AESTHESIA

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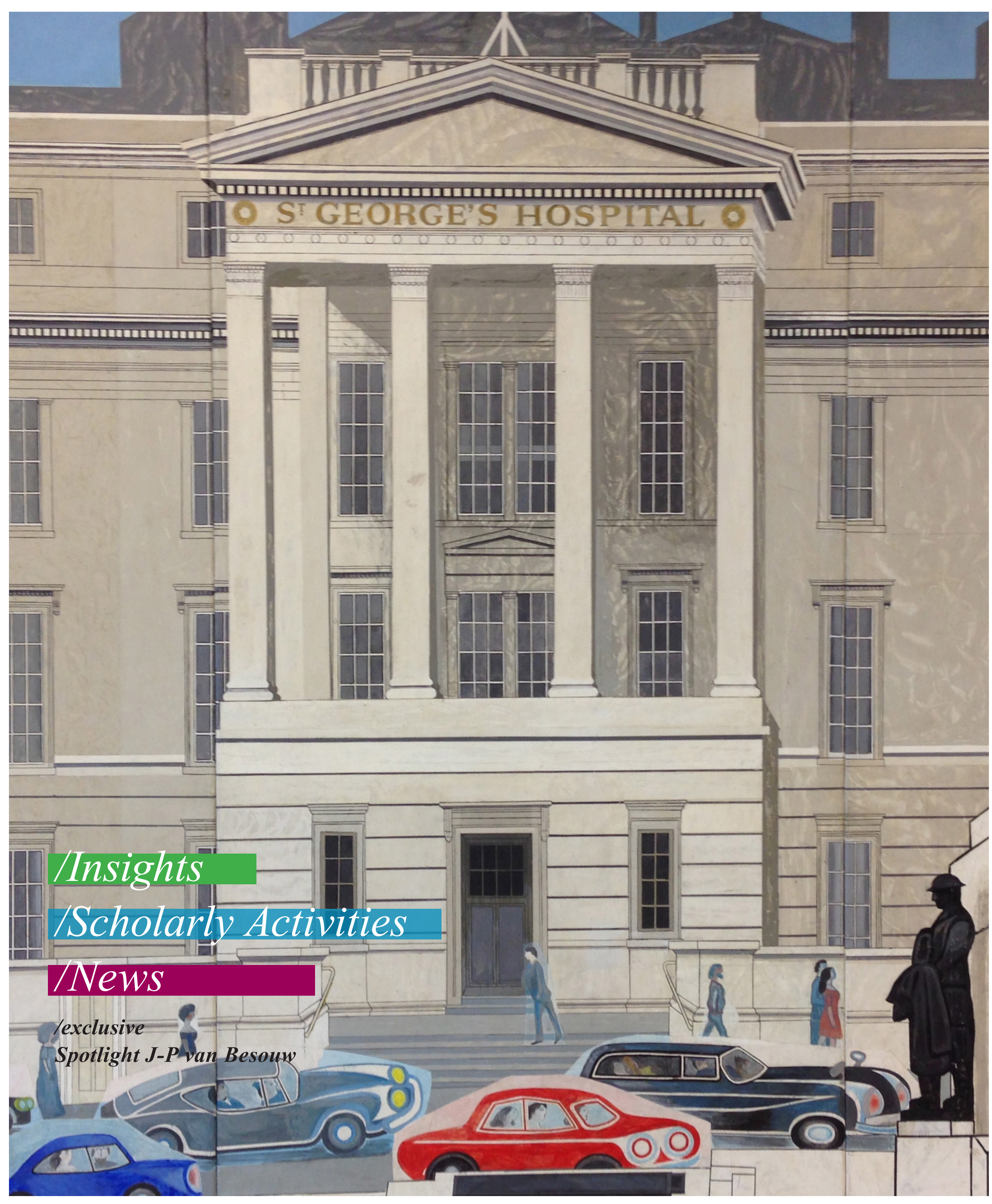
2014

BULLETIN | *DEPARTMENT OF ANAESTHESIA*
St. George's HealthCare NHS Trust



/Insights

/Scholarly Activities

/News

/exclusive
Spotlight J-P van Besouw

AESTHESIA

MEANING:

The normal ability to experience sensation

ETYMOLOGY:

Back formation from anaesthesia (loss of sensation), from Greek an- (not) + aisthesis (sensation). Earliest documented use: 1829; anaesthesia is from 1721.

Cover photo

St George's Hospital, Hyde Park Corner, London.
© the estate of Edward Bawden
Date painted: 1970s
Oil & paper collage on five panels, 91 x 225 cm (estimated)

Collection: St George's Hospital
From 1732 to the early 1980s St George's Hospital was located at Hyde Park Corner. This view of its prestigious buildings was commissioned from Edward Bawden to display in the Hospital's new premises at Tooting. It has hung in the main entrance at Tooting ever since.

