P111 PROCEDURAL EXPERIENCE, TRAINING OPPORTUNITIES AND ATTITUDES TOWARDS INTERCOSTAL CHEST DRAIN INSERTION: VARIATIONS BETWEEN CONSULTANTS, TRAINEES AND MEDICAL SUB-SPECIALTIES

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10.1136/thoraxjnl-2014-206260.252

Background and method Intercostal chest drain (ICD) insertion has long been considered a core skill for the general physician to master. The NPSA alert in 2008 highlighted potential hazards associated with this procedure, whilst recent guidelines[1] advocate the use of thoracic ultrasound to reduce complications. These developments have occurred at a time when trainees report a growing lack of confidence in their clinical experience and procedural capabilities, alongside a decline in training opportunities[2] that might address the latter concern. Nonetheless, competence in ICD insertion remains a compulsory or highly desirable procedural skill to acquire on a number of UK specialty training curricula including that for general (internal) medicine.

We carried out a survey of consultants and trainees who contribute to general medical services in hospitals across the Thames Valley region. This survey assessed factors including physicians' attitudes towards ICD insertion; prior and recent procedural experience; training opportunities; and clinical knowledge.

Results 90 clinicians (26 consultants; 41 registrars (ST3+); 23 core medical trainees (CT1/2)) responded to the survey. Most clinicians (94% of responses) felt that placing >5 ICDs was necessary to attain initial competence at the procedure; before continuing to place >5 ICDs on an annual basis in order to maintain that competence (78% of responses). However, only 17% of medical registrars surveyed reached this basic combined standard. Other key findings are summarised in Table 1.

Conclusion Our findings demonstrate a disparity between clinical reality and the expectations junior doctors and consultants have of the physician in training with regards to ICD competence. Most trainees cannot achieve the number of procedures they feel are required to attain independence, nor maintain that independence on an annual basis; whilst access to training in thoracic ultrasound is limited outside certain specialties. This inexperience is manifest in variable clinical understanding and procedural confidence.

Consideration needs to be given as to how medical training programmes might address these issues, and whether ICD insertion is even a skill that all general physicians can maintain competence in performing in the modern clinical environment.

REFERENCES

1 Thorax 2010;65 Suppl 2:ii61–76
2 Clin Med 2013;13(5):434–9

Abstract P111 Table 1 Sample of key findings from a survey of 90 clinicians relating to intercostal chest drain (ICD) insertion. Answers to clinical questions were derived using BTS Pleural Disease Guidelines (2010) and consensus between three respiratory physicians specialising in pleural disease

ATTITUDES *(answers on a Likert-type scale, 1 = strongly agree to 5 = strongly disagree)*	**Consultants**	**SpRs (ST3+)**	**SHOs (CT1/2)**
"ICD insertion is a core skill that all general medical registrars should be able to perform"	1.9 ± 1.3(SD)	2.3 ± 1.2	2.2 ± 1.1
"ICD insertion is a specialist skill only a select group of physicians should perform in future"	3.5 ± 1.2(SD)	3.1 ± 1.2	3.5 ± 0.8
TRAINING and EXPERIENCE *(trainees only)*		**SpRs**	**SHOs**
	None	20 (49%)	5 (22%)
	<5	14 (34%)	12 (52%)
	5 to 10	5 (12%)	5 (22%)
	10 to 20	1 (2%)	1 (4%)
"How many ICDs have you inserted in the last 12 months of your training?"	>20	1 (2%)	0 (0%)
	Yes	22 (54%)	12 (52%)
"Have you had access to simulation training in ICD insertion?"	No	19 (46%)	11 (48%)
	Yes + qualification	5 (12%)	0 (0%)
	Yes, not qualified	13 (32%)	5 (22%)
"Have you had any access to training in the use of thoracic ultrasound?"	No	23 (56%)	18 (78%)
CLINICAL KNOWLEDGE *(best of 5 questions, trainees only)*		**SpRs**	**SHOs**
Scenario 1: Small (<2cm) asymptomatic 1° pneumothorax in 22yo male	Correct	11 (27%)	2 (9%)
Best answer: observation only	Incorrect	30 (73%)	21 (91%)
Scenario 2: Patient with suspected pleural infection and "x" marked in radiology as site for aspiration by medical team on ward.	Correct	25 (61%)	19 (83%)
Best answer: repeat USS to identify safe site and immediate aspiration +/- ICD	Incorrect	16 (39%)	4 (17%)

P112 SPEECH AND LANGUAGE THERAPY BY SKYPE™ FOR VOCAL CORD DYSFUNCTION AND CHRONIC COUGH

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10.1136/thoraxjnl-2014-206260.253

Introduction The Airways Service at Royal Preston Hospital receives tertiary referrals from across the UK. When a diagnosis of vocal cord dysfunction (VCD) or chronic cough is made and speech and language therapy (SLT) required, patients undergo weekly therapy (minimum four sessions), which some may struggle to attend due to pre-existing commitments and/or travel time. As SLT typically does not require 'hands-on' therapy we felt that Skype™ videoconferencing may be a useful mode of treatment delivery. We present our initial experience of this service.

Methods A six-month pilot was completed whereby patients were offered SLT over Skype. Prior to therapy all patients were seen by the respiratory consultant and speech and language therapist for assessment and flexible laryngoscopy. Patients required confidential webcam access and proficiency. Symptom questionnaires were completed pre and post therapy (for VCD