggested a data set of information required that should be transferred from the outgoing anaesthetist to the incoming anaesthetist.\(^11\) A specific document allowing quick reference to vital clinical details that must be transferred to the incoming anaesthetist will be of benefit and may improve patient care.

Although one can argue that an intraoperative handover of patient care should only occur in stable patients, in reality this is not the case. Handover may occur because one anaesthetist has to move to another list adding an element of stress and time pressure to the handover process. The case may be a long or complex procedure with multiple different events during the anaesthetic and human error may occur with poor reliability of recall of information. The use of a cognitive aid when performing intraoperative handover could have positive effects on training. It may engrain the importance of information transfer and documentation from a junior level.

Inadequate handover has been condemned in coroners’ courts. Poor documentation opens up the clinician to litigation, an increasing concern within medicine in the UK.

We decided to look at issues that were occurring during intraoperative handover by surveying consultant practice. Our aim was to produce a more structured handover process, which would improve patient care and documentation and help with training.

We surveyed all 105 consultant anaesthetists at our hospital. We had 52 responses, and 42% of these consultant handover cases intraoperatively as part of their routine practice. As we are a busy tertiary hospital, lists are often run into a third clinical session, with different consultants sometimes covering each session. Some job plans require a consultant to have clinical
commitments for half a day and non-clinical commitments for the other session. This can lead to ‘all day’ lists being covered by multiple anaesthetists. Given this, it is surprising that only 58% agreed that intraoperative handover of elective patients is acceptable.

We asked if consultants would hand over an emergency ASA 1 stable patient, ASA 2 etc up to an ASA 4 unstable patient. Predictably, as the ASA score of the patients increased, consultants were less likely to hand over during the case. Almost 90% of consultants would hand over a stable ASA 1 patient compared to 10% who would hand over an unstable ASA 4 patient. On investigation of our serious incident reports, stability of the patient’s condition and appropriateness of the timing of handover had been an issue. When asked what common reasons for inadequate handovers within the department were, poor communication, poor documentation, and omission of important information were most frequently cited. Other prominent factors were information overload, lack of written information, lack of structure and formality and the frequency with which the lead consultant changes.

51% felt there was not enough room on the anaesthetic chart, with 64% of respondents wanting a dedicated space to document handover information and 48% of consultants feeling that a formal structured handover policy was needed.

We have established that intraoperative handover occurs regularly within our hospital. More importantly, we have identified a need for change and demand for a structured handover system.

With the increasing use and acceptance of checklist style cognitive aids, we introduced a laminated A5-size aide-memoire. This contains a series of clinical headings that should be used when handing over patients. The cognitive aid is attached to each anaesthetic machine in theatres. A sticker accompanies this, which can be attached to the anaesthetic chart, allowing anaesthetists to date and sign that handover has occurred. We have used several ‘plan, do, study, act’ cycles to gain feedback and make improvements. This has allowed the project to be promoted and accepted by the anaesthetic department.

We looked at attitudes towards the aide-memoire four months after it was introduced. We had a lower response rate (28 out of 105 consultants). However, 93% of respondents were aware of the aide-memoire and 40% felt that it had a positive impact on patient safety. It will be difficult to prove that we have improved patient safety, but the department has an increased awareness of the importance of good intraoperative hand over, and over time we hope to see less patient safety incidents related to this aspect of care.

Our intraoperative handover aide-memoire will be introduced as policy,
thereby meeting the ACSA standards, and importantly we aim to provide better patient care with its use.

Figure 3
An example of the stickers used to document intraoperative handovers

| Intraop handover check list used Time of hand over | Outgoing anaesthetist & contact info |
|__________________________________________|__________________________________|
| ________________________________________ | ________________________________ |
| ________________________________________ | ________________________________ |
| ________________________________________ | ________________________________ |
| ________________________________________ | ________________________________ |
| ________________________________________ | ________________________________ |
| ________________________________________ | ________________________________ |
| ________________________________________ | ________________________________ |
| ____________________________________________________________________________________________ |
| Incoming anaesthetist |  |

References

How to run local SAS educational meetings (and get CPD points)

Cheap CPD points are a rare commodity in the SAS anaesthetic world, particularly in Northern Ireland. In the past, tradition had it that these rare courses were booked up well before they hit our radar and, like grumpy teenage babysitters, we were left to mind the shop while those more organised than ourselves attended. There was even a rule passed by some managers that only one SAS grade was allowed to be away at a time, thus further hindering our efforts.

With this in mind our SAS lead, Kathleen Kelly, started a Teaching Day for all SAS anaesthetists in Northern Ireland. It has to be said that initially this was small and poorly attended, even though it was enthusiastically received. SAS grades were cajoled into presenting, and confidence slowly started to improve. At £30 it was fantastic value for money. The word got round, and attendance increased.

That was seven years ago and our November study day is now set in stone. Out of the 31 SAS grade anaesthetists in Northern Ireland approximately 20 attend. We take the course around different hospitals within the province, trying to make sure the travelling is shared and to increase the uptake. This year we are hoping to go to Enniskillen, Fermanagh. Small numbers mean that we can run airway workshops, simulations and scenarios, and ensure that everyone gets sufficient exposure to techniques. We generally split the day into a practical session in the morning and lectures in the afternoon. This year we are focusing on critical care, bedside ECHO workshop and obstetrics. There is a compulsory dinner included with the price of £60. This cements friendships and support to anaesthetists both SAS and consultants alike.

Our SAS group is named CCAGNI (Critical Care Anaesthetic Group Northern Ireland).

We have an RCoA representative, an AAGBI representative and a BMA representative within our group to provide feedback and assist with pressing issues. Despite the current problems within the NHS, such as job planning, the morale of our group is high. We have a strong identity, and our course is well supported by our consultant colleagues who, in small numbers, have started to attend our meetings.

This has by no means been an easy task. We are hugely indebted to Kathleen Kelly’s work in the early days. We presented her last year with the Kathleen Kelly Cup to thank her for for her huge contribution to the group. In future the Cup will be awarded to the SAS grade with the best presentation at the course.

Finding and contacting those in SAS grades has been the biggest ongoing challenge. Emailing key anaesthetists and phoning secretaries in each hospital has been the most successful method of extending our reach. There is a lot of movement within our grade so every year the information changes. We incorporated a survey in our last search, and this has revealed what a diverse and experienced group we are.

When starting a regional group, I think it is essential to start small and slowly build a core team that is enthusiastic and supportive. In this respect, we have been blessed with Seamus Bradley, Kathleen Kelly and Kathy Callaghan along with an increasingly keen team.

No one is forced to attend or present, but peer pressure eventually takes hold, and even the shyest of us have found courage to deliver a talk or a case study.

Our next course is in November 2015. If you are interested in attending, finding out more, or sharing your experience in a regional SAS group, please get in touch. Numbers are limited.

Dr Emma Stiby
Associate Specialist Anaesthetics
Musgrave Park Hospital, Belfast Healthcare Trust
emma.stiby@belfasttrust.hscni.net
Sub-specialty training in pre-hospital emergency medicine (PHEM)

In August 2014, five specialty registrars successfully completed the new GMC recognised training programme in PHEM.¹ We consider ourselves privileged to have been the first two Anaesthesia trainees to complete PHEM training, along with our three colleagues from an Emergency Medicine background.

This was a great occasion for all involved as it has taken many years of hard work by our forebears for PHEM to be a sub-specialty recognised by the General Medical Council. In this article we will explore the need for PHEM sub-specialists, explain the structure of the PHEM training programme and reflect on our experiences of the training programme.

Is there a need for doctors in the pre-hospital environment?

Every day, patients become critically ill or are injured outside the hospital environment. The care needs of the vast majority of patients can be met by the standard ambulance service response. However, in a proportion of these cases the needs of the patient exceed the current UK ambulance service scope of practice and enhanced care is required. Examples include the need for advanced airway management including the provision for pre-hospital anaesthesia, procedural sedation for extrication or limb splintage, and surgical techniques such as thoracotomy or amputation.

The aim of PHEM training is to train a doctor who has the knowledge, technical and non-technical skills to provide this level of enhanced pre-hospital care safely to these patients with the greatest needs in remote or challenging environments. However, in addition, the PHEM sub-specialist should be able to provide on-line clinical advice, respond to major incidents, support rescue from a range of potentially hazardous incident scenes and undertake emergency inter-facility transfer.

The training

From an anaesthetic trainees perspective, PHEM training occurs during the higher and/or advanced years of training. To be eligible, trainees must have done at least six months of approved emergency medicine training, and this may need to be achieved through a separate OOPE application. PHEM training involves spending one year (whole-time equivalent) working in a pre-hospital environment. This can either be achieved by doing a full year, or by blending the training with anaesthetic training over a two-year period. The training will not necessarily extend your CCT date, as modules such as Transfer, Trauma and Stabilisation, Cardiac Arrest and Sedation can be completed during it.

Trainees start in Phase 1A, which involves 100% supervised practice, typically lasting one month. This means, depending on where and when a pre-hospital patient with enhanced care needs arises, for example at the scene of a serious accident, there may be several or no doctors available to respond. Following extensive development between the Intercollegiate Board and the GMC, PHEM was approved as a sub-specialty in July 2011 and the standardised curriculum and assessment were agreed.

The photographs used on this article are reproduced with permission from Magpas Helimedix. Full consent for publication has been obtained.
At the end of Phase 1A trainees have a ‘Local Formative Assessment’ that is similar to the ‘Initial Assessment of Competence’ in Anaesthetic training.

On passing the assessment they enter Phase 1B, during which they can undertake clinical duties with indirect supervision. A proportion of duty periods (minimum of 20%) involve direct consultant supervision to enable formative work-place based assessments (WPBA) to take place. What these duty periods involve will vary amongst regions, but they usually entail an operational shift on a HEMS aircraft or in a rapid response car. As in hospital training, time is available for regional or national training days, personal development and study leave. At the end of Phase 1, trainees sit the National Summative Assessment (NSA) Part 1 – the Diploma of Immediate Medical Care administered by the Faculty of Pre-Hospital Care that is part of the Royal College of Surgeons of Edinburgh.

Successful completion of the NSA Part 1 will enable the trainee to enter Phase 2 of training, during which they build on areas learnt in Phase 1. Phase 2 also contains some distinct areas that are not covered in Phase 1, for example, training in providing remote clinical advice, and the ‘Silver Commanders’ role at major incidents. At the end of Phase 2, trainees sit the NSA Part 2 examination which consists of a written knowledge test, an Objective Structured Practical Examination (OSPE) and two full case simulations. Successful candidates gain the Fellowship of Immediate Medical Care. In addition to passing the exams, the trainee logbook (currently undergoing redevelopment, and intended to demonstrate the range of cases attended and procedures performed) and a minimum of 117 WPBAs need to be submitted to the Intercollegiate Board for Training in Pre-hospital Emergency Medicine (IBTPHEM) Training Advisory Panel (TAP) for approval. The TAP then assesses whether satisfactory completion of PHEM training has occurred and, if so, makes a recommendation to the RCoA that the trainee has successfully completed PHEM training. When the trainee’s Certificate of Completion of Training (CCT) in Anaesthesia is produced, it is annotated to show the sub-specialty of PHEM and a separate entry is made on the new sub-specialty GMC Register.