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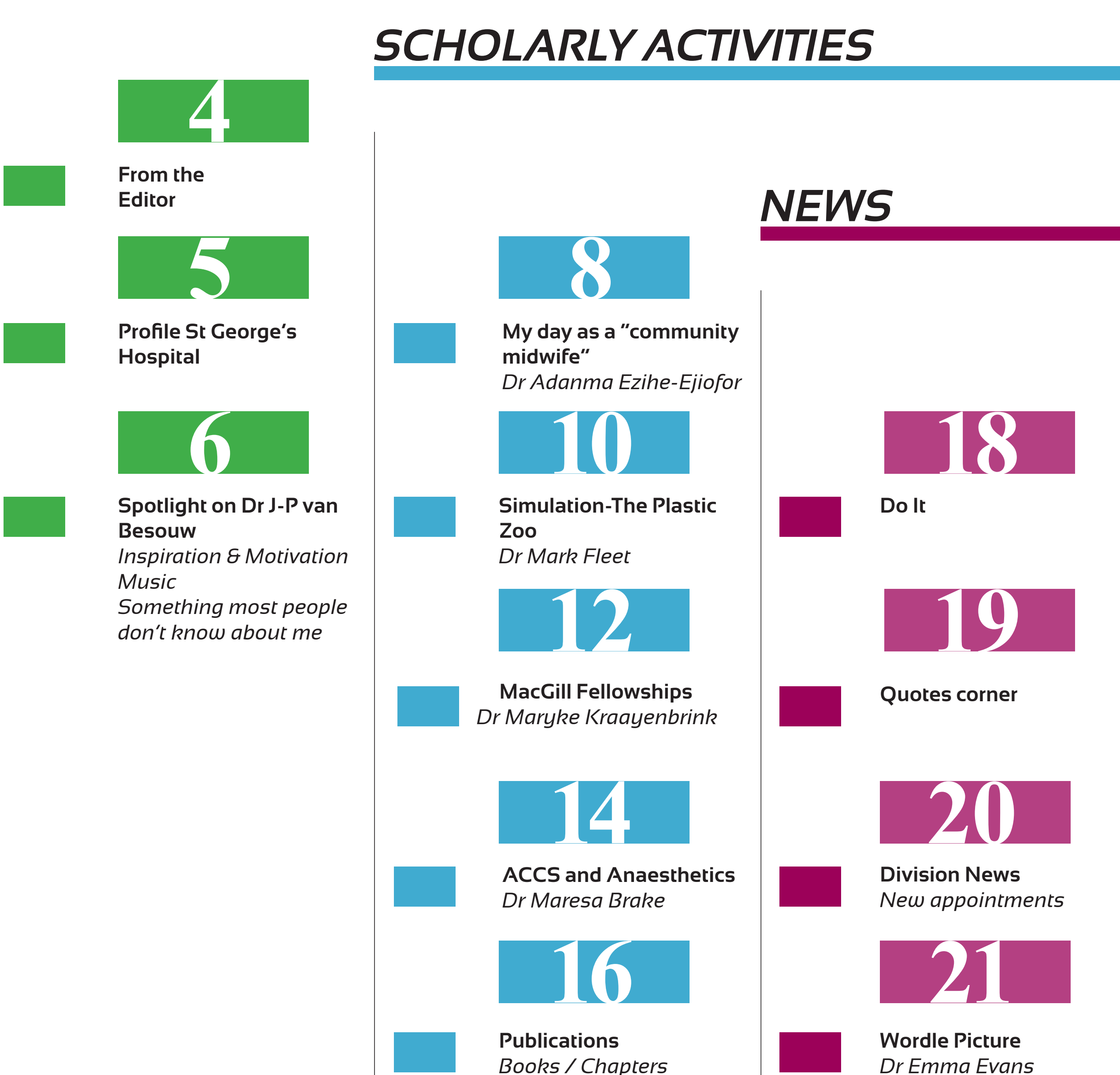

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From the Editor

Dr Tony Addei

"When the better becomes routine ..., then best might follow and the battle is won"
– Andrejowski

I am delighted to welcome you to the maiden issue of Aesthesia, a bulletin that focuses on sampling the anaesthetic department's activities in patient care, education and research.

I believe that we should highlight and be proud of the exceptional services we offer our patients, the hospital, the NHS and academia.

Aesthesia is a quarterly bulletin aimed at a variety of people - members and friends of the anaesthetic department, hospital and alumni.

In this edition, the spotlight is on Dr J-P van Besouw, President of the Royal College of Anaesthetists. He gives us an incredible insight into the things that inspire and motivate him.

In the scholarly activities section, Dr Ezihe-Ejiofor writes about empathy, and presents a fascinating account of an anaesthetic trainee trying out the job of a community midwife for a day. Dr Fleet writes a humorous but very well thought out piece on simulation, and Dr Brake, an Acute Care Common Stem trainee, reviews the six-month rotation she recently undertook in anaesthetics.

Quotes corner, Do It and the other articles are informative, reassuring and encouraging.

I sincerely hope that you enjoy this issue and would be very pleased to receive your contributions, comments and letters to the editor.

I would like to acknowledge the help of Dr Liban for his invaluable contribution, including his photography skills in capturing the pictures for the front cover and page 5.

Thanks also to everyone who has helped, and with your support Aesthesia should thrive.

Profile

St George's Hospital

The hospitals and health centres that make up St George's Healthcare NHS Trust have a rich history dating back to the opening of the original St George's Hospital on Hyde Park Corner in 1733.

St George's Hospital is one of the UK's largest teaching hospitals. It shares its main hospital site in Tooting, in the London Borough of Wandsworth, with the St George's, University of London (SGUL). This modern, innovative, academic and research organisation is built upon a rich history stretching back 250 years.

Alumni include John Hunter, known as the father of modern surgery, and Edward Jenner, creator of the first vaccine, used to eradicate smallpox.

A major acute hospital with around 1,000 beds, St. George's Hospital is an accredited centre of excellence for accident and emergency services, tertiary maternity and specialist care for more complex injuries and illnesses including neurology, cardiac care, renal transplantation, cancer care, vascular care and stroke. It is also home to one of the four major trauma centres and one of eight hyper-acute stroke units for London.

