



# Anaesthesia News

No. 251 June 2008

The Newsletter of the Association of Anaesthetists of Great Britain and Ireland.

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## World Congress in Cape Town

**Preparing for a  
consultant interview**

**Film review – Awake**

# CALL FOR ABSTRACTS

## ORIGINAL RESEARCH/AUDIT/CASE REPORT OR SERIES



THE ASSOCIATION OF ANAESTHETISTS  
*of Great Britain & Ireland*

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**Closing date for submission: 6th June 2008.**

\*The abstracts must conform to the journal's usual ethical, methodological and statistical standards. Authors may be asked to make changes to their abstracts before publication.

The Editor-in-Chief reserves the right to refuse publication



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The Association of Anaesthetists of Great  
Britain and Ireland  
21 Portland Place, London W1B 1PY  
Telephone: 020 7631 1650  
Fax: 020 7631 4352  
Email: [anaenews@aagbi.org](mailto:anaenews@aagbi.org)  
Website: [www.aagbi.org](http://www.aagbi.org)

Anaesthesia News  
Editor: Hilary Aitken  
Assistant Editors: Iain Wilson, Mike Wee  
and Val Bythell  
Advertising: Claire Elliott

Design: Amanda McCormick  
McCormick Creative Ltd,  
Telephone: 01536 414682  
Email: [mail@mccormickcreative.co.uk](mailto:mail@mccormickcreative.co.uk)  
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# From Brighton to Cape Town The 14th World Congress of Anaesthesiologists



Five Consultants, one Associate Specialist and three trainees from Brighton travelled to the 14th World Congress of Anaesthesiologists in Cape Town this March.

February in England had been a surprise with record sunshine. On February 29th this gave way miserable drizzle as we made our way round the M25 to Heathrow for the flight to Cape Town. The flight is twelve hours, with only a two hour time difference. The night gave way to bright sunshine as we made our final journey down the South African Atlantic coastline into Cape Town. Table Mountain was clearly visible as we made our final descent to the airport, and the early morning sun was bright and warm after the long English winter.

The main conference was preceded by various satellite meetings, and a weekend refresher course. This led on to a magnificent opening ceremony on Sunday afternoon with Archbishop Desmond Tutu as the guest of honour. The host was an African comedian called Solly Philander. I initially thought the organisers had taken a risk here. Solly was a rather camp free spirit with dreadlocks. My fear was soon dispelled as Solly kept us amused throughout, referring to us anaesthetists as his 'dream weavers'.

Desmond Tutu received an extended ovation at the beginning and end of his keynote presentation. He was reduced to a fit of laughter as he told us about receiving cryotherapy for prostate cancer. He hoped that other nearby structures has not been frozen as well. His shirt was along the 'Nelson Mandela' style. Having often been critical of Nelson Mandela's shirts, he now had a 'if you can't beat him, join him' attitude. A lively concert followed with traditional African singers and songs mixed with more familiar songs climaxing with an African soprano and tenor singing 'Nessun Dorma'.

Over six thousand delegates from over one hundred countries attended the main conference at the Cape Town International Convention Centre (CTICC), which ran from Monday to Friday, March 3rd to 7th. The scientific programme consisted of nine lectures, and five workshops running concurrently. Every conceivable anaesthetic subject was covered, with speakers from all over the world. There was something for everyone, and my colleagues all found something different to reflect their area of interest – see boxes. The smooth running of the congress was a tribute to the organisers. This was the result of many years of planning by the South African

Society of Anaesthesiologists led by Professor David Morrell from Port Elizabeth. In particular, the IT systems were superb with all registration and communication through the Internet.

There was a large trade exhibition with over eighty companies and stands representing ten members of the World Federation of Societies of Anaesthesiologists (WFSA) including the AAGBI. These were divided into areas called by the animals of the 'big five', The Lion, Elephant, Rhinoceros, Buffalo and Leopard zones.



Anthony Ger sharing his poster with Cyril Goddia, Senior Clinical Officer (anaesthetic teaching) Malawi

## The Airway Specialist

There was an all day Airway Symposium. Topics ranged from airway assessment through to extubation of the difficult airway as well as 'airway management of the morbidly obese patient' and 'what's new in airway management devices?'. Prof Cohen (USA) gave a very entertaining talk on the use of bronchial blockers for thoracic surgery, with some great video footage. At the trade exhibition there were a large number of new airway devices promoting easy intubation in difficult cases. At the Intavent stand, Dr Brain spoke about designing the LMA supreme. However, I was glad to see a lecture focusing on the need to maintain and teach basic airway skills such as facemask ventilation.

