

Recording no. _____

EUSAT

Endoscopic UltraSound Assessment Tool

Insertion of the endoscope	1 Unable to insert endoscope	2	3 Needs several attempts to insert endoscope	4	5 Perfect insertion of endoscope in first attempt
	Not visualized		Visualized with difficulty or badly positioned		Perfectly visualized with apparent ease
Presentation of:					
Liver	1	2	3	4	5
Aorta + truncus coeliacus	1	2	3	4	5
Left adrenal gland	1	2	3	4	5
Lymph node station 7	1	2	3	4	5
Lymph node station 4 Right	1	2	3	4	5
Lymph node station 4 Left	1	2	3	4	5
Orientation overall	1 Totally unacceptable investigation		3 Acceptable but unsystematic investigation		5 Systematic and thorough investigation demonstrating perfect knowledge of the anatomy
Biopsy sampling: Positioning of transducer	1 Major flaws in positioning		3 Some problems with positioning		5 Perfect positioning of transducer every time
Biopsy sampling: Use of sheath	1 Sheath is used in a wrong way with great risk of scope damage		3 Insecure localization of the sheath		5 Perfect use of sheath
Biopsy sampling: Use of Needle	1 Targeted sites are missed and/or important structures are damaged		3 Insecure use of needle with a few errors		5 Perfect use of needle in every biopsy
Biopsy sampling overall	1 Biopsies performed with major risk to the patient / equipment		3 Possibility of inadequate biopsies due to insufficient technique		5 Perfect sampling using excellent technique

Date: _____ Supervisor: _____

inary data suggest that performance of approximately 25 procedures secures basic competence in EUS-FNA for mediastinal staging.

489. Continuous medical education

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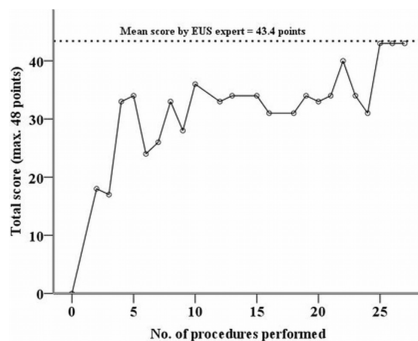
Training requirements for respiratory physicians performing ultrasound-guided transesophageal fine needle aspiration (EUS-FNA) for mediastinal staging

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Accurate mediastinal nodal staging is important for patients with resectable non-small cell lung cancer. EUS-FNA is an alternative to mediastinoscopy, but EUS training requirements are under discussion. The purpose of this study was to explore the amount of training needed to establish basic competency in EUS-FNA. Five experienced respiratory physicians from Denmark and the Netherlands were included in the study (3 men, 2 women). They had no prior experience in EUS. Each participant completed between 20 and 30 supervised EUS-FNA procedures. All procedures were video-recorded and blindly and independently assessed by three experts using a validated assessment tool.

Data will be presented as individual and averaged learning curves. Currently the first participant has finished training and her learning curve is presented in the figure below.

Differences in the acquisition of skills between trainees will be presented. Prelim-



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A Delphi study to create grade-specific competencies for a trust-wide non-invasive ventilation training programme

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Introduction: Non-invasive ventilation (NIV) is an expanding treatment modality for respiratory failure and is increasingly used in non-specialist acute areas. Although comprehensive national guidelines exist, there is no consensus as to the expected level of competency for non-specialist health professionals.

We used a modified Delphi process to create grade-specific NIV competencies which were then used to structure a comprehensive grade-based training programme.

Method: A 3 round Delphi process was used with an expert panel of 20 respiratory consultants, registrars, physiotherapists and nurses. A provisional list of competencies was created following amendment by the expert panel of an initial draft formulated by literature and peer review. In the second round, competencies were added or deleted following statistical analysis of grade-based relevancy rating using a 6-point Likert scale. Competencies where consensus was not reached were resent in the third round alongside expert viewpoint. Competencies with no consensus following 3 rounds were deleted. The finalised lists were sent to a selection of each grade for self-assessment of competency.

Results: A high variability was noted in competency expectation amongst our expert panel. Self-assessment showed gross lack of competency amongst junior doctors and nurses with high variability at specialist trainee level.

Conclusion: Competencies were used to create a grade-based training programme with objective trainee learning outcomes. The study revealed a high level of inconsistency regarding expectation amongst NIV specialists alongside exposing the lack of current formal NIV training and weaknesses of an apprenticeship model.

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A survey of intensive care medicine training for respiratory specialist trainees in the United Kingdom

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Introduction: The UK respiratory medicine curriculum requires trainees to spend a minimum of 60 working days in intensive care medicine (ICM) [1]. This should be a dedicated attachment, preferably with ICM on call rather than acute medical duties.

A previous British Thoracic Society survey found that 10% of trainees had inadequate exposure to ICM and just 59% participated in the ICM on call rota [2].

Aims: To assess availability of ICM training, experience offered, quality of placement and trainee satisfaction across UK.

Method: Online questionnaires were sent to respiratory trainees in 4 UK training regions.

