You cannot be an excellent obstetric anaesthetist without a good understanding of what your obstetric colleagues are getting up to. Learn how to read that CTG, be able to interpret the foetal blood gases, STAN and etc.

Communicates effectively with mothers, partners, medical colleagues and midwives

Skilled in regional analgesia/anaesthesia for labour and operative deliveries, and perhaps on some occasions providing effective general anaesthesia for a caesarean section.

Remains calm under pressure, and can manage challenging situations and make rapid decisions.

Suitably skilled to recognise and treat the sick parturient on the labour ward and liaise with intensive care.

Teacher, trainer and provider of up-to-date guidelines for the labour ward and information for mothers.

Committed to research and audit.

Can work without a routine, sometimes at unseasical hours.

Recognises and enjoys the alternative lifestyle to that provided in a windowless operating theatre.

Able to work as part of a multidisciplinary team. This will include seeing selected women antenatally and contributing to the care of women during labour, delivery and post-partum. 

OBSTETRICS

WHY SHOULD I CONSIDER A CAREER IN OBSTETRIC ANAESTHESIA?

Whilst the surgical repertoire changes, (minimally invasive cardiac surgery, endovascular repair of thoracic and abdominal aneurysms, etc), and arguably becomes less exciting for some anaesthetists, obstetric anaesthesia is increasing in complexity thereby presenting us with exciting challenges. Women with complex medical problems, who would never have achieved a successful pregnancy in the past, now appear regularly on the labour ward. The rising caesarean section rate, home deliveries in hospital, the obesity epidemic and the challenge of working with our multidisciplinary and obstetric colleagues are part of what makes life on the labour ward so totally different to the structured life of the operating theatre. If in addition to being an anaesthetist, you enjoy medicine/ obstetric medicine and miss patient (and their next of kin) contact, all human life, its most vulnerable, is to be found on the labour ward.

PERSONAL SPECIFICATION

TRAINING

Obstetric anaesthesia is a basic core topic in anaesthetic training and as such all trainees will spend a significant proportion of their early training/on-call years dealing with pregnant women. After all, women represent half of the population and caesarean section is the most frequently performed operation in the UK. In the UK, a career in obstetric anaesthesia does border something extra. In the first instance a trainee contemplating a career in obstetric anaesthesia should arrange to spend at least six months as an obstetric fellow in their senior training years. The RCoA sets the standards for anaesthetic training in the UK. Senior trainees contemplating a sub-specialty career should access the document: The CCT in Anaesthesia IV: Higher and Advanced Level Specialty Training Year 5, 6 & 7. The RCoA website also provides practical information on out of programme training/ research (OOPTR). Arguably, of all the sub-specialities obstetric anaesthesia provides the most fascinating opportunities for out of programme training, be that in the developed (especially Australia, the United States and Canada) or developing world. However if you choose to go to a developing country it may have training implications. These positions are rarely advertised, often require a thorough internet search and/or a useful contact. You may find that one of your obstetric anaesthetist colleagues can put you in contact with colleagues abroad.

Excellent training and research information (e.g. Guidelines for Obstetric Anaesthesia Research) is also available on the website of the UK-based Obstetric Anaesthetists’ Association (OAA) (www.oaa-anaes.ac.uk). The OAA has a global membership of more than 2300 members and aims to promote the highest standard of anaesthetic practice in the care of the mother and baby. In addition the OAA has excellent links with its fellow organisation in North America, the Society for Obstetric Anesthesia and Perinatology (SOAP) (www.soap.org) and many other countries around the world. Try to attend one of SOAP’s annual meetings, which are wonderfully stimulating and are usually held in a very attractive US venue.

You should certainly demonstrate your interest in obstetric anaesthesia by becoming a member of the OAA, which offers preferential rates for trainees, and you should aim to present a paper or a poster at one of its many meetings during your trainees years. The lucky trainee winner of the oral presentation wins a cash prize. Membership of the OAA also includes the specialist journal, The International Journal of Obstetric Anesthesia. In addition, do not forget that the website of the college of our obstetric colleagues: www.rcog.org. It provides excellent information much of which is of interest to anaesthetists.