Reflections on PHEM training

Being part of the first cohort of trainees in a new sub-specialty was always going to be an adventure! Whilst the overall number of workplace assessments at times seemed burdensome compared to anaesthesia training, it meant that during each shift we were driven to reflect carefully on our workload and actively distil out the lessons learned. This is a developmental process which air ambulance paramedics are particularly familiar with, given a working culture where debriefing and crew resource management are paramount. One quickly became aware that each patient brought unique environmental, logistical and clinical challenges. Whilst some of the medicine might be considered ‘straight forward’, the context in which it had to be undertaken often was not, e.g. the super-morbidly obese patient with respiratory failure ‘trapped’ at home, or the cardiac-arrest patient managed on-board a boat or the motorcyclist with multiple injuries over 45 minutes from a major trauma centre by air.

We were required to debrief a minimum of 30 cases as ‘case-based’ discussions. During monthly clinical governance meetings, missions involving patients being sedated or anaesthetised are routinely reviewed against the standard operating procedures (SOPs). Having to present and be intensively critiqued by experienced pre-hospital clinicians on a large percentage of one’s workload was an immensely valuable reflective learning process.

Working in an environment where checklists, SOPs and debriefing are integral parts of the routine, whilst possibly alien to some anaesthetists, became strangely refreshing in PHEM. The advantage of this approach was especially apparent during times of heightened physical and mental stress, as such practice results in a phenomenon known as ‘cognitive offloading.’ This is a novel concept in human factors. By using a checklist and SOPs, gone is the stressor of remembering dozens of steps in the heat of the moment. This frees up mental ‘bandwidth,’ allowing the PHEM practitioner to keep abreast of the bigger clinical picture, anticipating acute physiological changes in the patient, communicating with relatives, and tasking members of the team by name to work towards a clear goal. That is, taking a live resuscitated patient, safely to the right hospital, in the right time frame.

Whilst undoubtedly we saved life and mitigated pain and distress for many patients, we were often in
contact with unimaginable human grief, suffering, and death. Breaking bad news sensitively, clearly and with compassion to families is a vital part of Good Medical Practice, whatever the specialty. For anaesthetists working in the intensive care setting, this is a process carefully orchestrated by Senior doctors and nurses. In the community, it is no less important for patients’ relatives, when being done by a PHEM team. Compassionate clear and concise communication, particularly following sudden death, is of utmost importance to patients’ relatives.

The personal impact of sudden death involving children and babies was particularly challenging. We became more aware of the psychological impact of such cases, and the importance of caring for your whole team. Making time to defuse tension, using humour when words failed, and learning to relax in between ‘high stakes’ patients is an important lesson to take back to hospital practice. We found that our educational supervisors were hugely supportive following such experiences, along with the professional camaraderie within the small teams in which we worked.

So why would one want to undertake PHEM training with all these demands? A consultant said to me ‘After doing this job, nothing will scare you.’ And clearly, whilst it is not for the faint hearted, I found at times of greatest pressure, the PHEM training I had received clearly kicked into action and I knew what to do and how to do it. The initial training delivered through simulation – both high- and low-fidelity, fosters the development of what some have described as ‘muscle memory.’ So in increments, we were increasingly prepared for our ‘worst nightmare’ clinical scenario having developed and practiced plans for failure repeatedly before we encountered them on ‘live’ patients.

Due to the relative scarcity of training posts in PHEM, it is likely that trainees pursuing this sub-specialty will have to make some sacrifices. For many it will mean time away from home, family and friends in a less familiar part of the UK. Whilst we knew PHEM would have financial, physical and emotional costs as trainees – the reality hits home when your annual mileage is two to three times more than usual, and you’re spending most nights away from home in temporary accommodation with a modest budget to help fund it. The shifts, whilst often testing and exciting, can sometimes be dull and frustrating – particularly if the aircraft receives no missions or there is a dispatch problem. During such lulls in activity one has to use the time constructively, tapping into the past experience of the paramedics, perhaps by means of a simulation, logging onto an educational podcast, polishing the portfolio or simply preparing for the PHEM exams.

The lessons from our experience in PHEM have enriched us as doctors in domains such as leadership, communication, reflection, human factors, simulation, as well as acute medicine, resuscitation, obstetrics, paediatrics, and trauma. No doubt this will complement and enhance our anaesthetic practice. So whilst it is difficult to predict what our job plans as consultants in anaesthesia and PHEM will be like, it is encouraging to note the ‘direction of travel’ of the NHS which is concentrating trauma, heart and stroke care in major centres. This reconfiguration of hospital services explains in part the drive behind the development of Commissioned PHEM services like the Emergency Medical Retrieval Service (EMRS) in Scotland, the Medical Emergency Response Incident Team (MERIT) in the West Midlands and the planned Emergency Medical Retrieval and Transfer Service (EMRTS) in Wales. The formation of these services also reflects the long established PHEM practice in Australian and European systems utilising doctors.

Although out-of-programme-experience is available in such systems in non-PHEM training posts, there is an increasing recognition of the value of having physicians integrated into UK PHEM, with experience and training using an approved curriculum, validated by examination. This trend is likely to increase the small (but growing) number of NHS trusts advertising consultant posts with integral PHEM sessions. So whilst PHEM training might seem like a costly, unproven gamble to some, this new sub-specialty is likely in our opinion to offer experience, training and a career-path in anaesthesia like no other.

References
1. Intercollegiate Board for Training in Pre-hospital Emergency Medicine (www.ibphem.co.uk).
2. British Association for Immediate Care (www.basics.org.uk).
Measuring for Improvement in Clinical Supervision

Andrew Milne, ST4; Shamir Karmali, CT2 and Alice Man, Consultant
North Middlesex University Hospital, London

The standards of postgraduate training for junior doctors in the UK are well documented, but although it is a mandatory requirement to collect feedback from trainees on clinical supervision, there are currently no guidelines for this process. The North Middlesex University Hospital (NMUH) is a district general hospital and part of the Central London School of Anaesthesia. Visits by Health Education England and National Trainee Surveys have indicated that clinical supervision by the anaesthetic department requires improvement.

Student feedback is an accepted method of evaluating teaching. Since March 2014, a three pronged approach to collecting clinical supervision feedback from NMUH trainee anaesthetists has been employed: trainee feedback on individual supervisors on a quarterly basis via online survey, feedback from specific teaching lists using a smartphone app and a survey of trainee satisfaction assessing different aspects of clinical supervision via a bimonthly survey. All methods used a five-point Likert scoring system (1 to 5).

The response rate for the individual supervisors feedback varied between 40 and 82% per quarter, with individual consultant’s median rating ranging from 1.0 (IQR 1,1.5) to 5 (IQR 5,5). After each survey the anonymised results for all supervisors were presented to the department.

Forms from 53 teaching lists were submitted, representing 33% of all scheduled teaching lists during the study period. These revealed that learning objectives were agreed for all lists, while 91% (48) of these were achieved. Workplace based assessments (WPBAs) were completed during 60% (32) of the lists. The median trainee satisfaction was 4 (IQR 4,5). The response rate for the questionnaire assessing separate aspects of clinical supervision was 83% (10) in the first run and 58% (7) in the second. Areas which trainees rated low (e.g. clarity of objectives) were fed back to the consultant body.

Our innovative approach to gathering feedback employed modern multimedia, permitted a thorough, triangulated assessment of clinical supervision at the NMUH, and was well accepted by those surveyed. This feedback facilitated reflective practice and benchmarking amongst the department and permitted the preferential allocation of trainees to lists run by supervisors with higher feedback scores. Supervisors have also used this feedback as part of their appraisal and revalidation process. The records from the clinical teaching sessions have permitted early identification, and timely resolution, of trainings issues. It is likely that using these assessment tools long term will provide further improvements to the clinical supervision at the NMUH. There is potential for these simple assessment tools to be used on a wider scale to allow benchmarking and standardisation between different hospitals and even schools of anaesthesia.

References
The RCoA have published guidelines on returning to work after a period of absence. This publication emphasises the importance of a structured programme (including assessment and feedback). Since the introduction of these guidelines we have implemented a number of changes within our deanery in order to achieve these standards.

An initial audit of trainees who had returned to work after maternity leave demonstrated the need to improve the process. New checklists to be completed before leaving and prior to returning to work were introduced and information was published on the Welsh School website; this included information on Keep In Touch (KIT) days, courses and a one to one interview. A re-audit following these changes indicated that trainees had experienced a more structured return to work, including a delay in recommencing on-call commitments. Trainees reported increased levels of confidence and satisfaction, although many commented that they would like to attend a locally run course to regain their practical skills prior to commencing work. Following this feedback the authors developed a one-day course. Trainees on maternity leave were contacted to establish their learning needs and the course content derived from their responses. The course comprised skills workshops, simulations and a clinical updates lecture, all aimed at the particular needs of the attending cohort. The first course took place in July 2014 and included trainees returning from maternity leave and advanced ITU placements. Course feedback was extremely positive and a subsequent audit demonstrated an improvement in confidence levels upon resuming clinical duties.

The course has been continually developed and improved upon, guided by candidate feedback. A second day was run in conjunction with the Severn and Peninsula Schools in January 2015. This encompassed trainees and consultants returning from maternity leave and research posts and again the course feedback was extremely positive.

Following the success of the first two courses we have successfully obtained funding from the Welsh Deanery to further develop this course. We intend to continue our collaboration with Severn and Peninsula school and invite other acute specialties in Wales (such as Emergency Medicine and Paediatrics) to join the course.

We have used trainee experiences and feedback to improve the experiences of trainees returning to anaesthesia after a period of absence. A new practical course has been developed to support a return to clinical duties, with good success in trainees returning from maternity leave, research posts and ITU placements. It also has the potential to be used for ACCS trainees returning to their parent specialty. We believe that this model can be further used in other areas of medicine, especially those with a heavy practical skills demand.

Reference
1 Recommendations for supporting a successful return to work after a period of absence. RCoA, 2011 (www.rcoa.ac.uk/node/771).
Use of a Local CQUIN to Implement a Quality Improvement Strategy in Emergency Laparotomy Care for High Risk Patients

Avninder Chana, Victoria Banks, Jonathan Mole, Andrew Hutchinson and the QMC Emergency Laparotomy Development Group
Nottingham University Hospitals NHS Trust, Nottingham

In the UK approximately 30,000 emergency laparotomies are undertaken per year with an average mortality of 15%. There are wide variations in mortality between institutions and throughout the week. Some groups of emergency laparotomy patients have a disproportionately high risk of mortality and morbidity: these may be classed as ‘high risk’. Previously at our institution, analysis of a large data collection project assessed the care pathway for these patients, highlighting key areas of focus and targets for improvement.

A Quality Improvement Collaborative was established between anaesthesia, surgery, radiology, theatres and critical care departments. An integrated care pathway was created and implemented. This included ‘perioperative risk of death’ risk scoring for emergency surgical admissions; CT scan booking was streamlined with adaptation of electronic systems to highlight patient high risk status; electronic theatre booking systems were updated to include real-time displays of patients awaiting theatre according to urgency and high risk status, displaying imminent breaches; and working practices within the surgical directorate were changed to allow immediate consultant input at all times.