### Dr Sandeep Sudan

Consultant Anaesthetist,  
Brighton

## The Paediatric Anaesthetist

I travelled out early to attend the Paediatric Anaesthesia Satellite Meeting on Friday 29th February, followed by the South African Society weekend general refresher course. During the WCA itself, I attended paediatric related subjects on Monday and Tuesday, but then decided to attend less familiar subjects which included sessions on cardiac disease, advances in pharmacology, workshops on 'Blocks for eye surgery' and 'fiberoptic airway skills' and a full day of lectures on the recent highly successful and inspiring Caudwell Everest Expedition.



The venue, Cape Town International Conference Centre

### Dr David Campbell

Consultant  
Anaesthetist, Brighton

## Developing Countries

On the first day I attended a symposium called 'Developing Countries'.

Having worked previously in northern Kenya and Malawi, it was a pleasure catching up with colleagues and friends from these developing countries, especially the clinical officers from Malawi and Professor Paul Fenton, my anaesthetic hero, who set up a teaching programme in Malawi. The symposium was varied, pragmatic and very popular. It concentrated on ways we can promote, teach and assist safe anaesthesia, with special emphasis on the sick obstetric patient.

As one delegate said 'the other parts of the conference are for one billion people on the planet, and the developing world section is for the other five billion'.

### Dr Jim Cooper

Consultant Anaesthetist, Brighton

## The Generalist

My aim was to update my knowledge on familiar topics. There was a 'current topics' day with an update on the current thinking on reversal of neuromuscular blocking agents and about a new reversal agent for release later this year. There were plenty of talks on obstetric anaesthesia and analgesia including a lively debate for and against CSE for labour and caesarian section. CSE is used in only about 8% of cases in Europe and the United States. The 'against' vote was the winner. There was an excellent talk on 'The patient with a recent stent requiring major surgery'. Professor Sear talked on 'Hypertension – who to cancel'. It does seem that we cancel too many hypertensive patients unnecessarily. There was a whole day of regional anaesthesia with plenty of ultrasound-guided techniques.

**Dr Rex Yetton**  
Associate Specialist  
Brighton



*The authors during a conference break*

## The Trainee

Being a University of Cape Town Graduate, I was excited to travel back from Brighton to my home city, and privileged to be invited to display my poster titled 'Zambia; waiting time to theatre for non-obstetric emergency and urgent cases in Livingstone General Hospital.' I attended other symposia on obstetrics and trauma. I had hoped to return to England to complete my anaesthetic training, but due to a lack of forthcoming run-through training posts in the UK, I have now obtained a training post in Johannesburg.

**Dr Anthony Ger**  
Trainee  
Brighton/Johannesburg

## The Cape Town Experience

March is one of the most pleasant months in Cape Town. There were clear blue skies all week, with temperatures of 27-31 degrees and little wind. From the conference opening ceremony we were encouraged to experience Cape Town outside the conference hall. Solly at the opening ceremony had encouraged us several times to sample the Cape wines. There were tours of the Cape Winelands and a Cape Winelands dinner. The main conference dinner was in the theme of a traditional African Evening at 'Moyo at Spier' restaurant in the beautiful gardens of the Spier Wine Estate. There were organised tours to Robben Island, Cape Point and Cape Peninsula, Table Mountain and a City Tour. For the more adventurous there was a choice from the Cape Big 5 Wildlife Safari, Shark Diving, Sky Diving, Table Mountain abseiling and a helicopter ride. On Sunday March 9th some delegates took part in the 'Cape Argus Cycle Tour' joining some 35,000 other cyclists for a gruelling 109km from the city centre round the Cape Peninsula and back to the city centre.

## The return

Twelve hours after leaving the Sunday sunshine of Cape Town, we landed at Heathrow in gale force winds. The captain of the South African Airways airbus received a round of applause for his skilful landing. He remarked that it was high amongst his more testing landings in forty years of flying. Maybe the anaesthetic equivalent is the extubation of a morbidly obese patient.

Roll on the 15th World Congress in Buenos Aires, the 'Paris of South America', March 2012. Plenty of time to learn to Tango.

**Dr Rex Yetton**  
Associate Specialist,  
Royal Sussex County Hospital  
Brighton



# Don't stop the music

Do you like music while you work? I do, and am always intrigued when non-medical friends express horror when I let slip that the hushed sepulchral tones in theatre as seen in a hundred hospital TV dramas are not actually reflected in real life. "You listen to the RADIO? Shouldn't you be concentrating?" I always ask them if they can do whatever their job is with music in the background. The answer is usually yes. The issue also divides theatre teams, with some preferring to work without music. I have on occasion asked for the music to go off if I'm engaged in something a bit tricky, but on the whole, I think it adds to a relaxed atmosphere in theatre. I think all of our surgeons are fine with background music, but I guess the default position should be music off if one member of the team requests it. Volume is also an issue – the operative word here is "background". If anyone has to raise their voice, it's too loud. It's an operating theatre, not a disco.