Results: The response rate was 56% (121/214). 3 months ICM training was available to all trainees, 47% (57/121) had completed ICM training of whom 16% received 6 months experience, 61% had participated in ICM on-call rotas with just 14% having acute medical on-call commitments. 88% achieved ICM curriculum objectives and 91% were satisfied with their placement. 23% of trainees wished to gain further ICM accreditation.

Conclusions: The availability of dedicated ICM placements has improved. The majority of trainees are able to meet curriculum objectives and are satisfied with their rotation. ICM on call commitment remains regrettably low, as out of hours care provides invaluable learning opportunity. Supporting trainees wishing to pursue a career in ICM will provide challenges to training programmes and workforce planning. We plan to expand this survey across UK to assess ICM training at a national level.

References:

- [1] Speciality training curriculum for respiratory medicine 2007, JRCPTB.
- [2] Pattani H et al. Critical care as part of respiratory medicine training in the UK. *Thorax* 2006;61:1013.

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Special interest training in respiratory medicine across Yorkshire: A web based survey

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Introduction: The Joint Royal Colleges of Physicians Training Board (JRCPTB) published the training curriculum for Respiratory Medicine in August 2010. It identified areas of special interest enabling the trainees to undertake additional training. However, this is not formally recognized and there is no centrally agreed funding. Current options available for such training include as Out Of Programme Experience (OOPE) or during research into the subject area concerned.

Aim: To understand the current special areas of interest among trainees in Respiratory Medicine across Yorkshire, United Kingdom.

Method: A web-based questionnaire was designed and all the trainees (n=75) in the Yorkshire region were invited to complete the survey.

Results: The response rate was 52% (n=39). 69.2% (n=27) had a special area of interest.

Table 1. Areas of Special Interest (n=27)

Pulmonary Hypertension	3	11.1%
Adult Cystic Fibrosis	3	11.1%
Domiciliary NIV Service	4	14.8%
Lung Transplantation	0	0.0%
Occupational/Environmental Lung Diseases	1	3.7%
Intensive Care Medicine	4	14.8%
Interventional Pulmonology	10	37.1%
Allergy/Immunology	2	7.4%

15/27 (55.5%) agreed that a compulsory module should be implemented in the training curriculum towards pursuing a special area of interest, whilst 12/27 (44.5%) disagreed. 15/27 trainees considered 12 months as the ideal period for training, whilst 8/27 chose 6 months and 4/27 opted 3 months.

Conclusion: Majority of the trainees wish to specialize in a specific area of interest but there seems to be a lack of funding and training opportunities in the form of fellowships. Improving the current training curriculum will lead to better patient care and service provision in the National Health Service.

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Attitude of chest physicians working in provincial state hospitals, in Turkey toward continuous medical education

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Introduction: Continuing medical education is carried out primarily by medical associations. Bulletins are published on method.

Aim: To investigate post-training status and trends regarding this issue of chest physicians working in provincial state hospitals

Methods: Questionnaires, that consist of 18 questions about years of work, institution, participation in congresses and training activities, regular follow-up of publications and web sites, views about post- training; with permission of Ministry of Health; was sent to chest physicians. Participants, completed the questionnaire and sent back anonymously.

Results: 85 of 130 chest physicians in 36 provinces participated. Response rate was 65%. Average working years was 15.05±8.40. 44.7% were working in state hospitals and 54.1% were in chest disease hospitals. Participation to congresses on last 2 years was 3.59±1.62. 28.2% were attending education meetings regularly. 38.8% answered question of "Do you follow a publication regularly?" with "No". Participants who do not follow the web sites was 34.1%. While years of work increased, follow-up of web sites decreased (p=0,00).

Question of "Do you feel yourself declined in terms of professional information and facilities sometimes?" replied "Yes" by 58.8%.

Question of "Do you want to go institutions providing education on a temporary working for educational purposes" replied "yes" by who feel themselves declined in terms of professional information (p=0,008).

Conclusion: We found that our colleagues have been less interested in training activities. Training activities, independent of personal initiatives, will increase self-confidence and professional qualifications.

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Developing respiratory services – What are the needs of the respiratory clinician leaders and what can a short course deliver?

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Background: The development of services within health care systems is complex and requires expertise in clinical, economic and managerial issues. Within the UK, clinicians are being expected to work with managers and commissioners to develop services. This newly recognised area of work requires personal development. An ongoing programme of learning was developed to support respiratory leaders in this increasingly challenging role.

Method: The PCRS-UK have developed bi-annual courses to support clinical respiratory leaders in understanding the many issues that are required to enable the leader to influence service development and to support their own teams in changing services in line with best medical evidence. The course evaluations have provided useful information on areas that clinicians wish to develop as they move into leadership roles and demonstrate the potential development from attending a short course.

Results: 64 participants completed the most recent course. Around 2/3 of delegates provided feedback on their skills/confidence. This demonstrated widespread requirements in both understanding NHS policy and direction as well as core leadership skills (understanding others, developing groups, organising and chairing meetings, communicating with commissioners). The course achieved considerable improvements in confidence and skills in most of these areas.

Conclusions: There is a clear need to support the clinical respiratory leaders of the future who have considerable developmental needs to complement their clinical expertise. The areas for this can be identified and a relatively short and focused course can make a significant impact on these needs.