



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

Dr J Wardrope
The College of Emergency Medicine
Churchill House
35 Red Lion Square
London
WC1R 4SG

Friday 17th October 2008

Dear Dr Wardrope,

Re: "Airway Training in Emergency Medicine" by Mike Clancy, Jonathan Bengner, Jerry Nolan and Dermot McKeown

I write on behalf of the GAT Committee of the Association of Anaesthetists of Great Britain and Ireland regarding the above document which recently came to our attention via the Training Committee of the Royal College of Anaesthetists. As a Committee representing the vast majority of anaesthesia trainees in the UK, we have a number of concerns which I will set out below.

Of primary concern is the acquisition and retention of anaesthesia skills. In the first paragraph of the document it is stated there is a growing expectation that emergency physicians will become competent in all aspects of airway management. Whilst we obviously welcome the acquisition, during a period of anaesthetic training, of basic airway management skills and tracheal intubation of those who have suffered a cardiorespiratory arrest, we question the ability, within the current training programme, of Emergency physicians to acquire the more advanced skills involved in using induction agents and muscle relaxants. Current evidence indicates that Emergency Medicine trainees and consultants suffer a higher incidence of errors when undertaking rapid sequence inductions when compared to Anaesthesia trainees. Every hospital with an Emergency department has resident on-call anaesthetists who are well trained in managing airways and have, historically, competently provided this service.

Anaesthetists consider cases of airway compromise encountered in the Emergency department as amongst the more challenging. The document singles out paediatric airways as being too specialised for inclusion but no mention is made of other

predicted difficult airway scenarios, for example the trauma patient, the obese parturient, the patient with septic shock and the post-operative or post-radiotherapy head and neck malignancy patient to name a few. An Anaesthesia trainee in the first year of training would not be expected to manage cases such as these and yet that is exactly the level of experience an Emergency Medicine registrar who has completed ACCS will have. A comparison can be drawn with the Intensive Care Unit. Respiratory Medicine ICM trainees completing six months Anaesthesia in order to fulfil their ICBTICM competencies are often subsequently reticent to manage airways on the ICU. There is recognition that greater experience is required to adequately and safely manage these patients' airways. We are concerned that trainee Emergency physicians will not have the required skill and experience and, furthermore, will not be exposed to sufficient numbers of cases to maintain their abilities.

The GAT Committee feels that even if the difficulties in providing adequate training were to be overcome, it would be essential for the Royal College of Anaesthetists to set competency standards, including those necessary for revalidation and continuing professional development. The RCoA and AAGBI standards for minimum monitoring and equipment including the presence of a skilled assistant (Operating Department Practitioner or Anaesthesia nurse) should also be strictly adhered to.

Of greater concern is current practice. Anecdotal evidence suggests that advanced airway management including induction agents by Emergency trainees is widespread. It would appear that often, anaesthesia has been induced and the Anaesthesia team are subsequently called to take over care following an unforeseen deterioration. Not uncommonly, the experience is that anaesthesia induction may not even have been appropriate management. It is also the case that Anaesthesia trainees are being utilised to 'babysit' ventilated patients who have been anaesthetised by Emergency physicians. Many trainees are extremely reluctant to take over the care of patients who they view as having been anaesthetised by inexperienced members of the medical team. The GAT Committee will always strongly resist exposing Anaesthesia trainees in this fashion.

We, as a Committee, feel the best way to proceed is the collection of data to illustrate and reinforce these points and we would encourage the College of Emergency Medicine to initiate this. The GAT Committee is, of course, happy to assist by conducting a survey of our 3500 Anaesthesia trainee members' experiences to add to the body of data.

We look forward to your reply.

Yours sincerely,



Mark Hearn
GAT Committee