The recently built helipad is the second hospital helipad in London and the first south of the river Thames.

Anaesthetic Department

The department has over 90 consultants who provide expertise in the various anaesthetic subspecialties.

Our highly acclaimed courses include airway days (for trainees and also for consultants) for up to date teaching and training on airway topics and advanced airway techniques, transoesophageal echocardiology (TOE) courses (didactic and hands on learning, and live demonstrations), and regional anaesthesia courses (upper and lower limb regional anaesthesia and anatomy teaching on cadavers and live models).

There are many training opportunities, modules and fellowships available at St George's Hospital. Fellowships are advertised by the School of Anaesthesia.

Spotlight

Dr J-P van Besouw

BSc (Hons) MB, BS, FRCA, FRCP Edin, FRCS (Hon)

Dr van Besouw qualified in 1981 from St Bartholomew's where he began his anaesthetic training. He subsequently trained in London and Perth, Australia before his appointment in 1990 to St George's Hospital NHS Trust as a consultant and honorary senior lecturer with a specialist interest in cardiothoracic anaesthesia.

Dr van Besouw, known to most simply as "J-P" has been President of the Royal College of Anaesthetists since September 2012. In 2013, he was elected Vice-Chairman of the Academy of Medical Royal Colleges.

He is chair of the Board of Trustees of the Faculty of Intensive Care Medicine. He is an elected Governor of St George's Hospital, a Trustee of the Cardiothoracic Fund and Trustee of Trainees Fund at St George's Hospital.

J-P is a past Chairman of the Association of Cardiothoracic Anaesthetists (ACTA) and has been a member of a number of national working parties on cardiothoracic related issues. He is a reviewer for a number of anaesthetic journals and a member of the BJA Editorial Board and a Director of the BJA. For 13 years he was an FRCA examiner and chaired the exams committee at the College for the last 3 years of that tenure. He has published articles and lectured widely on cardiothoracic and examinations related topics.

He is married to Liliane - a medico legal adviser with the MPS and former consultant in anaesthesia and intensive care - and has three grown up children, including twin daughters.

J-P enjoys sarcasm, irony (a life long subscriber to Private Eye), gardening, rugby (Leicester Tigers) and travel, particularly in South West France.

Q&A

Inspiration

Book:
Voodoo Histories by David Aaronovitch. Using caustic rationality, it debunks the conspiracy theories that abound in modern day history, for example, who shot JFK. Aaronovitch carefully unpicks the illogical arguments fuelled by the conspiracy theorists.

I am keen to improve the public perception of anaesthesia as a specialty.

Person:

I am not sure that I hold any one individual in such high regard as to place them upon a pedestal.

I admire more, certain characteristics in people such as honesty, integrity, intelligence, determination and a degree of self-deprecation. As the poet John Donne said, "No man is an island...."

Place:

The view from La Matarie, our house in SW France, built in 1870 and abandoned 75 years ago, which we slowly restored over a 5 year period from 2006.

Anaesthesia equipment, event or person?

Person - Dr Brian Gillett.

He was Head of the Anaesthetic Department at Barts, when I was a medical student.

When I expressed an interest - as an HP- to pursue a career in anaesthesia, I went to see Dr Gillett and was offered a senior house officer post to start after house job; no advert, no interview, no references required!

Motivation

I dislike paternalism and firmly believe that doctors need to improve their communication skills. The selection of medical students based largely upon the attainment of knowledge tests is hardly likely to achieve this.

I am keen to improve the public perception of anaesthesia as a specialty. I like to challenge established dogma and make people think about what they do and the way they do it.

Music

Whatever is on Liliane's I-pod playlist at the time. We share a common library.

Something most people don't know about you.

I have never owned or worn a pair of denim jeans!

Photo: La Matarie, view from the house.

Dr Adanma Ezihe-Ejiofor
ST7 Advanced Obstetrics

My day as a 'community midwife'

'Yes, I would like to go out with the community midwives to get a personal feel of what they do'. Maria Brown's response to my request left me in no doubt that this was a very unusual request from an anaesthetic trainee. Maria is Lead for the Community Midwifery Team in St George's Hospital and she was my first point of contact.

What could an anaesthetist learn from a one day placement with a team of community midwives?

For one thing, our zones of greatest interest – the airway and the perineum are at opposite poles of the human anatomy. My quest was more along the lines of the non-technical. The ability to understand and to some extent speak each other's 'professional language' has been shown to enhance successful collaborative working.

I hoped at the end of this inter-professional education intervention (the fancy phrase I used to sell the idea to my Educational Supervisor) to come away with a better appreciation of the community midwives workload, situation and challenges.

Why the community midwives?

The evidence base for Enhanced Recovery Programmes continues to be strengthened with the adoption of the pathway across various surgical specialties.[1]

The obstetric population consists of a cohort of largely fit, young women and readily lends itself to the principles of enhanced recovery. The outgoing President of the Obstetric Anaesthetists' Association (OAA), David Bogod remarked at a recent OAA meeting that Enhanced Recovery in Obstetric Surgery (EROS) is an area to watch in the near future.

Opponents of early discharge think that it might lead to increased incidence of jaundice, feeding problems and infections in the new-born. The evidence to support these claims is not compelling.[2]

NICE guidance recommends that women who are recovering well, apyrexial and do not have complications following caesarean section should be offered early discharge (after 24 hours) from hospital and followed up at home, because this is not associated

> *Empathy is … the ability to step into the shoes of another person, aiming to understand their feelings and perspectives, and to use that understanding to guide our actions. That makes it different from kindness or pity.*
>
> ***Roman Krznaric***

with more infant or maternal readmissions.[3]

Studies that have shown favourable outcomes from early discharge have stressed the importance of domiciliary support. This translates to an increased workload for the community midwifery teams. It is obviously vital to engage with these 'stakeholders'.