Working in a specialist unit or a large busy unit with a reputation for guiding trainees in research, audit and their ultimate conclusion, an oral or a written presentation at a meeting, will serve you well. You should also aim to involve yourself in the teaching and administrative side of your local maternity service e.g. lecture on anaesthesia in labour at an antenatal class and/or a useful contact. You may find that one of your obstetric risk and patient safety matters.

THE FUTURE

One thing is certain: it is unlikely that women will cease to reproduce! In fact the workload seems to go on increasing, the 10% caesarean section rate of the 1980’s is today nearer to 30%. What may change is how the workforce will be deployed. The current eight to nine hour consultant anaesthetist cover on the labour ward may soon become 12 hours (as many of the obstetricians are now doing) and ultimately 24 hour. Coming involved in obstetric research can be difficult, e.g. suitable obstetric patients do not often turn up between 9 and 5, and if there are ethical constraints and it may be difficult to complete the research in the course of a fellowship. However if the opportunity presents, grab it! Audit is somewhat easier than research in obstetrics and you should certainly aim to complete at least one audit project during your fellowship. Our sub-speciality is actively involved in the Centre for Maternal and Child Enquiries, previous the Confidential Inquiry into Maternal and Child Health (CEMACH), an obstetric audit that is the envy of our colleagues worldwide.

One thing is certain: it is unlikely that women will cease to reproduce! In fact the workload seems to go on increasing, the 10% caesarean section rate of the 1980’s is today nearer to 30%. What may change is how the workforce will be deployed. The current eight to nine hour consultant anaesthetist cover on the labour ward may soon become 12 hours (as many of the obstetricians are now doing) and ultimately 24 hours. Coming involved in obstetric research can be difficult, e.g. suitable obstetric patients do not often turn up between 9 and 5, and if there are ethical constraints and it may be difficult to complete the research in the course of a fellowship. However if the opportunity presents, grab it! Audit is somewhat easier than research in obstetrics and you should certainly aim to complete at least one audit project during your fellowship. Our sub-speciality is actively involved in the Centre for Maternal and Child Enquiries, previously the Confidential Inquiry into Maternal and Child Health (CEMACH), an obstetric audit that is the envy of our colleagues worldwide.
In the operating theatre the anaesthetist performing any local anaesthetic block is responsible for checking the consent form with the patient especially with regards the laterality of the eye to be operated on in accordance with stringent guidelines, hence vigilance and attention to detail is essential. A certain degree of manual dexterity is advantageous in performing regional ophthalmic blocks. Good and effective communication skills are vital both in assessing the patient and in communicating with the surgeon to ensure optimal operating conditions. The ophthalmic anaesthetist has a key role in the following areas:

- Preoperative patient assessment, to assess patients and manage existing medical conditions prior to surgery
- Provision of local anaesthesia typically sub-Tenon (blunt needle technique) or peribulbar (sharp needle technique) blocks
- Provision of general anaesthesia when appropriate
- Administration of intravenous sedation for some undergoing complex procedures under local anaesthesia
- Patient monitoring throughout the operation
- Management of any perioperative complications including maintenance of haemodynamic stability and cardiopulmonary resuscitation
- Teaching and training of other staff
- Participation in audit and research projects
- Development of the ophthalmic anaesthesia service for the future

TRAVELING IN OPHTHALMIC ANAESTHESIA

Over recent years, the trend has been for ophthalmic surgery and anaesthesia to be undertaken on a day case basis and an increasing number of procedures are carried out under local anaesthesia. To facilitate this anaesthetic provision, an understanding of the relevant orbital anatomy, physiology and pharmacology is essential, together with the more clinical aspects of patient care including experience in day case anaesthesia. All trainee anaesthetists with an interest in ophthalmic anaesthesia should complete competency-based assessment of knowledge, skills, attitudes and behaviour in ophthalmic anaesthesia in accordance with the 2010 RCoA Curriculum for a CCT in Anaesthetics.