To implement these changes, and thereby promote best standards of care, a local ‘Commissioning for Quality and Innovation’ (CQUIN) payment was agreed, with targets of:

1. Preoperative risk assessment for all emergency surgical patients.
2. CT scan performed and reported within six hours.
3. Operation within NCEPOD urgency booking time.
4. Consultant surgeon directly involved during surgery.

Over 50% of our emergency laparotomy patients qualify as high risk and their in-hospital mortality has decreased from 23% to 19% over one year (overall 12% down to 10%). Process timelines show reductions in the time taken from CT scan to decision to operate, so that patients get surgical source control before they deteriorate. Length of hospital stay has also shown a trend towards reduction, with significantly less patients suffering very long LOS as a result of complications.

Implementation of the local CQUIN has driven significant improvements in our care of high risk emergency laparotomy patients. The quality improvement strategy is now established for emergency laparotomies in our institution which will ensure sustainability. The project has driven a cultural change in our multidisciplinary approach to these patients, with the primary focus on identifying individual patient risk and expediting the process of care.
Much of the population remain ignorant of the role of the anaesthetist. Sometimes I enjoy this fact and act to maintain the air of mystery surrounding ‘being knocked out’. Similarly, I have been known to smile and shrug off suggestions that there may be nothing to do after the ‘needle in the back of the hand’ and remain silent when asked if it ever gets boring hanging around after that point.

But at other times it frustrates me that so many seem so ignorant of the role of the anaesthetist. I don’t mean the patients necessarily – after all it’s our job to explain to them all that we wish them to know, but I have become increasingly irritated by my family and non-medical friends. I believe, after years of training, they should know that I am not ‘just on-call’ and that I am likely to be in the hospital, actually working. I also despair at being asked repeatedly, whether I think I’ll get called out or not, if I think it will be busy and at what time do I finish.

It wasn’t until I felt truly insulted that I decided to explain exactly what I had been doing during all that time I’d spent in hospitals, justify all the opportunity costs I’d missed due to studying and what those years of training were all about. Perhaps then, some may understand that yes, I am a fully-qualified doctor, have been for several years and am now training to specialise in anaesthesia and no, I’m not yet a GP.

A neighbour of my parents asked for advice. Their son had not achieved the qualifications required for entry to medical school. Where could he apply to train to be an anaesthetist? Would there be a course at the local college?

This same neighbour had previously expressed her disappointment and surprise, that I had not ‘made it’ as a doctor. She felt I could have gone ‘all the way’. I assume she meant down the path leading to the land of general practice.

Rather than protest to deaf ears and fixed views, I decided to write a book, detailing my years of training in anaesthesia. For clarification, I started my tales of Adventures in Anaesthesia from my first ever visit to theatre, as a medical student in third-year. I picked tales I’m sure we all recognise and indeed, experienced. Many anaesthetists will have their own similar stories or perhaps better ones.

My aim was to depict the training years, through my own personal development and the emotions I had experienced during my seven years of training, from being a brand new start in anaesthesia until my last on-call before taking up a consultant post.

I have tried to show the highs and the lows associated with training: feedback from trainers, agitation from surgeons, suspicion from midwives, and hopeful expectation from intensive care nurses. I portray the personal satisfaction which comes from mastering clinical skills and the desperation from coming face to face with illness and tragedy.

I wanted to engage and inform the reader whilst avoiding boring the socks off them: I wanted to entertain without irreverence lest I cause worry or panic, about the care they could expect to receive when asleep.

To be a true representation of hospital training, it had to address my annoyances, gripes and downright difficulties, so I spoke of being bleeped whilst in the bathroom, dealing with patients who lie, and of struggling to cannulate a grossly obese patient as she sighed and shook her head, declaring it a disgrace that doctors ‘never seem to be able to find a vein’.

To expedite the journey of my completed book to the public domain, I spared traditional publishing houses the task of turning me down and took on the steep learning curve of self-publishing. In doing so, I learnt many, many competencies and improved my grammar and IT skills massively.

Overall, I’ve enjoyed telling the tale but have a new appreciation of the work and attention to detail that goes into writing a book.

The finished product is available to buy from Amazon (http://amzn.to/1aaqKaJ), iBooks, Barnes and Noble (http://bit.ly/1aaqTuL) and other major online retailers as an ebook or in paperback. Please consider gifting it to your non-medical friends and family whom you feel need enlightening.

Names have been changed to protect the anonymity of patients and of those consultants who trained me. All the events are true and any mistakes are inadvertent and entirely my own.

Enjoy, and please do not hesitate to offer your feedback to me at drelliemay@gmail.com or leave a review on the websites above.
Here was a hospital devoted wholly to dental care. To me it seemed an oddity. The place had been gifted to London, I learned, by Mr Eastman of Kodak fame and it gained extra respectability from its next door neighbour, the Royal Free Hospital. They did fine work for the inner-city citizenry. And it was to The Eastman that I applied for a job, hoping for daytime work, with evenings free for exam prep. But I was not prepared for a brave new world I had not seen before.

To me as Registrar at the Eastman, a new horizon opened. Here was a world of speedy, short-duration anaesthetics, using nothing but nitrous oxide, made effective by a deliberate oxygen deprivation. It’s true: planned hypoxia was a necessary part of the process. It was imposed judiciously for short time-periods that maximized the alveolar partial pressure of what we still sometimes called ‘laughing gas’. Of course there was no oximetry. We could judge awareness and ‘depth’ by movements, by an automatic breathing pattern and by an eyelid reflex, while watching the patient’s skin color. Mirabile dictu, it worked! We got those teeth out, the patients were happy, and I think Horace Wells would have approved.

By today’s standards any hypoxia sounds awful. By what steps did we inflict this physiological trespass? I got my first lesson from the master himself, the Grand Old Man of dental anaesthesia, Dr Victor Goldman. At the Eastman he had been consultant anaesthetist forever, and had designed some essential items of equipment. He gave me a personal tutorial on the technical setup. A proud inventor, he showed me his tools of trade, including the Goldman nasal inhaler. This rubber-padded mask fitted over the patient’s nose and forehead, and was retained in place by an elastic rubber strap. This strap itself was an apt invention. Cut roughly to fit a patient’s head, I suspect it had been scissored by Dr Goldman himself out of an old tyre tube. It worked perfectly.

Then there was the McKesson Nargraf gas machine, an American apparatus, admirably suited for this particular application...but for none other I could think of. It delivered nitrous oxide and oxygen through two linked reducing valves, mounted side by side on a vertical stand.. A single control knob varied the mixture of gases over a full range, zero to one hundred percent. Flow rates were easily adjusted, and copious gases were delivered to the nasal mask, equipped with an outflow valve. To demonstrate the feeble potency of nitrous oxide, Dr Goldman inhaled 90% for minutes, while carrying on a flow of intelligent conversation with me. A Goldman vaporizer, fitted in the gas line, was supposed to add trichloroethylene. But with its high lipid solubility, it’s no wonder I found it almost useless in our quick hit-and-run cases.

With equipment explained, it was time for a Goldman demonstration. The master rose to the occasion with a nonchalance gained over many years. Our waiting room was filled with patients, waiting their turn. Each of them had walked in off the street, without appointment, driven by a bad tooth that he or she wanted out, since the Eastman was known on the street as an efficient, inexpensive extraction mill. Each walk-in patient was examined by a triage dentist, to identify the offending tooth, and to verify the subject’s suitability. The hospital had only three admission criteria: no food or fluid swallowed in the last three hours, an empty bladder, and the ability to climb without help the steps from street to the hospital entrance.

I dimly remember our first subject, a girl aged about 12. Holding the nurse’s hand, she bravely farewelled a parent, walked into the theatre and took her seat in the dental chair. At this first meeting, Dr Goldman gave her a friendly ‘hello’, and followed that by a stream of instructions plus stepwise adjustments of the gas mix. This was a routine he had perfected by practicing thousands of times:

‘Make yourself comfortable...I’m going to lean the chair back and adjust the headrest so you can relax... Here’s a mask that goes over your nose, so you can breathe gases through it... Please bite down gently on this rubber bite block; it keeps your mouth open. And breathe easy through your nose... There’s nothing to it...’

The anaesthesia scene in the London I knew in 1955 included features that were part of an era now gone. They deserve an inquiring backward look. Sixty years ago, to see dental anaesthesia at its historic finest, with nitrous oxide pushed to its limits, you didn’t need to visit Horace Wells in Hartford. You could just find your way to the Eastman Dental Hospital on Gray’s Inn Road in downtown London.
At first it was just oxygen, to wash out some lung nitrogen. Then for half a minute or more there was pure nitrous oxide, soon relieved by just a little oxygen, five percent, or a bit more when the patient began to look cyanosed. Dr Goldman kept up a commentary, directed at me, not to calm the nervous child. As the nitrous took hold there was excitement and some struggle, with the nurse giving firm restraint. It was not a pretty scene, but not unexpected. Soon the child’s struggles quietened, breathing became regular, and there was no eyelash reflex.

On a signal the surgeon went into action. Into the mouth went a mouth pack, to catch any loose tooth that got away. The offending tooth, sometimes more than one tooth, was extracted in short order. Surgery done! A burst of oxygen, then off with the mask! Pressure was applied with the mouth pack on the bleeding empty socket, the bite block came out, and the patient breathed air for less than a minute. Then waking but still-dizzy patient was helped onto a wheel-chair, pushed into the recovery room and laid on a bench. In less than half-an-hour, usually, such patients could be judged fully awake and street-worthy. Mission accomplished! And, with a fresh instrument kit, ‘Next please!’

This sequence was developed by Dr Goldman, and I was soon managing it nicely. Before long I was gassing as many as twenty patients each half-day session. They were aged from four years to retirees, whatever walked in off the street. The induction routine soon became unthinking, automatic. The first few moments with each new patient were critical, to set a reassuring, trusting atmosphere. Most patients knew what to expect and cooperated well. But children could be a challenge, to be treated with firm authority. With them my fellow Registrar, Dr Willie Coombe, was the master, and rarely was I able to match the suave skillfulness he demonstrated. He was older than I, tall and thin, a splendid ‘Cassius with a lean and hungry look’. To children he spoke quietly with a deliberate tone of friendly but firm command. They knew at once he was the man in charge and must be obeyed. I admired his skill but never quite matched his do-as-I-say authority and charm.

In a different class were the tough candidates. I soon learned that the subjects to fear in all of London were the Irish laborers, with wiry build, florid countenance and colorful language. Raised from infancy on a diet of mother’s milk plus draughts of Guinness, they had come to London looking for casual employment. Nitrous oxide alone could not touch them. One such subject in my care seemed mild enough, and I kept him on 95% nitrous for twice as long as usual. After awhile his breathing became reassuringly regular and I thought we had won. But when I tested his eyelid reflex, both eyes opened and one of them winked at me. To cope with these subjects, Dr Goldman allowed me to change the routine: Start the gas awhile, and then add a small syringe-into-vein dose of thiopentone.