Then there's the vexed question of the type of music. There's quite a wide age distribution in any given theatre team, and everyone has a different musical era. We used to listen to a local radio station that every morning played an hour of music from a given year, with listeners having to guess which one. I'm a seventies specialist, and Stewart, our auxiliary was our eighties specialist. If we got really stuck, we would send out to ask John on the theatre reception desk, who is a walking music encyclopaedia. Unfortunately, there was invariably a student nurse who would announce she wasn't born then.

Most people are happy with this sort of easy listening/Radio 2 – type stuff. At Christmas, you do tend to get wall-to-wall Slade and Wizzard, but that's fine too. A bit of light classical can be pleasant, although anything too Wagnerian can be a trial. (Has anyone else noticed that in fly-on-the-wall hospital documentaries, it's always some high-falutin' opera playing in the background in theatre?) My regular surgeons are pretty well trained, but occasionally you fill in for an absent colleague and realise the hell they experience every week.

One of our ophthalmologists thinks the pan pipes are just the thing to relax him while operating, but after an hour of that I am ready to shoot myself in the anaesthetic room. I can only applaud ophthalmology's move to local blocks for the majority of cases, which excuses the anaesthetists from this form of torture, but pity the poor patients who have to lie there and listen to it. Another of our orthopods likes experimental jazz – I'm not even sure I know what that is, but it doesn't sound too relaxing to me. I recently had an hour of PJ Harvey (the choice of one of our younger surgeons), who makes Leonard Cohen seem like a cheery chap. However, as with all things, the surgeons need to realise we have the upper hand. If I really don't like the surgeon's musical selection, I merely wait until he's scrubbed and change it – there's nothing he can do until the end of the case!

It all contributes to a relaxed, happy theatre team – which has got to be in the patients' best interests. No doubt at some point an edict will come from on high with a spurious reason why we can't do it (I'm sure there are whole tranches of people employed to make life as difficult as possible for those at the sharp end of the NHS – bare below the elbows? What's that about?) but in the meantime let the music play!

One of the things I like about editing this magazine (and hopefully you feel the same about reading it) is that you learn all sorts of things you never knew. They're not earth-shattering, they will help you pass no exam, but they're interesting all the same. Like when I first read the article about the origins of anaesthesia in Serbia, published on p17. It made me rather proud to be a British anaesthetist, as they were well to the fore in assisting in developing the specialty there after the war. We've also got a couple of important medico-political articles for some of our membership categories – after a long and protracted birth, the new SAS contract has finally been agreed, and you

can read a summary of what you need to know in this issue. In addition, this month's GAT page has the views of the GAT chairman about where we are with MMC now, and where he thinks we are heading, which is not entirely cheerful stuff. The GAT committee has been organised and eloquent on behalf of anaesthetic trainees throughout the last year or so, and continues to be so.

I'm also particularly proud of what I believe to be *Anaesthesia News's* first

film review. David Bogod stepped forward to be our answer to Barry Norman on the release of "Awake", a thriller with anaesthetic awareness as a key plot element. Read what he thought of it on p28.

Please keep sending me your articles and letters – if you think it's interesting, the chances are your anaesthetic colleagues will think so too!

**Hilary Aitken**  
Editor



## Peter Baskett

As this issue of *Anaesthesia News* was being prepared, AAGBI was saddened to receive the news of the death of Peter Baskett, who was President from 1990 - 92. The Association will publish a full obituary in due course.

### **DINGLE 2008: 10<sup>th</sup> Anniversary Conference** **Dingle, Co. Kerry, Ireland ~ 8<sup>th</sup>-12<sup>th</sup> October 2008**



**Final Call for Abstracts (Deadline 30<sup>th</sup> June 2008)**

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Full details: [www.dingleconference.co.uk](http://www.dingleconference.co.uk)

# COUNCIL

## *News & Announcements*

### **New AAGBI Working party on Needlestick Injury**

B\*GG\*R! We must all be familiar with the A delta pain and sight of the needle in a finger. I'm always astonished at the amount of C fibre pain and blood that stem from the white needle aimed at the bung of the Co-Amoxiclav that is now embedded in one of my digits. Some of us may also be familiar with the slower onset but no less excruciating psychological pain when that needle had previously been in a patient. Although the pharmacology of post-exposure prophylaxis is well-developed, there remain many problems in investigating the source of the injury, particularly as for most of those patients are unable to consent to being tested for blood borne viruses because they are anaesthetised, or sedated on ICU.