EROS is in place at St George's Hospital. What better time than during my Obstetric Anaesthesia Fellowship to engage?

4th July

Maria puts me in touch with Coral Bryan, another community midwife. After the initial 'shock' of my request, both are very supportive and go all out to facilitate this opportunity. A few phone calls, a few emails and we agree on a date.

The date immediately rings a bell as the Independence Day of the United States of America. What is not immediate recall is that on the same 4th of July, the Republic of the Philippines gained its independence in 1946 – ironically from the USA.

Enough of history!

So on Thursday, the 4th of July, I went out as part of the Ruby Team of community midwives. If you have any images of me struggling to deliver a ten pound baby with shoulder dystocia in a bath tub ... , you may safely banish such thoughts.

To have been part of that kind of real life drama, I would have had to go out with the Rainbow Homebirth Team. My presence caused a bit of a stir. 'Have you come to spy on us?' I was asked (tongue in cheek) by one of the team members. I assured them that I had no secret service contracts to my name!

The Ruby Team

The Ruby Team is a merger of the former Red and Pink Teams. It is based at St George's Hospital and geographically responsible for Tooting and Merton. Coral Bryan, the Ruby team leader, was my mentor for the day.

Coral arranged for me to witness two very different postnatal visit scenarios. Our initial trip is to a first time mother who is 'learning the ropes'. Both mother and partner participate in the assessment. Mother is examined, followed by baby who is weighed using a portable midwifery weighing sling. Outcome – mother and baby are doing well.

Our next visit takes us to the border between the Ruby and Emerald Teams. Unfortunately, this mother has lost her baby. Coral effortlessly doubles up as a midwife and a 'bereavement counsellor' during the visit. I also learn from Coral that midwife-led antenatal clinics run at St George's Hospital from Mondays to Sundays to enable them to cope with the huge workload.

Some days have double or even triple clinics. With over 100 new antenatal bookings each week, clinics have an attendance of hundreds of patients (new and old) every week.

The obstetric population consists of a cohort of largely fit, young women and readily lends itself to the principles of enhanced recovery.

Did I achieve my objectives?

Firstly, I picked up a few 'buzz words' which I have filed away. More importantly, if in the future I become a part of a team planning to introduce EROS into my hospital, I hope that a carefully timed vignette about my placement as a 'community midwife' would make the midwives see me more as an empathetic ally.

The author Roman Krznaric, defines empathy as "... the ability to step into the shoes of another person, aiming to understand their feelings and perspectives, and to use that understanding to guide our actions. That makes it different from kindness or pity."[4]

Sometimes, using our emotional intelligence to tap into the emotional energy in our organization brings about more sustainable change. Empathy has been described as a habit which we can cultivate. As part of this cultivation process, Krznaric recommends that we 'try another person's life'.

I was seeking to cultivate professional empathy so I decided to try another person's job. Albeit, just for one day!

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3. http://guidance.nice.org.uk/CG132/NICEGuidance/pdf/English.
4. http://startempathy.org/blog/2013/07/six-habits-highly-empathetic-people.

Dr Mark Fleet
ST6, Simulation Fellow

Simulation

The Plastic Zoo

The simulation centre has become an integral part of medical education. Ever since it's conception, the idea of simulation has drawn rather strange comparisons, none stranger than the association between simulation as a means to safer medical practice and polo mints.[1]

Educational posters

Within the George's Advanced Patient Simulation (GAPS) Centre, the machines and manikins as a means of training are a reality. The polo mints are missing, but one of the most striking features of the centre is the number of educational posters depicting animals.

Meerkats, Ferrets and Wombats stare back at you from glossy A2 posters lining the corridor (no prize for guessing which continent the clinical lead for GAPS comes from).

The animal acronym for each course is now a long standing tradition, but comparison between the simulation centre and the local zoo goes beyond these furry animals.

Analogy

The first analogy that can be drawn is between the cages and the simulation rooms. The SIM Labs are situated with an observation room on either side and the control centre overlooking both labs.

From within the control room, the all seeing facilitators (zoo keepers) can adjust the habitat and environment in order to produce the desired outcome (learning objectives). The participants can then be released into the cages, and with environmental manipulation, behavioural changes can be observed. Interaction between the participants can also be monitored and recorded.

On occasion, territorial posturing can even be witnessed. The promise of improvement in practice, and a free meal, act as motivation for continued observation and feedback.

With each course, the environment can be set up to mimic the natural environment of the participants, from A&E to a cardiothoracic theatre; just as zoo cages give the impression of the vast expanse of the Sahara Desert or the frozen waters of Antarctica. Each cage tries to replicate its occupier's natural environment, in order to observe natural behaviour.

However, in doing so, it often creates the feeling of unease and a variable degree of trepidation whenever it deviates from reality. Unlike a zoo, at the end of the day the simulation cages are opened, and the participants are released back into the wild.

Whether the skills and the behaviours learnt in the zoo are transferred back into everyday life is the subject of many a study[2,3] and is open to much debate.

> *The lions and hyenas can be allowed to interact together rather than having a cheetah with a hidden microphone ask if the zebra still has a pulse*

Photo: Dr Mark Fleet and HAL

Ethology

The analogy between simulation and ethology (the scientific study of animal behaviour) can be further expanded to encompass the world of mobile simulation. By taking manikins to the wards, we are keeping the participants in their natural environment. We are out of the 'zoo' and into the 'wildlife reserve', but there are boundaries, and safety precautions are established prior to the simulation commencing. Within the simulation laboratory, the illusion of the perfect environment is created, for example, the pre-prepared ECG and the fully stocked fridge.