One result from our non-stop flow of patients was boredom from the same routine. After the first twenty patients, how do you break the monotony? My trusted surgical colleagues in that era, Mr Bowes and Mrs Douton, were handy with tools, slick at their work, and a pleasure to deal with. But they, too, could get bored. So in a spirit of mutual trust, we sometimes switched roles. And a good time was had by all. These colleagues gave a good gas; today’s dentists have learned a lot since Horace Wells. On my side, I learned fast how to pull teeth, a skill I never had a chance to flaunt in Fellowship exams.

At the Eastman it was a pleasure to get acquainted with maestro Victor Goldman. Very early, I learned to show deference to this man of the City, and also to his automobile. On my first day I parked my vehicle right in front of the hospital entrance. It had come with me by ship from New York, and was a huge new American Pontiac, as long as a tennis court, and painted a gaudy two-tone green. In sedate London it looked offensive. And in front of the hospital it dwarfed my boss’s fine black Jaguar. It took no genius for me to choose a more remote parking spot in future. In fact, I soon opted for commuting on an economical scooter. But the ride from North London was hazardous. On a slippery wet street one day my small wheels lost grip, and I slid onto my side, a double-decker bus shuddering to a stop six feet from me. Never again! From that day I rode the rattling Northern Line tube from Edgware to King’s Cross.

A man about town, Dr Goldman taught me a little about living amongst London’s privileged class. He spoke circumspectly about his escapades as a habitué at the Savage Club, with its view over The Mall. He had encountered there some distinguished medics, and they had revealed to him, with strict anonymity, the sacred principles that governed medical care for royalty. Every test, every prescription, every proposed therapy or surgery, had to reflect tried and true orthodoxy, thoroughly validated in the mainstream. No place here for hopeful but untested novelties. There were also dentists of notoriety in London with whom Dr Goldman had built a private consulting practice. When he was away on one occasion, I had the honour of serving as his locum tenens. Perforce, I learned how to pack my car with his portable equipment, gas tanks and all, and set it up quickly in a posh dental surgery. I could handle his gas with aplomb, but not his nonchalance.

That’s all gone now. When I paid a nostalgic visit to the Eastman 12 years ago, much had changed. It was tough to find a place to park, and there was no walk-in outpatient anaesthesia service. I did find an updated surgery department, bearing proudly the name of Goldman. But general anesthesia is not offered there. Any patient who needs it is referred to a different place, where ordinary hospital procedures are
followed, with all of today’s benefits. They now include a proper H and P, usually an IV, a vital signs record, plus a gift from modernity known as sevo- or isoflurane. In most places it will be far from the fast, walk-in, walk-out service I had known.

Near the end of my Eastman stay I learned that the anaesthesia we practised was under professional question. Dr James Bourne, senior consultant at St Thomas’ Hospital was a critic, supported by a Dr Tom. I was shown a paper they published in the European literature. In it the possibility was raised that a patient, already breathing a hypoxic gas mixture, might suffer a vaso-vagal syncope while in a semi-sitting position. And that might cause injurious cerebral hypoxia.

That risk even Victor Goldman could not dismiss. But as master of dental gas, and supported by your humble servant, he could confidently report the clinical outcomes observed in multitudes of patients. My own personal score approached ten thousand, enough to give us opinions that deserved a hearing. Our patients were uniformly pleased and grateful. There were virtually no complications and no complaints. The process we followed at The Eastman had many simplifying positives. Criticisms were few and were scarcely mentioned in that environment.

Some items that we now insist on were omitted at The Eastman. We did not keep records of technique and vital signs, and found no real-world use for them. The process we followed was pure Goldman. It was unvaried and needed no repetitious paper record. Each patient’s surgery details were noted on his identity card and he became little more than a line item in the day’s procedure book. Rapid recovery to a state of street-worthiness was a big benefit. Out of thousands of patients I saw only one, an adult, whose discharge was a little delayed by persisting dizziness and nausea. In time he was well and on his way. Patients avoided the nuisance of changing clothes, and also the discomfort of getting an IV cannula plus the sore hand that followed it.

After sixty years I still retain a pragmatic respect for the nitrous oxide anaesthesia given at The Eastman. Without question it included a bout of oxygen deprivation that offends our present standards of safe practice. Yet these bouts were brief, apparently within the limits of tolerable hypoxia. When judged by outcomes, our modus operandi at The Eastman pleased the patients. No complaint reached me about what we did or how we did it. Each patient got what he came for and was satisfied. In the marketplace it spelled success.

There can be a different judge, the hospital manager, who must consider cost-effectiveness. I ask: What other mode of practice can enable a small team of surgeon, nurse and anaesthetist to give significant dental care to as many as forty patients in a day? Today’s anaesthesia offers us huge gains of predictability and safety. But while enjoying these benefits, we may pause to salute our predecessors. They also got the job done, in the spirit of Horace Wells.
Sir,

I thank Dr Law and Ms Hart for their interest in my article. However, I cannot agree that the medical negligence landscape has been unchanged by *Bolitho*. A number of examples of case law post-*Bolitho* demonstrate willingness on the part of the judiciary to critically assess conflicting medical expert opinions for their logic and to decide which body of opinion should be relied upon as the standard against which the provision of treatment of the defendant doctor (or other healthcare professional) should be compared. Lord Browne-Wilkinson was of the opinion that the ruling in *Bolam* had already given the courts the right to assess expert opinion in this manner, but that this had not previously been common practice.

In the same way as Bolam may offer a stimulus for doctors to maintain up-to-date practice, *Bolitho* demands that we critically assess our practice for its logical basis. A no fault redress scheme is certainly an alternative to litigation, but does not offer a replacement to the principles of *Bolam* and *Bolitho* as applied to medical negligence case law.

Dr E Combeer, Consultant Anaesthetist, Frimley Health NHS Foundation Trust

References

5. *Bolam* v Friern Hospital Management Committee [1957] 2 All ER 118.
Background to the collection
The historical Instrument Collection at the Hunterian Museum at the Royal College of Surgeons of England contains over 300 items of anaesthetic equipment, mostly dating from the mid-19th to mid-20th centuries. These items are mainly small in size, and include inhalers, masks, face-pieces, gags, bottles and drugs. The first item was donated to the museum in 1871, and the collection grew slowly until 1932 when Mr N Buxton FRCS presented over 70 pieces of anaesthetic equipment owned by his father, Dr Dudley Wilmot Buxton (1855–1931) who was an early pioneer in anaesthetics.

Items that have been conserved
Two pieces of anaesthetic equipment were selected for conservation through the Conserve our Collections scheme, using funds generously provided by the RCoA. Work was completed by conservators Liz Goodman ARC and Luisa Duarte at MOLA (Museum of London Archaeology) during June and July 2014.

RCSIC/S 7 – Coleman’s inhaler nose-piece for continuous administration of nitrous oxide, 1898
Description: This apparatus was designed and used by Alfred Coleman (1828–1902). It was given to the College in 1913 by Alfred’s son Frank, who described its use as follows: ‘The apparatus consists of a nose-piece connected by a flattened tube adapted to fit accurately over the forehead to an ordinary gas-bag, an intervening two-way stop-cock containing a valve which opened towards the nose, and an air-padded face-piece which completed the apparatus.’

The face piece for this apparatus (RCSIC/S 6) is also preserved in our collections, but did not require conservation. Frank Coleman explains that this section ‘was used in the first stage of anaesthesia, covering the mouth and the nasal inhaler, when the patient was ‘under’ it was removed’.

Alfred Coleman qualified MRCS in 1860. The same year he became one of the first candidates to be admitted to the Licence in Dental Surgery. He was senior dental surgeon to St Bartholomew’s Hospital and a Member of the Board of Examiners in Dental Surgery. Coleman took a keen interest in anaesthesia. In 1868 he was a member of the committee appointed to inquire into ‘The Value and Advantages of the Protoxide of Nitrogen as an Anaesthetic in Surgical Operations’, and he was prominent in introducing nitrous oxide into Britain. His method of administering gas through the nose, using this inhaler nose-piece, was introduced in 1898.

Summary of treatment: The apparatus is made from a range of materials including leather, rubber, elastic, iron, lead and copper alloy. The rubber tubing has deteriorated, becoming very brittle; it had completely broken into two fragments and was covered in hairline cracks. The cracks were consolidated, the break was adhered and supported and the item was cleaned.
RCSIC/S 19.3 Protheroe Smith’s chloroform inhaler tube and mouth piece in leather case, 1860–1900

**Description:** This is one of several of parts of Protheroe Smith’s apparatus that we hold (including two glass inhalers), and they constitute some of the oldest items in the series. The apparatus was invented by Protheroe Smith in 1847 and was described and figured by him in his article ‘Use of Chloroform in Midwifery Practice’ (*The Lancet* 1889;ii:770).

The item was part of the Dudley Buxton Collection which came to the College in 1931.

**Summary of treatment:** The item was cleaned. The lid, which had become detached from the case, was rejoined, and the corners of the case were reinforced.
Small Grants and Awards

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

Applications are invited for the following funds:

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

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

**Sargant Fund**
For education and research purposes.
**Value up to £2,500**

**Belfast Fund**
To fund grants for educational purposes.
**Value up to £600**

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

To apply
Please visit [http://bit.ly/1EU2CVq](http://bit.ly/1EU2CVq) to view the assessment criteria and download a copy of the application form. The deadline for applications is 5.00 pm on Friday, 28 August 2015.

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

To apply
Nominations are now invited for the 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 5.00 pm on Friday, 28 August 2015.

**Macintosh Professorship**
The RCoA has established a number of initiatives to foster research in anaesthesia, critical care and pain management. Their aim is to encourage experienced researchers as well as those who are in the early stages of developing a research portfolio. Macintosh Professorships are aimed at established clinical or laboratory researchers who are already performing at a high level. Their purpose is to recognise and disseminate the work of the award holders and facilitate their progress in the academic world.

Recipients of the award will have a national or international reputation in their field. Their curriculum vitae will be consistent with an individual who is performing at, or is on the cusp of, professorial level through research, innovation, and leadership. Those who show equivalent excellence in teaching and education will also be eligible for the award.

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 RCoA 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 RCoA 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
Please submit a synopsis of your proposed lecture, along with a CV and covering letter by email AND post to the NIAA Administrator at the address below by 5.00 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 5.00 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 by post and email to:

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

NIAA Research Grants
Results of round two 2014

On Thursday, 4 December 2014, the NIAA Grants Committee met to consider the second round of applications for 2014 on behalf of the AAGBI and Anaesthesia, The British Journal of Anaesthesia (BJA) and the RCoA, The British Society of Orthopaedic Anaesthetists (BSOA), the Difficult Airway Society (DAS), the Neuroanaesthesia Society of Great Britain and Ireland (NASGBI) and Regional Anaesthesia UK (RA-UK).

The committee considered 32 applications over seven categories for a requested sum of £1,305,588.98 and made a total of 10 awards over three categories to a value of £547,839. Success rate: 31%.

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.