The training in ophthalmic anaesthesia is delivered in optional units at both intermediate and higher levels within schools of anaesthesia. Currently, ophthalmic surgery is undertaken in a range of settings including general hospitals, isolated ‘stand-alone’ units and large single-speciality centres. All such settings must have appropriate staffing levels, skill mix and facilities. Some supraregional tertiary referral units such as the Birmingham and Midland Eye Centre offer advanced training modules in ophthalmic anaesthesia. Such advanced training provides specialist training opportunities for a senior trainee to gain further knowledge and experience in:

- General and regional anaesthesia for the range of ophthalmic surgical procedures including cataract, strabismus, glaucoma, vitrecterual, oculoplastic and corneal transplant surgery
- Anaesthesia for elective and emergency ophthalmic surgery
- Preoperative ophthalmic patient assessment
- Audit and research
- Levels of service provision in ophthalmic anaesthesia including staffing requirements, equipment, support services and facilities
- Gaining insight into guidelines and protocols in ophthalmic anaesthesia such as the joint report by the Royal College of Anaesthetists and the Royal College of Ophthalmologists

Ophthalmic anaesthetists who intend to work regularly with children will need appropriate training in paediatric anaesthesia in addition to specialist experience in ophthalmic anaesthesia. Any trainee who wishes to develop an interest in ophthalmic anaesthesia must make this known to their training programme director at the earliest opportunity so that this may be facilitated.

IMPROVING YOUR CV

The British Ophthalmic Anaesthesia Society (BOAS) organises an annual scientific meeting in the UK which provides useful specialist continuing education and professional development. This annual event is also an excellent opportunity for trainees to submit case reports and the results of audit or research work for verbal or poster presentation. Both the journals Anaesthesia and British Journal of Anaesthesia publish articles and original research relating to ophthalmic anaesthesia. In addition, reading the journal Ophthalmic Anaesthesia, which is published by BOAS, gives useful background information as it covers issues of topical interest and current new areas of development in ophthalmic anaesthesia. Attendance at specialist ophthalmic regional anaesthesia workshops such as those organised by the AAGBI and the Middletisham video-conference on local anaesthesia for ophthalmic surgery will provide trainees with additional experience to further enhance and refine their local anaesthetic techniques.

OPHTHALMICS

Anaesthesia for ophthalmic surgery is a recognised sub-specialty of anaesthetic practice. A broad spectrum of patients will be encountered, ranging from premature neonates to the very elderly who, because of their age, frequently require optimisation of concomitant systemic disease prior to surgery. Ophthalmic surgery is also commonly required for ocular manifestations of systemic disease and in ‘syndromic children’, hence a relatively high proportion of patients are seen with relatively uncommon medical conditions, making this a sub-specialty that presents the opportunity to encounter a wide range of disease conditions. Pre-operative patient assessment is particularly important for these reasons and is now commonly performed prior to surgery. During consultations, decisions are also made about appropriate patient selection for day surgery and choice of local or general anaesthesia.

Further training

Further training is usually gained in a specialist ophthalmic anaesthesia unit.

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PAEDIATRIC ANAESTHESIA

Paediatric anaesthesia involves the provision of anaesthetic and pain management services to the whole spectrum of the paediatric population, from extremely premature babies in the special care baby unit (SCBU) weighing 500g to 16-18 year old weighing 100kg or more. The provision, and training for, paediatric intensive medicine is usually obtained through a general paediatric training scheme incorporating a paediatric job, although it should be considered if you read this article early enough in your career.

There is no harm in declaring your early interest in paediatric anaesthesia or, before you can make any realistic progress, you must complete your basic and intermediate level training in anaesthesiology. For more details about the current CCT in Anaesthetics Training Programme please see the RCoA website. During these early years in your career you will be developing your CV, and there is ample opportunity to put a paediatric slant to it and bring credibility to your claims. Volunteer to help with as many paediatric case lists as you can to increase your general exposure and experience and therefore your logbook numbers over and above those required to achieve your Basic and Intermediate Level Training Certificates. Any previous paediatric jobs or student placements, including working with children outside the clinical environment should be particularly emphasised. Complete at least one audit cycle of a paediatric-themed audit and present it at a local or national meeting, preferably a national meeting, to increase your profile.