However, step outside of the cage, and it is still a simulation centre, just as the Sahara Desert of the zoo stops at the electric fence. On the wards, all of the nuances and faults that accompany a modern hospital are present, leading to the challenges of imperfection and "environmental error".

As with wild life reserves, the participants are more at ease in their familiar environment. The sense of an artificial landscape is not present and if things do not work as they should, that is reality and not "simulated error". The other advantage of simulation within this native environment is that multidisciplinary interactions can be observed in a slightly less contrived way than in the zoo. The lions and hyenas can be allowed to interact together, rather than having a cheetah with a hidden microphone ask if the zebra still has a pulse.

Collaboration

This line of thinking led to my main project during my year as the simulation clinical fellow – "How to get the wildlife reserves to talk to each other". A program was already underway looking at improving simulation across disciplinary boundaries. Each area - perinatal, paediatric, anaesthetics and accident and emergency (PPANDA) were running simulation within their isolated silos.

The idea of interaction between them, led to the PPANDA collaboration. The aim was to run large multi-disciplinary simulations from the start of the patient pathway in accident and emergency, through to theatres and the wards. In reality, the PPANDAs reverted back to the isolation of their wildlife reserves. Due to the complexities of organisation, timing and service delivery, only a handful of simulations occurred.

The PPANDAs went silent and it was only on tracking them down, that we were able to see interactions that had not been present before. Contact between simulation leads (alpha males and females) in each of the silos, had been maintained and truly interactive. Multidisciplinary simulations were occurring within the natural environment. Discussions regarding the use of simulation, were taking place in an informal environment. Lessons learnt, were being shared, and improvements in patient safety, were being implemented and disseminated.

Multi-professional environment

So is there a place for the Simulation Laboratory within medical education? Is fully immersive mobile simulation within a multi-professional environment the best way to deliver education? The answer lies within the desired outcomes. In ethology, the zoo allows a safer, more controlled environment, in which to deliver specific and targeted understanding of the individual animals and their behaviour.[4] The zoo allows for a safe environment, in which the animal can explore certain aspects of it's habitat.

The wildlife reserves are key to monitoring interaction of animals within their own environment, and studying the interaction between different communities (herds) and species. Control over the learning objectives in this situation is more limited than in the zoo. However, observation and reflection, often bring to light points that have not been considered prior to running the scenario.

The plastic zoo is therefore a tool, only to be used once the animals accept it, as an environment that they wish to explore.

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MacGill Fellowships

By: *Dr Maryke Kraayenbrink*

Miss Domini MacGill

was the secretary to the Anaesthetic Department at St George's Hyde Park Corner and St George's Tooting. She retired in 1985 and died in November 2000. In her will she left a sum of money to the Anaesthetic Department and this is used to fund travel and visits to other anaesthetic departments or meetings that would not be eligible under standard study leave arrangements, e.g. to visit a specialist unit in this country and abroad.

Photo: Ms Domini MacGill

Recipients of MacGill Fellowship bursaries

- Dr Jones Kurian (2001): visit to pain centres, New York
- Dr Nicola Summerville (2002): undertake difficult airway training, Chicago
- Dr Emma Evans (2004): obstetric anaesthesia course, London
- Dr Agnieszka Crerar-Gilbert (2004): setting up ATLS course, Mumbai
- Dr Fiona Wrightson (2005): trauma care, South Africa
- Dr Soni Desikan (2006): attend obstetric anaesthesia meeting, Miami
- Dr Elaine Harrison (2006): work with Interplast (plastic surgery), Sri Lanka
- Dr Plat Razis (2007): visit to neurosurgical ITU, Seattle
- Dr Richard Hartopp (2007): difficult airway training, Chicago
- Dr Patrick Wong (2008): undertake difficult airway training, Chicago
- Dr Andrzej Krol (2008): visit the Hospital for Special Services, New York
- Dr Linda Menadue (2008): visit the Children's Hospital, Vietnam
- Dr Nadja Muller (2008): obstetric meeting, London
- Dr Elizabeth Combeer (2009): help with tuition fees for Masters degree in Medical Law and Ethics

Recipients of MacGill Fellowship bursaries (cont)

- Drs Rebecca Lea-Smith, Moein Tavakkolizadeh, Natalie Gravell and Sarah Hammond (2010): participate in a surgical camp organized by Health Partnership Nepal
- Dr Yuriy Kuybida (2012): Post Graduate Certification in Medical Simulation
- Dr Carin Dear (2012): training of anaesthetists, Zambia
- Dr Sophie Childs (2012): visit Groote Schuur Hospital, Cape Town
- Dr Carolyn Johnston (2013): Quality & Safety forum, London
- Dr Elizabeth Ogilvie (2013): help with course on Anaesthesia in Developing Countries, Uganda
- Dr Mark Edsell (2013): Kings Fund Management Course, London

The MacGill Fellowship gave me a great opportunity to go to a prestigious American teaching hospital whose motto is "Crescat scientia; vita excolatur" ["Let knowledge grow from more to more; and so be human life enriched"] ”

Dr Patrick Wong
MacGill award 2008
University of Chicago Medicine

Value

Awards are available to junior and senior members of the Anaesthetic Department and will normally be funded up to *£1,500*.