<table>
<thead>
<tr>
<th>Award: AAGBI/Anaesthesia Research Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Sheila Black</td>
</tr>
<tr>
<td>Leeds Teaching Hospital NHS Trust</td>
</tr>
<tr>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Award: BJA/RCoA Project Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Tim Hales</td>
</tr>
<tr>
<td>University of Dundee</td>
</tr>
<tr>
<td>Improving opioid analgesia by targeting beta-arrestin2 signalling.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Award: BJA/RCoA PhD Studentship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Claire Gibson/Professor Dave Lambert</td>
</tr>
<tr>
<td>University of Leicester</td>
</tr>
<tr>
<td>Investigating the pharmacology of NOiceptin/OrphaninFQ receptors during cerebral ischaemia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Award: BJA/RCoA PhD Studentship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Graeme McLeod</td>
</tr>
<tr>
<td>University of Dundee</td>
</tr>
<tr>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Award: BJA/RCoA PhD Studentship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Marie-Anne Shaw/Professor Phil Hopkins</td>
</tr>
<tr>
<td>University of Leeds</td>
</tr>
<tr>
<td>Identification of genes contributing to malignant hyperthermia and related phenotypes from differential gene expression</td>
</tr>
</tbody>
</table>
Report of meetings of Council

At a meeting of Council held on Wednesday, 15 April 2015 the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**

**South West Peninsula**
Dr P R F Davies (Derriford Hospital)

*Dr P R F Davies (Derriford Hospital)*

**Deputy Regional Advisers**

**Mersey**
Dr L A Poole (Countess of Chester Hospital) in succession to Dr P Mullen

*Dr S-A Phillips (Belfast City Hospital)*

**College Tutors**

**Northern**
Dr K Fordy (Sunderland Royal Hospital) in succession to Dr E Rodger
Dr S J Robb (Sunderland Royal Hospital)

(Second College Tutor post)

**North Thames Central**
Dr P J Bishop (Colchester Hospital) in succession to Dr L Zsisku
Dr E Bertoja (UCLH) in succession to Dr J Holding

**North Thames East**
Dr T Kundishora (Newham University Hospital) in succession to Dr B John
Dr A T Watson (Broomfield Hospital) in succession to Dr R Martin

**Mersey**
Dr N J Price (Leighton Hospital) in succession to Dr P M Board
Dr A R Marchetti (Macclesfield District General Hospital) in succession to Dr N Zafar
Dr J Slee (Whiston Hospital) in succession to Dr Y M A Wong

**South East Scotland**
Dr C P Gardner (St John’s Hospital) in succession to Dr L M Carragher

**West Midlands North**
Dr T M Day-Thompson (Hereford County Hospital) in succession to Dr H Whibley

**Head of Schools**

Dr Helen Hobbiger (East of England Postgraduate School) in succession to Dr S Fletcher

**Certificate of Completion of Training**

Council noted recommendations made to the GMC for approval, that CCTs/Certificate of Eligibility for Specialist Registration (Combined Programme) [CESR (CP)] be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia. The doctors whose names are marked with an asterisk have been recommended for Joint CCTs/CESR (CP)s in Anaesthesia and Intensive Care Medicine.

**Anglia**
Dr Natalia Notkina

**Leicester**
Dr Jaspreet Kaur
Dr Rebecca Caroline Barker

**KSS**
Dr Vageshwary Veeraiah Mikkere

**London – North Central**
Dr Craig Anthony Lyness
Dr David Thomas Monks

**London – Barts and the London**
Dr Neil Angus James Macdonald
Dr Timothy Charles Lightfoot
Dr Olubukunola Ojo
Dr Sheelaj Sharma

**London – St George’s**
Dr Ben Felix Richard Singer*

**Mersey**
Dr Jill Nicholson

**Northern**
Dr Francoise Bari
Dr Ramesh Arumugam
Dr Simone Eloise Carbert
Dr Jennifer Ellen Sainsbury
Dr Vanessa Nina Nesbitt

**North West**
Dr Marion Lindsay Anderson

**South West Peninsula**
Dr Daniel Joseph Alexander Quemby

**Severn**
Dr Jonathan Edward Lightfoot
Dr Melanie Jane MacDonald
Dr Gemma Audrey Nickols

**Wales**
Dr David Anthony Burckett St. Laurent

**Wessex**
Dr Aparna Cockrell
Dr Rhys Thomas Lewis

**Stoke**
Dr Rituraj Srivastava
Dr Sameh Botros

**Warwickshire**
Dr Frank Ludwig

**West of Scotland**
Dr Niranjali Yatiwelle

**Leeds and Bradford**
Dr Brendan Donal Robert Sloan*
Dr Rituparna Banerjee

**Sheffield**
Dr Jonathan Hadyn Rosser*
At a meeting of Council held on Wednesday, 20 May 2015 the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**

**West of Scotland**
Dr N O’Donnell (Gartnavel General Hospital, Glasgow) in succession to Dr L Newman

**Sheffield and North Trent**
Dr S Sanghera (Northern General Hospital, Sheffield), in succession to Dr G Hood

*Dr N A Leslie (Leicester General Hospital)*

**Leicester and South Trent**
*Dr N A Leslie (Leicester General Hospital)*

**Deputy Regional Advisers**

There were no appointments this month.

**College Tutors**

**South Thames West**
Dr P Bathke (Epsom and St Helier Trust) in succession to Dr G P Thorning and Dr S M Bailey

**KSS**
Dr D Melville (St Richard’s Hospital) in succession to Dr R Hill

**West Midlands South**
Dr S Chavan (Queen Elizabeth Hospital) in succession to Dr D Turfrey

**Mersey**
Dr S Griffiths (Walton Centre for Neurology and Neurosurgery) in succession to Dr T G Mahalingam

**Wessex**
Dr E Dyson (Queen Alexandra Hospital, Portsmouth) in succession to Dr I R Taylor

**Head of School**

There were no notified appointments this month.

**Certificate of Completion of Training**

Council noted recommendations made to the GMC for approval, that CCTs/Certificate of Eligibility for Specialist Registration (Combined Programme) [CESR (CP)] 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.

**Leicester**
Dr Alison Elizabeth Fiorini

**KSS**
Dr Caroline Alice Harrison Dean

**London – North Central**
Dr Rachel Baumber*

**London – Barts and the London**
Dr Davina Dic Lan Wong

**South East**
Dr Niamh Mary Deidre Rose Gavin

**Mersey**
Dr Emily Christie

**Northern**
Dr Udaya Kumar Chakka

**North West**
Dr Khristine Ann George

**South West Peninsula**
Dr Claire Nadine Todd

**Severn**
Dr Pheobe May Syme

**Wessex**
Dr Emma Fitzgerald*
Dr Harriet Jennifer Edgar

**Birmingham**
Dr Michael Roman William McAlindon*
Dr Nikhil Shivaj Desai
The meeting was held at Queens’ College, Cambridge. The Chairman welcomed members and guests and also Mr Kevin Storey, Chief Executive of the RCoA.

The President, Dr J-P van Besouw, gave an update on College matters which included:

- The amount of exposure to emergency surgery and anaesthesia and to sub-specialty training is being reviewed. Records of training experience will be electronic in the light of complaints that there was too much documentation.

- Following a recent court ruling on consent, the onus seems to be on the doctor to decide how much to tell the patient. The guidance on consent is being reviewed in conjunction with the AAGBI.

- Following the impending retirement of Mr Kevin Storey, two new directors have been appointed, one for Finance, and one for Communications. There was a round of applause for Mr Storey.

The Club was very fortunate in having as guest speaker Ms June Mendoza OBE, an internationally known portrait painter who has painted hundreds of portraits, including those of royalty, politicians, actors and doctors from around the world, and of the College President, Dr J-P van Besouw. The format of the meeting though different proved extremely successful. It was fitting that Dr van Besouw should act as ‘interviewer’ (in the Michael Parkinson mode) to ask Ms Mendoza about her life in portraiture. He had selected a well thought-out range of paintings, which were projected on the screen, not only to illustrate the range of subjects but also her consummate skill. Among the famous people she had painted were the Queen (five times), the Queen Mother, the Princess Royal (Patron of the College), Jacqueline DuPre, Margaret Thatcher, David Starkey, Virginia Wade and Lee Kwan Yew. Using the many portraits, she illustrated the importance of first getting to know the personality of the sitter, then composing the picture. Correct lighting is crucial, and so she prefers to paint in her studio. Then she needs to pay attention to the background and clothes, so that they do not clash or distract. She paints directly on to canvas without preliminary sketching whenever possible, but has to refer to photographs for certain sitters and for group portraits such as the House of Commons. What made it such a fascinating hour were also the snippets of stories associated with the paintings.

The Chairman and members heartily thanked both Ms Mendoza and Dr J-P van Besouw for their double act.

The Chairman gave special thanks to the President and to Mr Storey for supporting the SFC. This was Dr J-P van Besouw’s last update as President before he demits office later in the year. As this was her last meeting as Chairman, she also thanked Miss Karen Slater and staff of the Membership Department for so ably administering the meetings of the SFC, and Dr Ann Ferguson for compiling the lists of exhibitions and events. She then introduced Dr Ian Calder, the incoming Chairman, and wished him well.

The next meeting of the SFC will be held on Thursday, 15 October 2015 at the RCoA in London.
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) FULLY BOOKED

24 August 2015
ANAESTHETISTS AS EDUCATORS: ANTS (ANAESTHETISTS’ NON-TECHNICAL SKILLS)
RCoA, London
£220 (£165 for RCoA registered trainees)

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
£425 (£320 for RCoA registered trainees)

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

30 September 2015
CPD STUDY DAY
The Waterfront Hall, Belfast
£200 (£150 for RCoA registered trainees)

2 October 2015
CPD STUDY DAY: THE ESSENTIALS OF INTENSIVE CARE
RCoA, London
£200 (£150 for RCoA registered trainees)

2 October 2015
NASGBI CPD STUDY DAY: NEUROANAESTHESIA AND NEUROCRIITICAL CARE
RCoA, London
£175 (£145 for NASGBI registered members)

5 October 2015
BJA/NIAA RESEARCH METHODOLOGY WORKSHOP
RCoA, London
£150

5–6 October 2015
FICM EXAM PREP COURSE
Rose Bowl, Leeds
£270

6 October 2015
ANAESTHETISTS AS EDUCATORS: EDUCATIONAL SUPERVISION
RCoA, London
£220

6 October 2015
 DEVELOPING WORLD ANAESTHESIA
RCoA, London
£150

7 October 2015
AIRWAY WORKSHOP
The Teacher Building, Glasgow
£260 (£195 for RCoA registered trainees)

15 October 2015
AIRWAY WORKSHOP
RCoA, London
£260 (£195 for RCoA registered trainees)

16 October 2015
CAREER IN ANAESTHESIA
RCoA, London
£45

21 October 2015
CAREER IN ANAESTHESIA
Rose Bowl, Leeds
£45

23 October 2015
ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
RCoA, London
£220 (£165 for RCoA registered trainees)

4 November 2015
PATIENT SAFETY CONFERENCE
Thinktank Theatre, Birmingham
£215
5–6 November 2015
UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE
Edinburgh Royal Infirmary
£450

6 November 2015
JOINT RCoA/RSM MEETING: EMERGENCIES IN ANAESTHETIC PRACTICE
RSM, London
Please visit RCoA website for event fees.