The GMC guidance initially issued in 1997 allowed for testing unconscious patients in exceptional circumstances, but this advice has now been withdrawn following the Human Tissue Act, which makes any such testing illegal.

I was first involved in this issue three years ago as Chairman of a Clinical Ethics Committee, and raised it in public at WSM 2007. Quite independently, Stuart White from Brighton was looking at the same subject which led to his editorial "Needlestuck" in December 2007's *Anaesthesia*.

AAGBI Council has now established a Working Party, which I chair, to look at the issue, which affects not just anaesthetists, but other medical specialties and, above all, nursing colleagues. The Committee is drawn from experts from within AAGBI, ICS, RCoA, the RCN together with ethicists and a lay representative. We intend to look at the various options for testing for Blood Borne Viruses, and to consider strategies to effect a change in the law.

I'd be very interested to hear from Members who have been affected by needlestick injuries, and with any suggestions. I may be contacted via AAGBI, 21 Portland Place, London W1B 1PY.

Andrew Hartle  
AAGBI Council Member

### **Research funding applications**

Members interested in applying for research funding are reminded that the system has changed, as highlighted in the article in May's edition of *Anaesthesia News*. All AAGBI research funding is now awarded under the auspices of the National Institute for Academic Anaesthesia, and the deadline for applications this year is July 25th, 2008. For further details see <http://www.aagbi.org/grants2.htm>

### **Could you help a fellow anaesthetist?**

The Association has been contacted by a number of members recently, seeking advice about working in anaesthesia with a disability such as increasing deafness. We are interested to hear from any members with a disability, whether congenital or acquired, who might be able to share their experience with a newly-afflicted colleague. Advice on matters such as modifications to the daily working environment which have proved helpful, or experience of the occupational health process might be of use to a fellow anaesthetist. Please contact either Ian Johnston, Honorary Membership Secretary or Diana Dickson, Chairman, Welfare Committee, at 21 Portland Place if you have experience of working in anaesthesia with impaired health.

### **Honour for Surgeon Captain Charles Johnston**

Surgeon Captain Charley Johnston, who is currently the Armed Forces Representative on AAGBI Council, has recently been appointed as a Queen's Honorary Physician. We are delighted to congratulate him on this honour.

### **Has your email changed?**

We are aware that many trusts are switching to web-based NHS email, and many members' email addresses have changed. Please could you let the membership department ([members@aagbi.org](mailto:members@aagbi.org)) know if your work email address has changed recently. This is particularly important for Linkmen, to ensure that they continue to receive all communications.



## **EBPOM JULY 2008** IET/Savoy Place, London

### **7th EBPOM: 3 & 4 JULY**

- Pay for performance – a lever for improvement in surgical care.
- Implications for peri-operative beta-blockade: POISEd for thought.
- Fast track peri-operative care of hip fracture patients.
- ACC/AHA 2007 Guidelines on Perioperative Cardio-vascular Evaluation and Care for Non-cardiac Surgery.
- Regional anaesthesia: peri-operative benefit?
- Haemodynamic optimisation: Where next?
- Peri-operative fluids and renal failure.

#### **PLUS EBPOM Workshops, 2 July 2008**

Ultrasound Guided Nerve Blocks and ECHO; and CPEX

### **GREAT FLUID DEBATE: 2 JULY**

- Poor post operative fluid balance costs lives.
- There is no place for 0.9% Sodium Chloride in routine peri-operative care.
- Safe fluid management of major surgical cases demands cardiac output measurement.
- Urine output should not be measured in the first 24 hours following major surgery.

#### **Speakers include:**

**Prof Lee Fleisher** (principal author ACC/AHA 2007 Guidelines);  
**Professor Sir Bruce Keogh** (NHS Medical Director);  
**Dr Judith Hulf** (President, Royal College of Anaesthetists)

**[www.ebpom.org](http://www.ebpom.org)**

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# Medical Training

## – *where next?*



In 2008, one of the key issues to be settled will be that of the role of the doctor. To a large proportion of us, this may seem to be fairly straightforward, or not even to be in question. However, clarity in our own minds needs to be translated such that politicians may understand. At the time of writing, the Department of Health has recently published the Government response to Sir John Tooke's Independent Review of Modernising Medical Careers, 'Aspiring to Excellence'. In it, the Health Secretary, Alan Johnson, recognises and agrees that postgraduate medical education and training should have broad-based beginnings, flexibility and an aspiration to excellence. He also agrees that policy development should be evidence-led and, where significant shifts are involved, proceed in consultation with the medical profession. So far, so good.