Local opportunities to participate in paediatric anaesthetic research; many departments have academic/research fellowship posts which could be invaluable in allowing you to pursue this in more depth. Along similar lines, try to get involved in paediatric patient research and write for publication; at the very least read relevant journals such as Paediatric Anaesthesia (for which you are entitled to a reduced trainee subscription rate) and see if you can get involved in the correspondence pages. Ensure you have done the basic training courses, EPLS/APLS, MEPA or other simulation courses, and become an instructor if you wish. Get involved in a local or national interest group, taking the initiative if necessary, for example, can you help your local resuscitation officers deliver basic paediatric life support update? Join any relevant local societies and attend their meetings; again seize the initiative and if there is nothing relevant in your area then expand the management section of your CV and set one up. You should certainly join the Association of Paediatric Anaesthetists (APA), contact your local APA Linkman via the APA website for more information, and explore the possibilities of their Annual Scientific Meeting which is an excellent platform for exhibiting your work in either oral or poster format. There is a trainee representative on the APA Council – could it be you one day? Don’t forget the GAT ASM is also a great national forum for presenting or displaying your hard work.

All anaesthetic trainees must complete the essential higher unit of training in paediatric anaesthesia as per the RCoA 2010 Curriculum Document. In my deanship, this is often relegated to the last three months of training when it is almost too late an opportunity to nurture a fledging interest. It is therefore advisable to complete this training module during your ST3/4 years to gauge whether your interest could be seriously pursued.

Whether you are a ST who is about to start the higher training module or a CT looking for inspiration, meet and interact with your local paediatric anaesthetists as soon as possible. This will allow you to get a feel for the job and whether it might suit you in years to come, and also increase your local profile within the paediatric anaesthesia workforce in your region. It is a sub-speciality which is increasingly becoming centralised; some district general hospitals have reduced their paediatric workload with a resulting impact on the more traditional role of anaesthetic jobs ‘with an interest in paediatrics’. However, these things often come full circle and you may find that there will be future development opportunities within your Regional Managed Clinical Network, something else about which your local paediatric anaesthetists may be able to inform you. An early insight into these longer-term issues should enable you to consider fully any conflicts of interest between sub-specialisation and geographical locum work that may arise and those particular family and which could influence your career decisions. Along similar lines, you will also need to investigate whether your deanery is advanced to take a postgraduate programme in paediatric anaesthesia, and if so how you access it. Previously, it may have been sufficient within some deaneries to declare an interest (hacked up by your logbook and CV) and put your name down, but this is increasingly being superseded by competitive application and interview, especially for the 12 month post within specialist paediatric centres. Not every deanery has the scope to offer an advanced training programme in paediatric anaesthesia, and if yours does not then you will need to explore the feasibility of taking time out of programme and competing for a fellowship post, either in the UK or combined with the opportunity to go abroad. Overseas fellowship positions (commonly in Canada, the USA and Australia) require early application as there are often waiting lists, and must be prospectively approved by your regional advisor as with any other out of programme position. If it turns out not to be a realistic option, then another consideration is one of the increasingly popular post-CCT fellowships. If you consider all your options in advance, discuss them with the appropriate people and prepare properly, the choice could be all yours.

Achieving your ultimate aim is a question of identifying it, declaring it, getting the relevant and important people on your side and listening to their advice and direction. Ensure you cover the basic essentials well in advance, and then any exciting extras you can add will be truly beneficial. If paediatric anaesthesia interests you then go for it – it is an immensely challenging and rewarding job which I, for one, thoroughly enjoy. And how many people can say that about their day job?
PAIN

What is it like to be a consultant in pain medicine? Is it better to consider anaesthesia, and what is the future of acute pain? How much pain training do I need to do before advanced pain training? Do I have to sit an examination?