10–11 November 2015
ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
RCoA, London
£425 (£320 for RCoA registered trainees)

12–13 November 2015
INTRODUCTION TO LEADERSHIP AND MANAGEMENT: THE ESSENTIALS
RCoA, London
£395

18 November 2015
ANAESTHETISTS AS EDUCATORS: ANTs (ANAESTHETISTS’ NON-TECHNICAL SKILLS)
RCoA, London
£220 (£165 for RCoA registered trainees)

19–20 November 2015
RCoA WINTER SYMPOSIUM: A REVIEW OF TRENDS AND CONTROVERSIES IN CURRENT PRACTICE
RCoA, London
£395 (£295 for RCoA registered trainees)

21 November 2015
CONTINUING PROFESSIONAL DEVELOPMENT DAY
RCoA, London
£240 (£180 for RCoA registered trainees)

JOINT RATE
A joint rate of £490 (£370 for RCoA registered trainees) is available for those attending both the RCoA Winter Symposium and the Continuing Professional Development Day

24 November 2015
JOINT RCoA/RCEM STUDY DAY: MAJOR TRAUMA
RCoA, London
£200 (£150 for RCoA registered trainees)

24 November 2015
ANAESTHETISTS AS EDUCATORS: SIMULATION UNPLUGGED
RCoA, London
£220 (£165 for RCoA registered trainees)

27 November 2015
FPM 8TH ANNUAL MEETING: CLINICAL UPDATES IN PAIN MEDICINE
RCoA, London
£195 (£140 for RCoA registered trainees)

30 November 2015
CLINICAL DIRECTORS MEETING (JOINT WITH THE AAGBI)
RCoA, London
By invitation only

1 December 2015
LEADERSHIP AND MANAGEMENT: WORKING WELL IN TEAMS... AND MAKING AN IMPACT!
RCoA, London
£220

2–4 December 2015
RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT
Holiday Inn, Birmingham
£490

11 December 2015
RCoA CAREER DAY
Manchester Conference Centre
Free of charge

14 December 2015
CPD STUDY DAY: CHALLENGES IN PERIOPERATIVE CARE OF THE ELDERLY SURGICAL PATIENT
RCoA, London
£200 (£150 for RCoA registered trainees)

8.30 am
Registration

SESSION 1: ADVANCES IN REGIONAL ANAESTHESIA
Best for breast?... Serratus plane vs PECS vs Paravertebral (1A01, 1D02, 2G02, 2G03)
Quadrateus lumborum... the new TAP (1A01, 1D02, 2G02, 2G03)
Adductor canal... the perfect block? (1A01, 1D02, 2G02, 2G03)

SESSION 2: INNOVATION IN REGIONAL ANAESTHESIA
Using catheters in regional anaesthesia (1A01, 2G02, 2G04)
New drugs... liposomal bupivacaine, the panacea (1A01, 1D01, 1D02)
Ultrasound and MRI for needle placement (1A01, 1A03)

SESSION 3: UPDATES IN REGIONAL ANAESTHESIA
Outcomes in regional anaesthesia... what should we measure? (1G01, 1I05, 2G01)
Most influential papers in the last 24 months (2G02, 2G03, 2G04)

SESSION 4: EDUCATION
Where are we now with education in regional anaesthesia? (2H01, 2H02)
A license to practice regional anaesthesia? (2H01, 2H02)
Maximising safety with nerve blocks (2G01, 2G04)

5.20 pm
Close

DRINKS RECEPTION FOR ALL
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?
Dr J Oram, Leeds

Insertion of PICC’s, Hickmans, Ports. Introduction, how we do it – three short videos
Dr A Johnston, Cambridge

Catheter tip positioning
Dr A Bodenham, Leeds

Central venous access in the very small child
Dr J Bennett, Birmingham

Common problems
Blocked catheter management
Fibrin sleeves, mechanical blockage, fibrinolytics
Dr A Johnston, Cambridge

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
Dr T C See, Cambridge

4.30 pm
Close

ULTRASOUND WORKSHOP

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

8.45 am
Registration

Workshops
- 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

PROGRAMME MAY BE SUBJECT TO CHANGE

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

Workshops
- Anaesthesia for upper airway obstruction
- Anaesthesia for children with heart disease
- Time critical transfers

4.15 pm
Panel discussion and 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 through 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
- Awake FOI (2A01)
- Front of neck access (2B02)
- Extubation (1C02)
- The paediatric airway (3A01)
- Jet ventilation (3A01)
- Human factors (1L03)

4.00 pm – Close
Please note that programme stations may be subject to change

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

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

Day 1
9.00 am
Registration
EPOCH trial (2A03, 2A06)
Professor R Pearse, London
Airway management (3A01)
Dr A Higgs, Warrington
Goal directed therapy (2A04, 2A05)
Dr J Cosgrove, Newcastle
Transfer medicine (3A10, 3A11)
Lt. Col R Thomas, Dyfed
Obstetrics (2B05, 3B00)
Dr P Barclay, West Middlesex
Duty of candour and wilful neglect (1F01, 1F03, 1F05)
Mr C Dewhurst, London
Echocardiography for anaesthetists (3G00)
Dr N Morgan-Hughes, Sheffield
Bridging antithrombotic medication (1A02, 1E05)
Professor B Hunt, London
5.20 pm
Close

Day 2
8.40 am
Registration
Acute pain (1D01, 1D02)
Dr E Bain, Liverpool
Lung protective ventilatory strategies (2C02, 2C01)
Dr S Rogers, Liverpool
Regional anaesthesia (2A12, 3J03)
Dr T Adams, Lancashire
Is oxygen a dangerous thing? (2A07, 3J03)
Professor R Sneyd, Plymouth
Perioperative medicine (2A07)
Professor M Grocott, Southampton
Ebola (3C00)
Dr N Beeching, Liverpool
NAP5 results and conclusions (1E06, 3J03)
Dr J Pandit, Oxford
Managing a patient with pulmonary hypertension (1A01, 2A04, 3G00)
Dr G Martinez, Cambridge
4.30 pm
Close

PROGRAMME MAY BE SUBJECT TO CHANGE
ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
Monday, 28 September to Tuesday, 29 September 2015
Tuesday, 10 November to Wednesday, 11 November 2015
RCoA, London
£425 (£320 for RCoA registered trainees)
CPD Matrix codes covered: 1H01, 1H02, 2H01, 2H02
Event organiser: Dr S Williamson

Day 1
■ Personal learning objectives
■ Learning theories
■ Learning styles
■ Planning learning

Day 2
■ Workplace teaching
■ Assessment of professionals
■ Practice teaching and feedback
■ Practice teaching debrief

DRINKS RECEPTION FOR ALL

ANAESTHETISTS AS EDUCATORS: ANTS (ANAESTHETISTS’ NON-TECHNICAL SKILLS)
Monday, 24 August 2015
Wednesday, 18 November 2015
RCoA, London
£220 (£165 for RCoA registered trainees)
CPD Matrix codes covered: 1H01, 1H02, 2H01, 2H02
Event organiser: Dr P Milligan

This one-day course is designed for anaesthetic trainees and consultants, who wish to enhance their understanding of human factors and non-technical skills as applied to anaesthesia. It is also aimed at anaesthetists in a clinical or educational supervisor role, who wish to become more familiar with using ANTS for observation and feedback for trainees.

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

■ Educational critical incidents
■ Governance of education

Morning rotational workshops
■ Skills for appraisal
■ Educational supervision
■ Feedback

Afternoon rotational workshops
■ SUIs – How to deal with them and support a trainee through them
■ DIDs – Defining the problem, initial support
■ DIDs – Sorting problems, responsibilities, return to work

ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
Friday, 23 October 2015
RCoA, London
£220 (£165 for RCoA registered trainees)
CPD Matrix codes covered: 1H02, 2H01
Event organisers: Dr T Dorman and Dr A Cooper

■ Introduction to adult learning
■ Small group teaching
■ Presentation skills
■ Summary, feedback and homework

Rotational workshops
■ Teaching in theatre: introduction to teaching in the clinical setting
■ Assessment and effective feedback: introduction to and review of current methodologies
■ Supervision: principles of effective clinical and educational supervision
■ Trainees with problems: cause, analysis and remediation
CPD STUDY DAY
Wednesday, 30 September 2015
The Waterfront Hall, Belfast
£200 (£150 for RCoA registered trainees)
Event organiser: Dr B Darling

The CPD Study Day is designed to cover the essentials you need to keep up to date with your revalidation in anaesthesia.

Lectures on the day may include:
- The National Institute of Academic Anaesthesia (NIAA)
- IPPV during anaesthesia
- Refractory hypoxaemia in a DGH – what are my options?
- Perioperative medicine
- Benefits of CPEX
- NAP5
- Perioperative fluid optimisation

Trainee Abstract Competition
The closing date for abstract submissions is 23 August 2015. To enter the competition, please visit the RCoA Events page (www.rcoa.ac.uk/education-and-events) where more information on how to apply is available. Abstracts for presentation will be selected by the judges prior to the meeting.

PROGRAMME MAY BE SUBJECT TO CHANGE

JOINT RCoA/RSM MEETING:
EMERGENCIES IN ANAESTHETIC PRACTICE
Friday, 6 November 2015
RSM, London
Please visit the RCoA website for event fees
Event organiser: Professor R Mirakhur

9.00 am
Registration

Cardiac arrest in theatre (1B04, 2A06)
Dr D Gabbott, Gloucester

Obstetric haemorrhage (2A06, 2B05, 3B00)
Dr N Lucas, Middlesex

Update to the DAS guidelines (to include a section on extubation) (1C02, 2A01, 3A01)
Dr S Radhakrishna, Coventry

Human errors and possible prevention (1I01, 1I03, 3J02)
Dr K Fong, London

Malignant hyperpyrexia (1B04, 2A06)
Professor P Hopkins, Leeds

Managing the acutely injured brain (2A02, 2F01, 3F00)
Professor M Smith, London

Anaphylaxis (1B01, 2A06)
Dr L Garvey, Denmark

NAP6 (3J02)
Dr N Harper, Manchester

Equipment failures (1A03, 2A06)
Dr T Clutton-Brock, Birmingham

5.15 pm
Close

5.20 pm
DRINKS RECEPTION FOR ALL
CONTINUING PROFESSIONAL DEVELOPMENT DAY
Saturday, 21 November 2015
RCoA, London
£240 (£180 for RCoA registered trainees)
Joint Rate: A joint rate of £490 (£370 for RCoA registered trainees) is available for those attending both the Continuing Professional Development Day and the RCoA Winter Symposium
Event organiser: Dr J Nolan

9.00 am
Registration
The Continuing Professional Development Day 2015 will comprise of 12 lectures, running in two different streams. Delegates are able to choose six lectures, one from each session.