In order to manage the 2008 transition period 'bulge' of trainees, Johnson

recommends post-CCT fellowship posts in order to free up training numbers, particularly in trauma and orthopaedics; and 'transit' posts, created to "provide applicants in oversubscribed specialties with experience and training to change specialty, for example surgery to anaesthetics". This 'flexibility-by-another-name' is probably sound; anaesthesia has traditionally attracted motivated trainees from other specialties after an average of 18 months. Of more concern is the Department of Health's view that any future strategy will need to involve a "reduction in training posts, to be met by an increase in service posts". A stronger disincentive for our brightest school leavers, medical students and foundation doctors to entertain continuing their medical education in this country cannot be imagined.

On the questions of the role of the doctor and the fundamental changes to the training programme as proposed

by Tooke, Johnson shies away from any definitive statement, instead preferring to defer to Lord Darzi and the awaited final conclusions of his "NHS: Next Stage Review", due out this year. Darzi is, amongst other things, tasked with tackling an overhaul of training and workforce planning. It seems that, once again, our training is in the hands of an eminent surgeon.

So when does Alan Johnson think that definitive changes to the structure of postgraduate medical education and training will take place? Will it be 2009, as envisaged by Sir John Tooke's panel, in order to expedite the transition process and achieve stability? Or perhaps in 2010, allowing for any effect of 'mission creep'? I suspect we're being naive to assume implementation will be predicated on the needs of those individuals most involved: the trainees. Indeed, the last possible date for the next General Election is June 2010.

And the Secretary of State's conclusion on changes to training: "I envisage implementation beginning from 2011". The rationale for delay in this case is "to consult with the medical profession and to achieve consensus". It is hard to imagine a greater consensus amongst the profession than the 85% support achieved by the conclusions of the Tooke report. In addition, Johnson comments that "it seems sensible to evaluate whether the MMC 2008 model of training meets the needs of stakeholders before making any further changes". There are many interested parties in planning postgraduate medical education but by far the most important 'stakeholders' are those who have already, and continue to, stake their careers on it: once again, the trainees.

In the meantime, we are to continue with a training structure that few are happy with and that all recognise may well be significantly altered in three years' time. Happy times ahead, I'm sure.

Do we have any pointers as to where the conclusions of the Next Stage Review may lie? Fortunately, we have Lord Darzi's interim report, rushed out in

October 2007 ahead of the November General Election-that-never-was. Addressing medical training, Darzi states that MMC's principles were sound but implementation was not. He goes on to say that "workforce planning needs to be more evidently and consistently linked with new models of care and with financial and service planning at all levels". It will certainly be interesting to hear specifically what new models are proposed and exactly how financial planning will impact on the workforce. Of course, it is tempting to speculate...

On consideration of a further Darzi point, one hopes that "matching the commissioning of training places to that of services" does not lead to inflexibility during the crucial early stages of training. The price of motivation is self-determination, and our political masters would do well not to forget the fuel of professionalism on which the NHS engine has latterly been running.

The Next Stage Review report is due out at the end of June. The GAT Committee has invited Lord Darzi to speak at our ASM in July (<http://www.aagbi.org/gat/asm.htm>) and we hope he can find the



time in his busy schedule to join us in Liverpool. In the meantime, I urge you to watch the headlines, challenge the politicians (MMC policy consultation periods in the recent past have typically lasted a mere 10 days) and have your say in determining not only the role of the doctor but the shape of training. Contact us at [gat@aagbi.org](mailto:gat@aagbi.org) if you have an points you wish to raise.

**Chris Meadows**

Chairman, Group of Anaesthetists in Training

## Help for Doctors with difficulties

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help ([www.bma.org.uk/doctorsfordoctors](http://www.bma.org.uk/doctorsfordoctors)). To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor\*. A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

If for any reason this does not address your problem, call the AAGBI during office hours on 0207 631 1650 or email [secretariat@aagbi.org](mailto:secretariat@aagbi.org) and you will be put in contact with an appropriate advisor.

\*The doctor advisor scheme is not a 24 hour service

# BOOK YOUR PLACE NOW!

# GAT 2008

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# Liverpool

## 2-4 JULY

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	GAT Members booking before the 02/05/08	GAT Members booking after the 02/05/08	Non members
One day	£150	£200	£290
Two days	£220	£270	£360
Three days	£270	£320	£420



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# The Consultant Appointment Process



Applying for a consultant job in the NHS is one of the most important events in our professional lives. Knowing how to approach the process and ensuring the application is done well is vital if the job is to be secured. This personal view of the NHS process has been formed after interviewing many candidates for a variety of specialties in my Trust.