Pain medicine has superseded the term ‘pain management’ as pain develops into a specialty in its own right. It ‘describes the work of specially qualified medical practitioners who undertake the comprehensive management of patients with acute, chronic and cancer pain using physical, pharmacological, interventional and psychological techniques in a multidisciplinary setting’ 1.

The Faculty of Pain Medicine at the Royal College of Anaesthetists was launched in April 2007 and is a sub-unit of the Academy of Anaesthesia. The curriculum covers knowledge of acute, chronic and cancer pain management. An entrance examination to the Faculty is under development by the Faculty and should be initiated in 2012. Passing this examination will be compulsory in the future for those wanting to become a fellow by examination. Successful applicants can then use the postnominals FFPMRCA.

Details of the competencies required and application forms are available on the Faculty website. It is strongly advised not to start an assessment around the time of the examination, as the work will continue. Watch the website for the publication of ‘best practice’ guidance for different topics, such as ‘Complementary therapies for Spinal Cord Stimulation’. Upcoming ones include Paediatric Pain and Cancer Pain. The current Dean of the Faculty is Professor David Rowbotham. There is a contact address for the Faculty if you have any queries, and there is always a trainee representative on the Board to whom you can address your questions. The Faculty and deaneries work closely together, and you may find regional pain training initiatives emanating from the deaneries, such as the Royal College of Anaesthetists and the Pain-London Pain Training Advisory Group, which is a sub-unit of the Academy of Anaesthesia.

The pain medicine curriculum is now finalised. It was developed with reference to the excellent publication of the International Association for the Study of Pain: Core Curriculum for Professional Education in Pain, third edition, editor J. Edmund Charlton. The subject matter is wide ranging, from the basic science of pain transmission to an understanding of psychological aspects, interventional techniques, pharmacotherapy, and pain in special groups such as the very young and old. The curriculum covers knowledge of acute, chronic and cancer pain management. An entrance examination to the Faculty is under development by the Faculty and should be initiated in 2012. Passing this examination will be compulsory in the future for those wanting to become a fellow by examination. Successful applicants can then use the postnominals FFPMRCA.

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There are several categories of fellowship of the Faculty which are explained on the Royal College of Anaesthetists’ website 2. Trainees who are interested in a career in pain medicine should seek a post in advanced pain training with a view to becoming a fellow by examination. Successful applicants can then use the postnominals FFPMRCA. Details of the competencies required and application forms are available on the Faculty website. It is strongly advised not to start an assessment around the time of the examination, as the work will continue. Watch the website for the publication of ‘best practice’ guidance for different topics, such as ‘Complementary therapies for Spinal Cord Stimulation’. Upcoming ones include Paediatric Pain and Cancer Pain. The current Dean of the Faculty is Professor David Rowbotham. There is a contact address for the Faculty if you have any queries, and there is always a trainee representative on the Board to whom you can address your questions. The Faculty and deaneries work closely together, and you may find regional pain training initiatives emanating from the deaneries, such as the Royal College of Anaesthetists and the Pain-London Pain Training Advisory Group, which is a sub-unit of the Academy of Anaesthesia.

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and blocking sessions. A recent survey of trainees in the Birmingham School of Anaesthesia showed that the majority of trainees are exposed to an average of only four pain clinics. Eleven out of 65 trainees attended more than 12 pain clinics. There was a better rate of attendance at procedure sessions, perhaps reflecting a greater interest in this side of the work. Background reading and attendance at a pain meeting, such as the Annual Scientific Meeting of the British Pain Society, or at one of the BPS educational seminars held at Churchill Hospital, or one of the days organised specifically for trainees by the Faculty of Pain Medicine would be beneficial.

Hospitals with a multidisciplinary clinic should provide an opportunity to work with a psychologist or attend a pain management programme. Links with palliative care services often exist, and you should make a positive effort to gain experience in the management of cancer pain. Time with other physicians such as a neurologist, rheumatologist or rehabilitation physician can be most informative. Trainees should seek out these opportunities if they are not immediately available.