<table>
<thead>
<tr>
<th>STREAM A</th>
<th>STREAM B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SESSION 1: RECENT ADVANCES</strong></td>
<td><strong>SESSION 1: RECENT ADVANCES</strong></td>
</tr>
<tr>
<td>1A Videolaryngoscopy for all</td>
<td>1B Emergency laparotomies</td>
</tr>
<tr>
<td><strong>SESSION 2: CLINICAL PRACTICE 1</strong></td>
<td><strong>SESSION 2: CLINICAL PRACTICE 1</strong></td>
</tr>
<tr>
<td>2A Anaesthesia for the obese patient</td>
<td>2B Major trauma</td>
</tr>
<tr>
<td><strong>SESSION 3: CLINICAL PRACTICE 2</strong></td>
<td><strong>SESSION 3: CLINICAL PRACTICE 2</strong></td>
</tr>
<tr>
<td>3A Perioperative fluid therapy</td>
<td>3B ß-Blockers, statins and stents in perioperative care</td>
</tr>
<tr>
<td><strong>SESSION 4: CRITICAL INCIDENTS</strong></td>
<td><strong>SESSION 4: CRITICAL INCIDENTS</strong></td>
</tr>
<tr>
<td>4A Resuscitation guidelines 2015</td>
<td>4B Anaphylaxis</td>
</tr>
<tr>
<td><strong>SESSION 5: PERIOPERATIVE MEDICINE</strong></td>
<td><strong>SESSION 5: PERIOPERATIVE MEDICINE</strong></td>
</tr>
<tr>
<td>5A The anaesthetist as a perioperative physician</td>
<td>5B Preoperative risk stratification</td>
</tr>
<tr>
<td><strong>SESSION 6: CLINICAL PRACTICE 3</strong></td>
<td><strong>SESSION 6: CLINICAL PRACTICE 3</strong></td>
</tr>
<tr>
<td>6A How to do ultrasound and how it improves your life</td>
<td>6B Acute pain management</td>
</tr>
</tbody>
</table>

3.35 pm
Close

JOINT RCoA/RCEM STUDY DAY:
MAJOR TRAUMA
Tuesday, 24 November 2015
RCoA, London
£200 (£150 for registered trainees)
Event organisers:
Dr S Reid and Dr J Nolan

- 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 MAY BE SUBJECT TO CHANGE

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**

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

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

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

4. **Step 4**
   Log your CPD Credits earned by logging a Personal Activity on the CPD System/e-Learning/e-Portfolio.
RCoA WINTER SYMPOSIUM: A REVIEW OF TRENDS AND CONTROVERSIES IN CURRENT PRACTICE

Thursday, 19 November to Friday, 20 November 2015
RCoA, London
£395 (£295 for registered trainees)
Joint Rate: A joint rate of £490 (£370 for RCoA registered trainees) is available for those attending both the RCoA Winter Symposium and the Continuing Professional Development Day
Event organiser: Dr R Alladi

Day 1
9.00 am
Registration
SESSION 1: CARDIOVASCULAR
■ Perioperative hypertension: implications for our practice
■ 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 – some tips
5.25 pm – Close
DRINKS RECEPTION FOR ALL

Day 2
8.30 am
Registration
SESSION 5: OUTSIDE THEATRES
■ Safe sedation – best practice, drugs and techniques, patients’ perspective
■ Anaesthetic management for procedures outside the operating theatre
SESSION 6: MANAGEMENT ISSUES
■ How to maintain a good image in your department?
■ Quality and outcomes – best practice?
FREDERIC HEWITT LECTURE
PRESENTATION OF RCoA AWARDS
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

PROGRAMME MAY BE SUBJECT TO CHANGE

8TH ANNUAL MEETING: CLINICAL UPDATES IN PAIN MEDICINE

Friday, 27 November 2015
RCoA, London
£195 (£140 for trainees)
Event organisers: Dr S Gupta and Dr S Balasubramanian

9.00 am
Registration
Pain following amputation
Dr M Neil, Dundee
Perioperative management of patients on opioid maintenance therapy
Dr Scott-Warren, Manchester
Trainee publication Prize
Developments: FPM
Dr K Grady, Dean, FPM
Patrick Wall Guest Lecture
Professor A Rice, London
Debate: ‘WHO pain ladder for cancer pain’
Against – is not valid in modern practice (Professor S Ahmedzai, Sheffield)
For – is still valid in modern practice (Dr M Chaudhari, Worcester)
Pulsed Radiofrequency: where are we now?
Dr C McCrory, Dublin
Chronic pain and teenagers
Dr Vasu, Leicester
Non-analgesic effects of opioids
Dr S Ramaswamy, London

5.00 pm
Close
FRCA Examinerships academic year 2016–2017

The College invites applications for vacancies to the Board of Examiners in the Fellowship of the RCoA, for the academic year 2016–2017. Examiners will be recruited to the Primary examination in the first instance. The number of Examiners required will reflect the number of retirements from the current Board of Examiners.

Applicants shall be assessed against a comprehensive Person Specification (PS) which, along with the Job Description (JD) and applications forms for this role can be downloaded from the College website (www.rcoa.ac.uk/node/313).

An outline of key essential requirements for the role of FRCA Examiner, are set out below (although applicants must read the PS and JD before applying):

**a Essential**

1. Fellow by Examination, a Fellow ad eundem, or a Fellow by election of the RCoA.
2. In good standing with the RCoA.
3. Holds full registration, without limitation, with the GMC.
4. At least five years’ experience as a consultant/SAS grade.
5. Shall currently be active in clinical practice in the NHS.
6. On 1 September 2015 shall have the expectation of completing at least ten years as an FRCA examiner.
7. Can demonstrate active involvement in the training and assessment of trainees.
8. Within the past five years shall have visited a Primary or Final FRCA examination.
9. Good written and verbal communication skills.
10. Ability to work as part of a team.
11. Documentary evidence of satisfactory completion of Equal Opportunities training in the last three years and willingness to undertake further exam specific E&D training on an annual basis.
12. Able to commit to long-term and active involvement in examiner duties including the ability to devote a minimum of 12 days per academic year to the role. This includes both the delivery and development of the examinations

**b Desirable**

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

Copies of the PS, JD and application form can also be obtained by contacting, the Training and Examinations Directorate (020 7092 1525 or exams@rcoa.ac.uk).

The closing date for receipt of completed application forms is Monday, 12 October 2015.

ELECTION TO COUNCIL OF THE COLLEGE 2016

Prospective Council Members’ Education Session

8 September 2015
4.00 pm to 6.00 pm at RCoA, London

If you are interested in standing for election to Council for 2016 and would like to attend the education session, please contact the Chief Executive’s office on 020 7092 1612.

Details of the Council election vacancies will be available on the website from September 2015.

Deaths

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

Professor M H Holmdahl, Sweden
Dr D Jewkes, London
Dr R Millar, London
Dr L A Pike, Michigan, USA

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).
Consultations

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

<table>
<thead>
<tr>
<th>Originator</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Party Parliamentary Group for Patient and Public Involvement in Health and Social Care/ The Patients Association</td>
<td>Invitation to provide written evidence on Complaints Handling in the NHS and Social Care Sector</td>
</tr>
<tr>
<td>General Medical Council</td>
<td>changes to improve our fitness to practise investigations and hearings</td>
</tr>
<tr>
<td>General Medical Council</td>
<td>Lay and Patient Involvement in Curricula Development and Assessment Systems</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Consultation on the implementation of the recommendations, principles and actions set out in the report of the Freedom to Speak Up review</td>
</tr>
<tr>
<td>British Thoracic Society</td>
<td>Draft guideline for the Ventilatory Management of Acute Hypercapnic Respiratory Failure in adults</td>
</tr>
<tr>
<td>Royal College of Surgeon (England)/Children’s Surgical Forum</td>
<td>Standards for the Non-Specialist Emergency Surgical Care of Children</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>Guideline on Intravenous fluids therapy in children</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>Guideline on transfusion</td>
</tr>
</tbody>
</table>

The RCoA Bulletin is published bi-monthly and distributed to over 16,000 anaesthetists worldwide, the vast majority being in the UK. Advertisements for courses and meetings from anaesthetic societies, or those organisations that are of interest to anaesthetists, are accepted with prior approval of the Editor or Editorial Board.

Advertisements must fit with the aims and aspirations of the RCoA and be related to anaesthesia, critical care and pain medicine. Please contact bulletin@rcoa.ac.uk for separate commercial advertising rates.

Rates below are valid up to and including the May 2016 issue:

- **Quarter page (portrait)** (85 mm by 124 mm)
  - £283 +VAT
- **Half page (portrait)** (85 mm by 252 mm)
  - £560 +VAT
- **Full page** (175 mm by 252 mm)
  - £897.50 +VAT

Please go to the website (www.rcoa.ac.uk/node/19445) to complete the necessary Terms and Conditions and to submit your advert online.
Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

Dr Y Ahmad
Queen Alexandra Hospital, Portsmouth Hospitals NHS Trust

Dr R Arumugam
South Tyneside District Hospital, Tyne and Wear

Dr T W A Mackie
Northumbria Healthcare NHS Trust, Tyne and Wear

Dr K A Parsons
Chesterfield Royal Hospital, Derbyshire

Dr M Raza
Luton and Dunstable University Hospital, Bedford

Dr S Sharma
Basildon University Hospital, Essex

Appointment of Members, Associate Members and Associate Fellows

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

Associate Fellows
Dr Thomas Kelgiorgis
Dr Ashok Sinha

Members
Dr Patrick Jonathan Cowan

Associate Members
Dr Sally Farid Abou Ghazaleh
Dr Gemma Louise Talling
Dr Stefan Richard Cozma

PROFESSIONAL STANDARDS COMMITTEE
Patient Information Lead

The RCoA is currently looking for a consultant anaesthetist to take part in the updating and development of the Patient Information Leaflets (www.rcoa.ac.uk/patientinfo).

What does being the Patient Information Lead member involve?
The Patient Information Lead will be the chair of the Patient Information Working Group of the Professional Standards Committee. Working closely with the Lay Committee, they will update the patient information leaflets on a five-yearly basis, respond to ongoing inquiries regarding the leaflets and develop new leaflets as necessary. This editorial position will require strong attention to detail and, most importantly, a passion for providing information to patients regarding different aspects of anaesthesia.

How do I get involved?
Please submit a short CV, with a brief statement of your strengths suited to the advertised position by 31 July 2015.

For further information please contact:
pkwok@rcoa.ac.uk.

PGCert Multidisciplinary Healthcare Simulation

If you are a health care professional with an interest or involvement in delivering training and education, this course is for you.

This course provides you with the knowledge and skills required to design, develop and facilitate multidisciplinary healthcare simulation training.

The programme offers you the opportunity to study:
- how the principles of adult and experiential learning theory can be applied to simulation training.
- the process of creating simulation scenarios using various simulation techniques and concepts underlying effective debriefing.
- the variety and importance of human factors in healthcare practice.

For more information, please contact Jessica Dalton on j.a.dalton@bham.ac.uk and have a look at our website: www.birmingham.ac.uk/healthcare-simulation.
PATIENT SAFETY CONFERENCE
Wednesday, 4 November 2015
Thinktank Theatre, Birmingham
£215
CPD Matrix code covered: 1I05, 1F05, 1I02, 3I00
Event organiser:
Dr T Clutton-Brock

8.45 am
Registration

■ Update from the Safe Anaesthesia Liaison Group (SALG)
■ Update from the AAGBI Safety Board
■ The link between freedom to speak up and patient safety
■ Influencing others and improving patient safety
■ Developing safer clinical systems
■ National Audit Projects – using data to improve quality and patient safety
■ Anaesthesia and undergraduate medical education
■ Training for patient safety: the review of the national curriculum
■ Improving regulation of medical devices
■ What can healthcare learn from Formula One?
■ Applying safety learning from the nuclear power industry to anaesthesia

Abstract competition
This year the Patient Safety Conference will be held at the Thinktank Theatre in Birmingham. Trainees are welcome to submit an abstract entry with the subject matter of Patient Safety which will then be selected to present at the event.