When appointing a consultant colleague, the NHS expects to pay around £2.5 – £3 million in salary over the next 25 years. This is a significant investment, and management and prospective colleagues must seek the *best person for the advertised job*. What is a consultant and what makes them different to a trainee? In my view every consultant is a provider of service, a team leader, a trainer, a colleague, and represents the future of the NHS.

Your preparation for a consultant post started when you first walked on to a ward. Achievements as a trainee are important, as are insights about your character, even as far back as University. Your reputation, established over the training years, amongst peers about such things as enthusiasm for work follows you into the interview room.

## The advert

The advert will describe the post and any specialist interest. There is usually a phone number within the advert for a department contact, often the clinical director, and they expect to answer questions about the job at an early stage. Phone the department secretary, explain who you are and who you would like to speak to. If the contact is not available, find out the best time to phone back or leave your mobile number along with a couple of suggested times to make it easy for the contact to speak to you. Be as flexible as you can about your availability – remember, the same individual will be receiving many similar calls from other candidates.

## Pre-shortlisting visiting

Prior to shortlisting for a consultant appointment it is normal to visit the department to meet the clinical director and a few of the local consultants. A guided tour is commonly offered and should be accepted. Some departments have an organised approach to this process and arrange a timetable with

military precision; others are shambolic. All offer insight into the way the department works. As a prospective candidate, expect to wait around while people try to fit you in to their clinical day and when you leave, ensure the secretary thinks you are polite and delightful! At this visit, ask anything that concerns you about the job and the sessions on offer. There is often flexibility within job plans. Take a CV with you to describe to the CD what your training has been and be ready to explain why you want the job. Comments about the reputation of the department and hospital are more helpful than just describing the desirability of the location.

The CD will advise if there are other people you should visit prior to shortlisting. Trusts vary in what is expected, but in most this visit is restricted to the department.

## Application – your CV

If you decide to apply for the post, ensure your application form and CV are accurately and well filled in. Ensure you read and follow instructions precisely.

Some Trusts now only use application forms, whilst others encourage you also to submit your CV. Whatever the situation, the written submission should be correct, succinct and organised. It is worth investing time and effort as a well structured, bound CV on good quality paper has impact. Take advice from senior colleagues about the content and layout of your CV before submission. Since a large number of applications is the norm, quality of preparation ensures that your CV will stand out from the crowd.

Select your referees carefully. Ideally this should be someone who knows you well and has worked with you during the last two years. The CD or College Tutor are ideal as one of the referees, but always ask a referee before naming him or her. After submission, confirm with the Human Resources Department who is handling the administration of the appointment that your application has arrived.

## Shortlisting

Shortlisting is performed by members of the appointments committee by assessing the CVs. Methods of scoring CVs for shortlisting varies between interviewers. I look for a well-trained, motivated colleague with evidence of being a team player who completes what they start. Since most SpR training schemes are similar and produce excellent quality anaesthetists, evidence of additional activity such as peer reviewed publications, experience abroad, humanitarian activity, leadership/responsibility, excellence in team sport or other activities, suggests (to me) someone who is well motivated. The Royal College representative will consider in more detail the quality of training and ensure candidates are eligible for appointment.

Commonly the Chair and non-executive members do not shortlist. Scores are added and the best four to six candidates are invited for interview, depending on the number of posts. Shortlisting information is often sent out by post; phone if you are in doubt or away.

## After shortlisting

Following shortlisting, the hard work begins. The task is to demonstrate that you are the best fit for the team. This takes time and energy and may require more than one visit. In the department try to meet as many of the consultants as the secretary can arrange. Think of a few questions to ask beforehand and always carry your CV. This process is hard – many of us are not good at “selling” ourselves. However, meeting your prospective colleagues gives you a chance to assess them, and allows them a chance to meet you. Make sure you see as many of the younger consultants as possible – they may be offended if left out, and as recent successes of this process, may give helpful insights. Bear in mind that as far as potential colleagues are concerned, your personality may be more important than impressive academic achievements – they will be working alongside the successful candidate for many years and want the process to appoint a “good colleague”.

In addition to the anaesthetic department, you should now arrange appointments to see the chief executive, medical director and any other medical representatives on the appointments panel. Trust Executives are interested to meet candidates to brief them about the Trust and the local clinical environment. In these meetings ask about the local Trust plans, current pressures, targets and opportunities. You are not expected to be an expert in the details; however as a consultant you will be involved with working and planning



in the NHS so it is helpful to demonstrate interest in these issues. Their secretaries are goldmines of information about the Trust – talk to them while you wait.

Visiting is time-consuming and two or three days of leave may be required to do the job properly. It is often impossible to see everyone unless the department organises things efficiently, but do your best to try to see key people.