Chronic pain lends itself to audit and clinical research, and some larger hospitals will participate in drug trials, some of which may be industry sponsored. It is a helpful exercise to be trained as an investigator, even if only temporarily. A good quality audit study and presentation at a pain meeting is an essential part of a pain CV. There are ample opportunities to do this, though academic work may not always be undertaken out of hours. Even with a year for advanced pain training the time allocated to pain is often too short to allow for the development of some of these ideas. There has been much debate about whether an advanced pain trainee should continue to be on the anaesthetic on-call rota, or will he/she lose anaesthetic skills? This issue has not yet been resolved but it is most likely that you will continue to be on-call for emergencies during advanced pain training. Make sure that you are free during the day before you start your on-call to make the most of the training that is on offer. For the 2010 curriculum, three months of higher pain training are required before you can apply for advanced pain training.

Either way, pain training must be completed within a reasonable time, which will be between one year and eighteen months. The norm is one year, you may be competing for training posts and may find it difficult to extend training. Successful training requires dedication and determination from both trainee and educational supervisor. Learning about pain extends through the whole of your career. It takes time to become confident in dealing with a pain patient; they are not all the ‘difficult’ people they are perceived to be; often the mistrust comes from past unsatisfactory encounters with a medic. You need a natural empathy, and an optimistic outlook on life improves patient outcomes!

After a long training as an anaesthetist, most trainees will want to combine anaesthesia and pain medicine at the start of their consultant career. Make sure that you have at least four sessions are allocated for pain work; fewer than this will mean that you can never do it properly. Remember that trainees will have to recertify in both subjects.

In summary, pain medicine is an interesting and compelling career, in a field that is rapidly developing and gaining greater recognition, and there is a dedicated Faculty to support training and uphold standards. It requires an in-depth medical knowledge, a coordination of scientific and psychosocial skills, dedication, team working ability, and perseverance. Once understood, it can be a most rewarding career, both within, and without, anaesthesia.

PLASTICS AND BURNS
Anaesthesia for burns and plastic surgery is varied and rewarding and there is huge potential to make a visible difference to the lives of children and adults. The caseload is mixed and it is not limited to any one age group or site. This is one of the few areas of anaesthesia where you meet the same patients many times over your career and develop your own professional relationship with them. It is frequently fast-moving, advanced and the anaesthetist often uses the latest technology and techniques. Developments such as the first facial transplant are making it an increasingly exciting area. This specialty is different and florid by forging collaborative links with a host of specialties including ENT, gynaecology, plastic surgery, maxillofacial and orthopaedics. There is still the misconception that this is an aesthetic specialty; however, there is likely to be at least one area in your hospital in which you can carve a niche. Potential patient groups may include:

- Burns (resuscitation, intensive care management and transfer)
- Breast surgery (reconstruction following cancer, cosmetic surgery)
- Skin cancer (excision and reconstruction, management of metastasis)
- Head and neck (oral cancer reconstruction, craniofacial surgery)
- Children (left lip and palate, clefts, ear anomalies, congenital anomalies)
- Hand and upper limb surgery (hand trauma, degenerative conditions such as arthritis)
- Lower limb trauma reconstruction
- Microsurgery for bone and soft-tissue reconstruction and free tissue transfer

HOW TO DEVELOP YOUR CV
Desirable qualities are an attention to detail and meticulous anaesthetic technique. The ability to balance an extremely varied workload and a capacity to foster good working relationships as part of a multidisciplinary team make this specialty a particular challenge. If you have an interest in plastics and burns, let your training program director or clinical lead know early on. Training doesn’t have to be in a dedicated block; it could be performed piecemeal over time. Some larger centres may offer dedicated blocks and one year fellowships either as a separate block or during the CCT. IAPT provides general guidance and the Association of Burns and Reconstructive Anaesthetists (ABRA) is helpful in providing a syllabus, but it may be possible to put together an interesting module yourself which would look good on the page.