Abstract Deadline:
Midnight, Wednesday 26 August 2015

Please visit the RCoA website for more information.

4.45 pm
Close

NEUROANAESTHESIA AND NEUROCRITICAL CARE CPD UPDATE
Friday, 2 October 2015
RCoA, London
£175 (£145 NASGBI members)
Event organiser: Dr J Dinsmore

9.00 am
Registration

■ Rotating workshops:
  1. Emergency management of cervical spine injury
  2. Neurosurgery in pregnancy
  3. Management of the child for emergency neurosurgery
■ How should we use ethics objectively in medical decision-making; dilemmas in the diagnosis of brain death and organ donation.
■ Management of bleeding and clotting in neurosurgery and neurotrauma.
■ Intravenous fluids in neurosurgical and trauma patients – the latest.
■ Intra-arterial thrombectomy – the future.

4.30 pm
Close
17th Current Controversies in Anaesthesia & Peri-Operative Medicine

Dingle, Co. Kerry, Ireland
7th - 11th October 2015

We are delighted to announce that the 2015 conference is in collaboration with:

- The Intensive Care Society of Ireland’s (ICSI) Autumn Meeting, Saturday 10th October 2015.
- The South of Ireland Association of Anaesthetists (SIAA) Annual Scientific Meeting, Saturday 10th October 2015.

Speakers include

- Liam Brennan - Vice-President, Royal College of Anaesthetists
- Tim Cooke - RCoA Advisor to National Audit Projects
- Mike Grocott - Director NIAA Health Services Research Centre
- Gary Minto - Consultant Anaesthetist, Plymouth
- Monty Mythen - Chair RCoA Perioperative Medicine Programme
- Rupert Pease - NIHR Research Professor & Consultant in Intensive Care Medicine, Queen Mary University of London

"Superb. All speakers were consistently good."
"I thought it was absolutely fantastic from the quality of lectures the great entertainment to the hotel staff who were so welcoming and efficient. Of course the scenery goes without saying!"
"Good program, beautiful venue, friendly conference"
"Loved it! The setting, the content, the company"
"Useful meeting. Well organised, good range of topics covered."
"Really well organised with interesting and relevant content."

Regional EBPOM 2015 - Exeter

Sandy Park
17th November 2015

- Colin Berry, Exeter - A model of care for perioperative medicine: the role of the anaesthetist
- Frances Forrest, Bristol - Setting up a 'Preparation for Surgery' Service
- Malcolm West, Southampton - Prehabilitation - designing a preoperative exercise training program
- Peter Nightingale, RCoA - 'Critical Care Services - The Future': an update
- Monty Mythen, UCLH - Manpower issues and the economic case for change
- Raman Moonesinghe, UCLH - Long term outcomes from surgery
- John Prowle, Barts - Follow up of acute kidney injury complicating surgery
CARDIOTHORACIC ANAESTHESIA,
CRITICAL CARE AND ECHOCARDIOGRAPHY

Association of Cardiothoracic Anaesthetists’
Education and CPD Meeting
Royal Society of Edinburgh, Edinburgh
12–13 November 2015

This meeting will be highly relevant to trainees of all specialties, including those considering or actively pursuing a career in cardiothoracic anaesthesia and critical care. Additionally, it will also be appropriate for consultants and career grade doctors wishing to obtain education for their continuing professional development (CPD) portfolio, as well as learning or re-enforcing important practical skills. This will allow consultants to update the specific specialist requirements for revalidation and CPD as detailed in Level 3 of the Royal College of Anaesthetist’s Matrix for revalidation.

The first day will consist of a rolling programme of three workshops on ‘Management of Bleeding, Critical Care Ultrasonic Imaging, Lung Isolation and One-Lung Ventilation’. The second day will be a series of lectures addressing the basic theoretical knowledge that is used in the everyday practice of cardiothoracic anaesthesia, critical care and echocardiography.

For more information go to www.actameetings.co.uk
or email Jane Heppenstall (jane@eventmanagementdirect.co.uk)
or Faye Deakin (enquiries@eventmanagementdirect.co.uk)

PROGRAMME – FRIDAY 13 NOVEMBER 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30-09:10</td>
<td>ACUTE LUNG INJURY ASSOCIATED WITH LUNG RESECTION (2A07, 2C01, 2C02, 3G00)</td>
</tr>
<tr>
<td>09:10-09:50</td>
<td>POSTOPERATIVE CARE AFTER THORACIC SURGERY (1D02, 2A07, 2E01, 2C02, 2C04)</td>
</tr>
<tr>
<td>09:50-10:30</td>
<td>EQUIPMENT FAILURE AND MISUSE (1A03, 1I01, 1I03, 3G00)</td>
</tr>
<tr>
<td>10:50-11:30</td>
<td>COFFEE</td>
</tr>
<tr>
<td>11:30-12:10</td>
<td>ECHOCARDIOGRAPHY FOR NON-CARDIAC ANAESTHESIA (2A03, 2A04, 3G00)</td>
</tr>
<tr>
<td>12:10-12:40</td>
<td>CRITICAL CARE ULTRASONIC IMAGING (2C01, 3G00)</td>
</tr>
<tr>
<td>12:40-13:20</td>
<td>LUNCH</td>
</tr>
<tr>
<td>13:20-14:00</td>
<td>CURRENT TECHNIQUES OF CARDIOPULMONARY BYPASS (2A07, 3G00)</td>
</tr>
<tr>
<td>14:00-14:40</td>
<td>IS TIVA ASSOCIATED WITH MORE ADVERSE OUTCOMES THAN INHALATIONAL ANAESTHESIA? (1I05, 3G00)</td>
</tr>
<tr>
<td>14:40-15:20</td>
<td>DIAGNOSIS AND ASSESSMENT OF HAEMODYNAMIC SHOCK (2C03, 3G00)</td>
</tr>
<tr>
<td>15:20-16:00</td>
<td>WHAT IS THE BEST POSITIVE INOTROPE TO TREAT HAEMODYNAMIC SHOCK? (1A02, 2C03, 3G00)</td>
</tr>
</tbody>
</table>
Resuscitate, Recover, Mobilise
The State of the Art is changing.....
You have told us you want more interaction with the speakers, more engagement, better networking, and clearer take-home messages.
We have listened. Sessions will be planned to allow more debate and clear clinical learning points. There will be more opportunities to mix informally with experts and other delegates.
Interactive sessions, social media and open-access online resources will let you get the answers you need to translate the latest research to your clinical practice.
Please register for State of the Art by visiting soa.ics.ac.uk

BOOKING NOW OPEN
12-14 NOVEMBER
2015

Dublin
DUBLIN

Access for free with your college subscription
bjaoxfordjournals.org
bjaed.oxfordjournals.org
The Writers Club has seen more than 450 trainees through the SAQ Papers with a successful first-time pass rate for those who have kept to the necessary disciplines. But many trainees apply far too close to the examination to derive anything like the full benefit from Membership. That full benefit includes free admission to the SAQ Weekend Courses, the acquisition of a large and useful collection of answer sheets and a valuable motivation towards sustained revision.

Membership fee: a single payment of £400
Members are entitled to all benefits until successful in the SAQ Paper
Attendance to the SAQ Weekend Course – free of charge

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

Candidates are urged to join earlier than later for the Spring 2016 Examination to reap maximum benefit

Enquiries to: writersclub.msa@gmail.com

### Courses for the RCoA Examinations

<table>
<thead>
<tr>
<th>Courses</th>
<th>Dates 2015/2016</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary SBA/MCQ</td>
<td>7–13 August</td>
<td>24–30 October</td>
</tr>
<tr>
<td>Primary SBA Only</td>
<td>7–9 August</td>
<td>24–26 October</td>
</tr>
<tr>
<td>Primary MCQ Only</td>
<td>10–13 August</td>
<td>27–30 October</td>
</tr>
<tr>
<td>Primary OSCE/Orals</td>
<td>16–23 October</td>
<td>January 2016</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>2–4 October</td>
<td>December 2015</td>
</tr>
<tr>
<td>Primary Viva Weekend</td>
<td>9–11 October</td>
<td>January 2016</td>
</tr>
<tr>
<td>Final SBA/MCQ</td>
<td>14–20 August</td>
<td>February 2016</td>
</tr>
<tr>
<td>Final SBA Only</td>
<td>14–16 August</td>
<td>February 2016</td>
</tr>
<tr>
<td>Final MCQ Only</td>
<td>17–20 August</td>
<td>February 2016</td>
</tr>
<tr>
<td>Final SAQ Weekend</td>
<td>21–23 August</td>
<td>February 2016</td>
</tr>
<tr>
<td>Final Written ‘Booker’</td>
<td>23–28 August</td>
<td>February 2016</td>
</tr>
<tr>
<td>Final Viva Revision</td>
<td>November 2015</td>
<td>May 2016</td>
</tr>
<tr>
<td>Final Viva Weekend</td>
<td>November 2015</td>
<td>May 2016</td>
</tr>
</tbody>
</table>

‘I passed the Exam on Thursday and put a lot of this down to your course. Yes, you absolutely need to put in the hard work before, but the course is instrumental in reinforcing topics, developing a structure for answers and, realising that the 3C’s is really very true! I have so much more to say but don’t want to waffle on too much. All the advice we were given on the course I took on board and this really did contribute to my success. I am a Mersey Convert. I came to the MCQ Course and passed first time; and now the OSCE/SOE. I will definitely be coming on all the Finals Courses!’

– Feedback Primary Candidate 2015

To see details of all of our courses please visit: [www.msoa.org.uk](http://www.msoa.org.uk) or contact us at: [enquiries@msoa.org.uk](mailto:enquiries@msoa.org.uk)
CONTACT INFORMATION

Chief Executive’s Office
Kevin Storey  
Chief Executive  
020 7092 1612

Mark Blaney, Director of Finance  
finance@rcoa.ac.uk  
020 7092 1581

Natasha Marshall, Facilities Manager  
facilities@rcoa.ac.uk  
020 7092 1510

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

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

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

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

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

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

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

Meetings and Events  
events@rcoa.ac.uk  
020 7092 1673

National Institute of Academic Anaesthesia (NIIA)  
info@niiia.org.uk  
020 7092 1680

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

Sonia Larsen, Director of Communications  
larsen@rcoa.ac.uk  
020 7092 1532

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

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

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

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

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

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

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

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

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

Training and Examinations Directorate
Russell Ampofo, Director of Training and Examinations  
020 7092 1522

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

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

Equivalence  
equivalence@rcoa.ac.uk  
020 7092 1655

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

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

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

Trainees  
trainee@rcoa.ac.uk  
020 7092 1573

Quality Assurance  
020 7092 1652

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