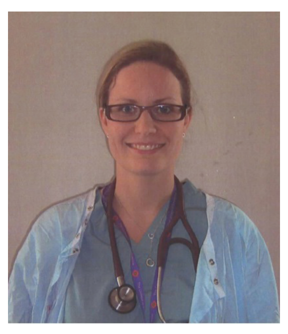
Applications for a MacGill Fellowship to

The Trustees of the fund, Dr Maryke Kraayenbrink and Dr Elaine Monahan on not more than 2 sides of A4 paper, stating:

1. Name and position of applicant
2. Unit or venue to be visited
3. Reasons for visiting
4. An estimate of the costs to be incurred

Recipients of the awards are expected to make a presentation of their visit to the Department on their return.

Photo: Drs Sarah Hammond (L) and Rebecca Lea-Smith (MacGill award 2010) at a surgical camp organized by Health Partnership Nepal.



Dr Maresa Brake
CT2 ACCS

ACCS & Anaesthetics

INVALUABLE

I am a CT2 ACCS (Acute Care Common Stem) trainee at St George's Hospital. I have recently completed my six months Anaesthetics rotation. Prior to Anaesthetics, I spent six months in Accident & Emergency and a further six months in Acute Medicine; all at St George's Hospital.

As an Emergency Medicine trainee, my aim was primarily to gain airway skills (such as predicting a difficult airway) and become familiar with anaesthetic equipment and drugs (and their pitfalls). Part of this training also involved pre-operative assessment and optimisation of patients.

The first two months: Day Surgery

My first few months were spent mainly in the Day Surgery Unit (DSU). I was paired up with a consultant anaesthetist for every list. The learning curve was steep. However, the high turnover of patients meant that I quickly learnt how to use the anaesthetic machine (just weeks prior to this a complete enigma for me) and learnt about anaesthetic drugs that are commonly used.

Having a regular supervisor for the first few weeks and months was invaluable - my Physiology and Pharmacology knowledge increased exponentially with one-on-one tutorials in virtually every session.

Graduation to more exciting anaesthesia

After gaining the "Initial Assessment of Competencies" I was finally "allowed" out of DSU. Many days thereafter were spent in CEPOD (emergency theatre) and St James theatres. I progressed from seeing fit and well patients to learning about anaesthesia in acutely sick patients with multiple co-morbidities. I was given more responsibility and performed Rapid Sequence Inductions independently. Supervison "loosened" - no longer was someone looking over my shoulder.

One of my favourite days

I particularly enjoyed one day in the Cardiothoracic theatres. I arrived promptly in the morning to learn that my first patient had been cancelled. This was not an issue however, as I was one of only two trainees there that day. I was promptly moved to another theatre - the first patient was due to have a thyroidectomy with a sternotomy. A central line and arterial line were on the cards. After that I moved to my original theatre for a CABG, and for the first time I saw a bypass machine in action.

En-route to Cardiothoracic ITU post surgery with the patient I was grabbed by a Consultant anaesthetist who told me that there was a double lumen tube to be inserted.The day encompassed everything I had learnt in the previous months: the application of physiology, practical skills (I inserted a multitude of central and arterial lines), and I also saw things I had never seen before. Everyone was extremely enthusiastic about teaching me.

Pros and cons of training in a teaching hospital

Working in a large teaching hospital such as St George's has its pros and cons. One perceived downside is that ACCS trainees could get less experience as we do not go on call. This means, we work 9am until 5pm. On the other hand, we see a vast variety of pathologies and we anaesthetise patients for a multitude of procedures, in an age range spanning from premature infants to centenarians. I have thoroughly enjoyed my time here and felt it was an invaluable learning experience.

But alas, despite the above I have not been "turned" to anaesthetics!

St George's Day Anaesthesia Forum

Wednesday, 30th April 2014

St George's Healthcare NHS Trust
Blackshaw Road, Tooting, London SW17 0QT

Quality Improvement in Anaesthesia and Surgery

08.30 Registration — Michael Heron Lecture Theatre, 1st Floor, Grosvenor Wing

Chairman: Dr J Bernard Liban

09.00 Quality Improvement – Global perspective
Prof Carol Peden – Macintosh Professor of Anaesthesia of the RCoA
Associate Medical Director for Clinical Quality for NHS England (South)

09.25 Quality Improvement - RCoA perspective
Dr J P van Besouw – President, The Royal College of Anaesthetist
Consultant Anaesthetist, St George's Hospital

09.50 Emergency Laparotomy Network
Prof Carol Peden – Health Foundation Quality Improvement Fellow
Founder Member of Laparotomy Network

10.10 Patient Experience Improvement
Dr Carolyn Johnston – Consultant Anaesthetist, St George's Hospital
Former Darzi Clinical Leadership Fellow

10.30 Coffee – Restaurant

Chairman: Dr Mark Edsell

11.00 Fractured neck of femur network
Dr Richard Griffiths – Consultant Anaesthetist, Peterborough Hospital
Founder of the Hip Fracture Perioperative Network

11.30 Why is it sometimes so difficult to implement change?
Dr James Clarke – Consultant Anaesthetist, St George's Hospital
Former Clinical Associate at the Institute of Innovation and Improvement

12.00 Service Improvement at St George's
Mr Steven Bradbury – Head of Service Improvement, St George's

12.15 Results of ACQUIRE
Dr Adam Shonfeld – Consultant Anaesthetist, St George's
Dr Liz Williams – Lead in Anaesthesia Quality Improvement