## The interview

The interview is the final hurdle. Practice beforehand with some experienced colleagues if possible. A brilliant interview does not guarantee the job but gives you an excellent chance of selection: conversely it is difficult for the panel to justify appointment following a poor interview. On the day, arrive in good time with change for the car park.

The panel Chairman, who is usually the Chair or a non-executive director of the Trust, is responsible for ensuring a fair procedure is followed and will introduce you to the panel members. Some trusts require a presentation as part of the interview. The panel always wishes to see you performing at your best and will ask a series of open questions to try to get you talking and showing your personality and strengths.

The RCoA representative will ask about your training and other members of the panel will have worked out several questions to ask each candidate. These will include topics within anaesthesia and the local situation, and also broader NHS consultant issues.

The panel do not expect you to have an in-depth knowledge of NHS management but will expect you to have a working knowledge of topical events – for example the Tooke report, MMC, or patient safety. There may be a topical local “political” issue, and this is where your groundwork at the visits can pay off. *Be yourself* and try to relax. Humour is fine in small amounts but risks making you appear flippant. The best questions will not have a simple correct answer - the panel wish to hear your opinion. Sometimes interviewers may ask a question in an unclear way, so do not be afraid to ask for clarification.

At the end of the interview the chairman will ask if you have any questions or anything else you would like to add. This is not the time to discuss details of the job plan or interview expenses, all of

which should have been done before this point. It is the opportunity to clarify any key points you may have, or to expand on an area that you feel was not covered in the interview: however commonly candidates have no further questions at this time, so do not feel obliged to make one up!

### The interview decision and references

References are seen normally after the candidate has been interviewed and offer important support for your application. A weak or negative aspect in a reference stands out, as most are very positive.

After all the candidates have been interviewed, the chairman opens the discussion about who should be appointed. Normally the RCA representative starts by confirming whether all the candidates have a CCT, are on the specialist register and are appointable. There is then a discussion with each interviewer in turn summing up their views. During this phase an order of preference begins to emerge

and the chairman will seek to get a unanimous vote. The person who most closely demonstrates the competencies required for the post will be appointed.

Once the panel has decided the successful candidate, they are brought back to the room and congratulated. The chairman will often offer disappointed candidates the opportunity to receive feedback about the process from one of the panel. Sometimes a poor performance can be discussed usefully; more often the interview has been fine, but someone else has been preferred on the day.

In summary, a meticulously-prepared, good quality CV and careful visiting should stand you in good stead at the interview. Working at selling yourself both during the visits and the interview will give you the best chance of success. The “local favourite” or sitting locum is not always the first choice - nothing is decided until after the interviews!

**Dr Iain Wilson**

Honorary Treasurer AAGBI

Joint Medical Director Royal Devon and Exeter NHS Foundation Trust

## ANAESTHESIA APHORISMS

Submitted by John Asbury, Glasgow, and Yoav Tzabar, Carlisle.

*Have in your mind values (eg for HR, BP, Saturation) beyond which you will always intervene – and do so. It helps in the situation when you are watching a monitor and thinking ‘It’ll surely resolve at the next measurement ... , no.. OK at the next ...’ – by which time your patient has been hypotensive for 20min.*

*It's easy to put drugs into a patient, but much more difficult to get them out.*

*The bigger the case, the bigger the bin liner needed.*

*If something is nebulously 'just not right' check the patient first, not the monitor.*

*When it comes to moving the patient off the operating table, the heaviest part of the patient is always handled by the smallest nurse.*

*Always recheck the position of the airway device when you have moved the patient into theatre.*

*Nobody notices when things go right, but everybody notices when they go wrong.*

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## 11th Anaesthesia Forum

29 September - 2 October, 2008

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For further details please contact

Alan Stedman, Queen Alexandra Hospital, Cosham, PO6 3 LY

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## 4TH NATIONAL ANAESTHESIA RESEARCH MEETING (NARM)

organised by

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FULL DETAILS OF THE CONFERENCE AND ABSTRACT  
SUBMISSION CAN BE FOUND ON THE ANAESTHESIA  
RESEARCH TRUST WEBSITE AT:

[www.anaesthesiaresearch.org.uk](http://www.anaesthesiaresearch.org.uk)

## The History Page

# The Development of Anaesthesia in Serbia

The history of the beginnings of anaesthesiology in our country dates from 1945 when two British anaesthesiologists, Russell Davies (East Grinstead) and Patrick Shackleton (Southampton) came to Belgrade, together with a group of plastic surgeons.