The AAGBI and RCoA bulletins provide useful CPD topic guidance. The National Burn Care Group is a useful resource and provides a forum in which burns anaesthetists can be endorsed by RCoA. Demonstrate commitment by presenting at journal clubs and morbidity and mortality on relevant cases you have seen. There are regional and national meetings also and ABRA offer a trainee prize. The specialty is often underrepresented at departmental level so offer to run some specific pre and post fellowship teaching sessions, an interesting area may be the choice of fluids and how they may affect survival. Free tissue transfer. Audit activity is made easier as...
Our surgical colleagues are only too keen to have an anaesthetist’s collaboration. There are a number of collaborative areas to make a contribution to research and development such as pain relief following burns or the effects of anaesthesia on grafts.

You cannot be an excellent anaesthetist without knowing what the surgeons are up to, therefore it is vital to work closely with and attend some local surgical teaching sessions so that you know the difference between a TRAM and a DIEP flap! The British Association of Plastic and Reconstructive Surgeons (BAPRAS) have twice yearly surgical teaching sessions for anaesthetists. ARAF has a free paper section at their annual yearly conference which provides a good opportunity to submit a poster for a prize; this is not oversubscribed and you could win a good place. Similarly, plastics and burns patients have been working in a tertiary referral unit for reconstruction or major burn resuscitation. It is worthwhile having an extra string to your bow.

The field of pre-operative assessment (pre-assessment) and optimisation is a rapidly changing environment. As little as a decade ago, it was commonplace for patients undergoing high-risk, complex surgery with life-threatening co-morbidity to be seen by a surgical house officer a week before surgery, and then seen on the ward by an anaesthetist the night before. This left very little time for necessary investigations and management plans to be put in place, where alone for an unpressured discussion of risk/benefit and truly informed consent. Thankfully, things have moved on. However, it is still in its infancy, and systems for pre-operative assessment vary greatly from trust to trust.

WHAT DOES PRE-OPTERATIVE ASSESSMENT INVOLVE?

Exposure to pre-operative assessment can be quite variable as a trainee. Obviously the basics are fundamental to all anaesthetic practice. However, the whole process of pre-operative assessment is much more complex. Most trusts now have consultant sessions in a pre-assessment clinic. This gives an opportunity to optimise the patients prior to surgery, assess their physiological reserve (for example using cardiopulmonary exercise testing) and to give some estimation of the risks involved in the whole peri-operative period. This requires not only a good knowledge of the various surgical procedures undertaken, but also the medical management of the common co-existing conditions encountered. Developing good working relationships across all the specialties is therefore essential.

Often a more significant role is the management of the patient’s anaesthetic requirements, as a whole. As many disciplines are involved, structures need to be in place to ensure good communication, and in most centres there has been an increase in the role of leading the service. Many hospitals now undertake nurse pre-assessment for the majority of patients, and they need to have good, evidence-based, robust guidelines upon which to act. Developing such documents and ensuring all colleagues agree to them can be challenging!

IMPROVING YOUR CV

If you have an interest in pre-assessment, it is important that you make your wishes known to your rota coordinator. Most trainees spend only a few sessions as a ‘supernumerary’ in clinic, and consequently have limited exposure to pre-assessment. If you are able to attend, the more responsibility you will be able to take on. Make sure that you record clinics attended in your logbook. There are also national courses and seminars available to those wishing to pursue an interest. Many of these are multidisciplinary, providing a good insight into the many facets of a pre-assessment service.

Pre-assessment skills often overlap with those in other areas of anaesthetic practice. The management skills often associated with day surgery will be of benefit, and any evidence of interest in management will be helpful. Similarly, a background in intensive care or cardiothoracic anaesthesia can be useful in familiarising yourself with the management of the common co-morbidities encountered.

CPX testing in the UK is beginning to move from an area of research interest into established practice outside of the main teaching centres. As well as providing information as to how best to optimise patients peri-operatively (both in terms of direct interventions and also allocation of resources e.g. critical care), it provides useful objective information to guide the patient consent process. CPX sessions are, in most centres, now lead by anaesthetists, with opportunities for trainees to become part of the team. This gives you the opportunity to see how else pre-assessment can be implemented. Many hospitals now undertake nurse pre-assessment for the majority of patients, and they need to have good, evidence-based, robust guidelines upon which to act. Developing such documents and ensuring all colleagues agree to them can be challenging!