12.30 Close of the meeting

Publications

Books

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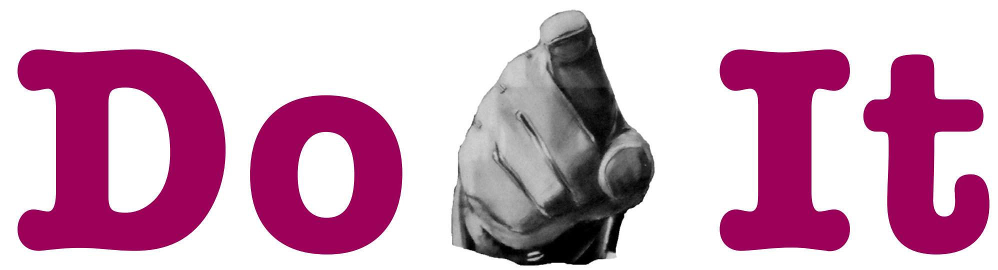
See next issue for:

- **Research**
- **Case Reports**
- **Conference Proceedings**
- **Lectures**



HANDOVER

**Good handover does not happen by chance.
It requires work by all those involved.**

Important things to remember:

Clinical handover should be a two way process and ideally **face to face**

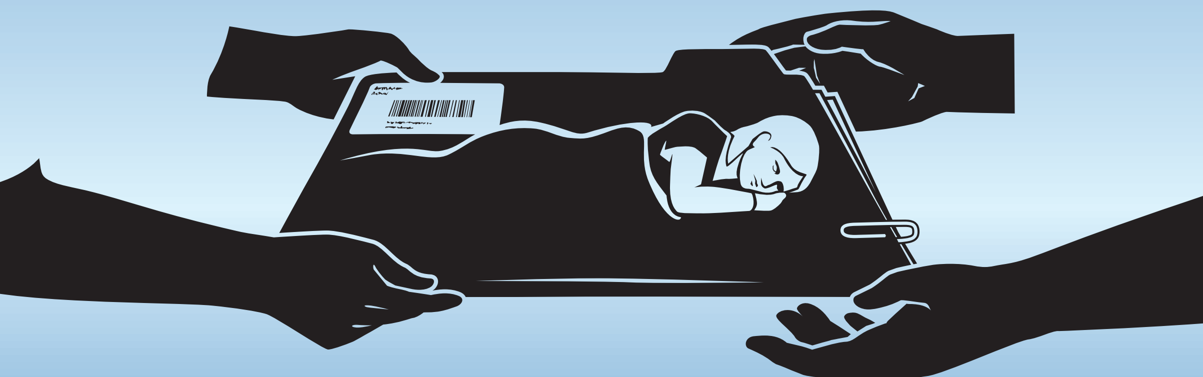
When handing over a patient you should give the receiving person **enough information** to deliver safe care

When receiving a patient you should **speak up** if there is anything you do not understand

Both parties should **confirm understanding** to be sure that information has been correctly received

Handovers of all descriptions should be prompted by **Situation, Background, Assessment, Response (SBAR)** and should include a written and verbal component shared between the responsible outgoing and incoming clinician. This should include the **Minimum Data Set** for your ward or service.

Handover is also an opportunity to identify patient safety issues such as a missing risk assessment, missing ID band or a missed medication using a fresh pair of eyes.



For more information on the SBAR tool, the Minimum Data Set for this area or the Handover process look at the Patient Safety section of the **intranet** or contact **Yvonne Connolly**, Head of Patient Safety, on **020 8725 4078** or at **yvonne.connolly2@stgeorges.nhs.uk**

St George's Healthcare
NHS Trust

Quotes Corner

"If someone doesn't value evidence, what evidence are you going to provide that proves they should value evidence.
If someone doesn't value logic, what logical argument would you invoke to prove they should value logic?"
 Sam Harris

"The plural of anecdote is not data."
 Marc Bekoff

"Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."

Atul Gawande

"Absence of evidence is not evidence of absence."
 Carl Sagan

"Be sceptical, ask questions, demand proof. Demand evidence. Don't take anything for granted. But here's the thing: When you get proof, you need to accept the proof. And we're not that good at doing that."
 Michael Specter

Division News

Dr Andrew Rhodes has been appointed Divisional Chair for the Children's, Women's, Diagnostics & Therapeutics Division. Andy has served as Clinical Director for Critical Care with great distinction and brings an outstanding track record of clinical leadership to the role of Divisional Chair.

The anaesthetic department has introduced a separate obstetric on call rota for consultant anaesthetists. Out of London's 24 maternity units, we have become one of only two to have access 24 hours a day, 7 days a week to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions. This fulfils a recently introduced London Health Programmes standard.

That makes it 9 consultant anaesthestists on call daily, covering the various subspecialties across the trust outside normal working hours.

The Paediatric Intensive Care Unit (PICU) is the 1st UK intensive care unit to use Cerner electronic documentation. This includes advanced patient assessments, intensive care charting and end of bed work stations, releasing time to care and enhancing patient safety.

Congratulations & All The Best

Recognitions/Awards

Dr Jeremy CASHMAN (2013)
Humphry Davy Medal Awarded by Royal College of Anaesthetists London

Dr Agnieszka CRERAR-GILBERT (2013)
1st prize Poster Presentation ACTA Nottingham

Dr Nick FLETCHER (2013)
1st prize Oral Presentation ACTA Nottingham

New Appointments: Consultants

Dr Gihan ABUELLA - Neuro
Dr Pallavi DASANNACHARYA - General
Dr Jelena DEVIC - General
Dr Carolyn JOHNSTON - Obs
Dr Fauzia MIR - Trauma
Dr Teresa PARRAS - General
Dr Kanchin PATIL- General
Dr Puneet RANOTE - Trauma
Dr Adam SHONFELD - General

Locum

Dr Hasmita BAGIA - General
Dr Fauzia HASNIE - Pain
Dr Michele KIGOZI - Neuro
Dr Craig McGRATH - Cardiothoracic
Dr Kim NG - Paediatrics
Dr Asif NASIB - General
Dr Christopher POLLITT - General
Dr Kamalakkannan SUBHAS - Neuro
Dr Phillipa WEBB - Neuro
Dr Reshma WOOGRASINGH - General

Clinical Fellow posts

Dr Anastasia LEGGA - General/ Emergencies
Dr Georgia MONANTERA - Bariatrics
Dr Myra MALIK - Obstetrics
Dr Suman BISWAS - Simulation/ Obstetrics
Dr Sadhish SHANMUGAM - Cardio/ Vascular/Trauma

Other Appointments

David MASON - Specialty Manager

FRCA exam success

December 2013 and March 2014:

Dr Alexander EELES
Dr Benjamin MORRISON
Dr Jemma LOOKER
Dr Josephine GORDON
Dr Kimberley HODGE
Dr Samantha JONES
Dr Ximena WATSON

Recent alumni appointments to Consultant posts:

Dr Richard GEORGE – St Peter's Hospital
Dr Nikunj SHAH – St Peter's Hospital

Retirements:

Dr James CLARKE
Prof George HALL
Dr Jane STANFORD
Mrs Jacqui BRIMMELL

Wordle picture

using patient comments regarding Obstetric Anaesthetic Services

By: *Dr Emma Evans, Lead Obstetric Anaesthetist*

Wordle or Word Cloud comments are larger as their frequency in feedback increases, so it is reassuring that 'Professional' comes out top.

Diary

S+ GEORGE'S
SCHOOL OF ANAESTHESIA

PROTECTED TEACHING DATES - 2014

May 16th

- ST3-4 Study Day, St. George's Hospital AM only.TBC (Please email to register if you would like to attend. 20 spaces only)

May 22nd

- ST5-7 Study Day, Guy's Hospital -Vascular & Peri-operative Medicine

June 2nd & 3rd

- ST3-4 Study Day, St. George's Hospital - Prep for Final SOE

June 26th

- ST5-7 Study Day, Guy's Hospital -Paediatric Anaesthesia

July 15th

- ST5-7 Study Day, St. George's Hospital? (Lecture Theatre C) -SESA Trainee Reps

August 28th

- ST5-7 Study Day, Guy's Hospital -Regional Anaesthesia Workshops

September 25th

- ST5-7 Study Day, Guy's Hospital -Human Factors

October TBC

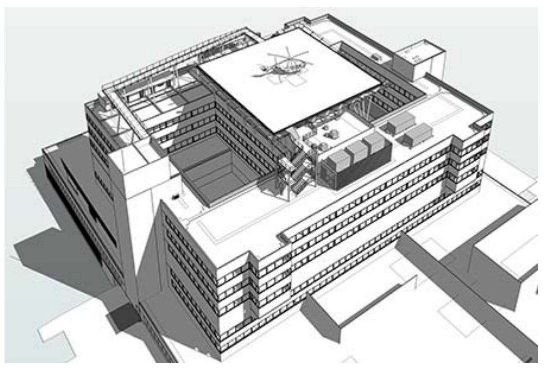
- ST5-7 ?? -SETSA Day

November 20th

- ST5-7 Study Day, Guy's Hospital -Thoracic and Cardiac Anaesthesia

December 18th

- ST5-7 Study Day, -Developing World Anaesthesia



DEPARTMENT OF ANAESTHESIA
St George's Hospital, Grosvenor Wing
1st Floor, Lecture Theatre F

WEEKLY EDUCATIONAL MEETINGS
April 2014
WEDNESDAYS, 8am

April 2nd

- St George's 'Perfect Week' – NO MEETING

April 9th

- M&M Critical Care

  Dr Phil Newman

April 16th – EASTER BREAK

April 23rd

- An update on cardiovascular monitoring

  Dr Maurizio Cecconi

April 30th

- St George's Day Anaesthesia Forum Quality Improvement in Anaesthesia and Surgery

9.00am – 12.30pm, Michael Heron Lecture Theatre (see full programme for details)

NEXT ISSUE

AESTHESIA

Humphry Davy

Life and Works

Scholarly Activities

CAT-Review Research

SPOTLIGHT

Dr Jeremy Cashman

Write for AESTHESIA

PROMOTE DEPARTMENTAL ACTIVITIES IN PATIENT CARE, EDUCATION AND RESEARCH

You may write on any topic that you believe would be of interest to members and friends of the department.

There are no word limits on articles, but they may be abridged for publication.

For further information, please contact Tony Addei (Anthony.Addei@stgeorges.nhs.uk)

ST GEORGE'S DAY

Anaesthesia Forum

Wednesday 30th April 2014

(To celebrate St George's Day)

At

St George's Healthcare NHS Trust

Blackshaw Road, London SW17 0QT

Michael Heron Lecture Theatre

9am-1pm

Quality Improvement in Anaesthesia & Surgery

The programme will include among others, presentations from the national experts in the field of quality improvement:

Dr JP van Besouw, Dr James Clarke, Dr Richard Griffiths and Professor Carol Peden

For more information and registration, please call the Division of Anaesthesia on 0208 7253317/0051 or email: Bernard.Liban@nhs.net

This meeting is usually awarded 3 CPD points