In 1945, against the prevailing political background, Sir Harold Gilles discovered there was a large number of the Yugoslavian population injured in the war who could be helped by plastic surgery. There was little or no expertise in this branch of surgery in Serbia at the time, so he set out to achieve two things. Firstly, to ask the newly formed United Nations Relief and Rehabilitation Administration (UNRRA) to set up a training program in Serbia and secondly to persuade the Ministry of Health of the United Kingdom to provide a teaching team for this program. It was soon agreed that the main plastic surgery units in England at that time could provide rotating teams which would successively visit Belgrade to undertake this mission.

By late 1945 a complete British Army Field Hospital was flown from Italy to Belgrade and installed in the Belgrade Trade Union Hospital (Bolnica Trgovacke Omladine) with a capacity 120 beds,

which was at the time unoccupied. It had two operating theatres which were to be staffed by one senior domestic surgeon and four surgical trainees. The British input began with the arrival of Mr. John Barron (plastic surgeon) and Dr Patrick Shackleton (anaesthetist) to Belgrade. The Serbian team consisted of Dr Ivo Arneri (plastic surgeon) and Dr Sever Kovacev, who was chosen to administer anaesthetics. Dr Russell arrived in Belgrade the following year and both British anaesthetists began work on obtaining anaesthetic equipment, introducing up to date anaesthetics into surgical practice, and educating young doctors in the field of anaesthesiology. Dr. Sever Kovacev, who later became Professor of Anaesthesiology at the Novi Sad University, was their first student.

These first students of Dr Davies and Dr Shackleton became in turn the first local teachers of anaesthesiology in the region and it can be said that all Serbian anaesthesiology developed from the work of these two British anaesthetists.

Dr Shackleton and Dr Davies carried out their education plan on a larger scale when they started organizing anaesthesiology training courses for all hospitals in the country with the aim



*Dr Russell Davies with the Yugoslav medal, pictured in his garden in Winchester.*

of demonstrating modern techniques and equipment. They discovered that there was a factory in the country which produced ammonium carbonate as a waste product. Dr Davies persuaded UNRRA to agree to buy the plant for nitrous oxide production for the British Oxygen Company at a cost of £40,000. He felt that this plant would help the economy of the country, there being no

manufacturer of nitrous oxide in Europe south of the UK at the time.

Dr Davies also planned a National Blood Transfusion service based on his knowledge of the system applied in Britain. He submitted a paper to the Ministry of Health, and although it took five years to come to fruition, a Blood Transfusion Laboratory and the system to support it were developed along these lines.

Patrick Shackleton and Russell Davies remained in our country for three years and during that period educated five Serbian anaesthesiologists. On their return to Britain they continued to teach, and many well-known British anaesthetists were trained by Patrick Shackleton and Russell Davies.

Very close ties between British and Serbian anaesthesiologists have existed continuously from these beginnings in the post-war period up to the present day. Dr Shackleton remained an active participant in all events that took place or were related to our specialty. He campaigned for a national association of anaesthesiologists and the establishment of an award in the field of anaesthesiology. It is to their credit,



*Dr Patrick Shackleton, pictured while President of AAGBI (1967-69)*

coupled with the diligence of the first Serbian anaesthesiologists, that a relevant Article of Law was adopted excluding all other than qualified physicians to administer anaesthesia. This law was passed in the 1950s when many European countries still lacked laws regulating administration of anaesthesia. From that time the population of anaesthesiologists in Serbia grew rapidly and at present there are approximately 450 qualified anaesthesiologists.

During the years that followed we were convinced that the history of Serbian anaesthesiology must be remembered, so we sought ways to keep it alive and pass it on to future generations.

The idea of organizing the Anglo Serbian Days of Anaesthesia originates from the time of Professor Stanley Feldman's visit to Belgrade in 1987. On the professor's return to London we exchanged letters and initiated proceedings to bring the idea into existence. Around this time I went to London and met John Zorab, who had been a student of Dr Davies and Dr Shackleton. John Zorab gave us great assistance in the organization of our first two meetings. From that time forward John and I maintained a regular correspondence right up to his death.

The first meeting was held in 1988. It was our wish that our first two teachers would be present on this occasion but, unfortunately, Patrick Shackleton had already passed away, and Russell Davies was too unwell to attend the event. In a letter addressed to us all he evoked the first days of anaesthesia in our country. He was awarded a supreme Yugoslav medal which was received on his behalf by John Zorab, who at the time was President of the World Federation of Anaesthesiologists.

The nineties were dire times for our country. Unfortunately meetings and events of this nature were unfeasible. However, during this period our friends from England did not forget us and a



*John Zorab*

number of our Serbian colleagues went to England to further their education or to emigrate. Even the exceptionally unfavourable political climate and the bombing of Serbia in 1999 did not make us falter in our conviction that due recognition had to be given to the two exceptional English doctors who fathered the beginnings of our profession.

This year we plan to organize our fourth meeting, once again in October.

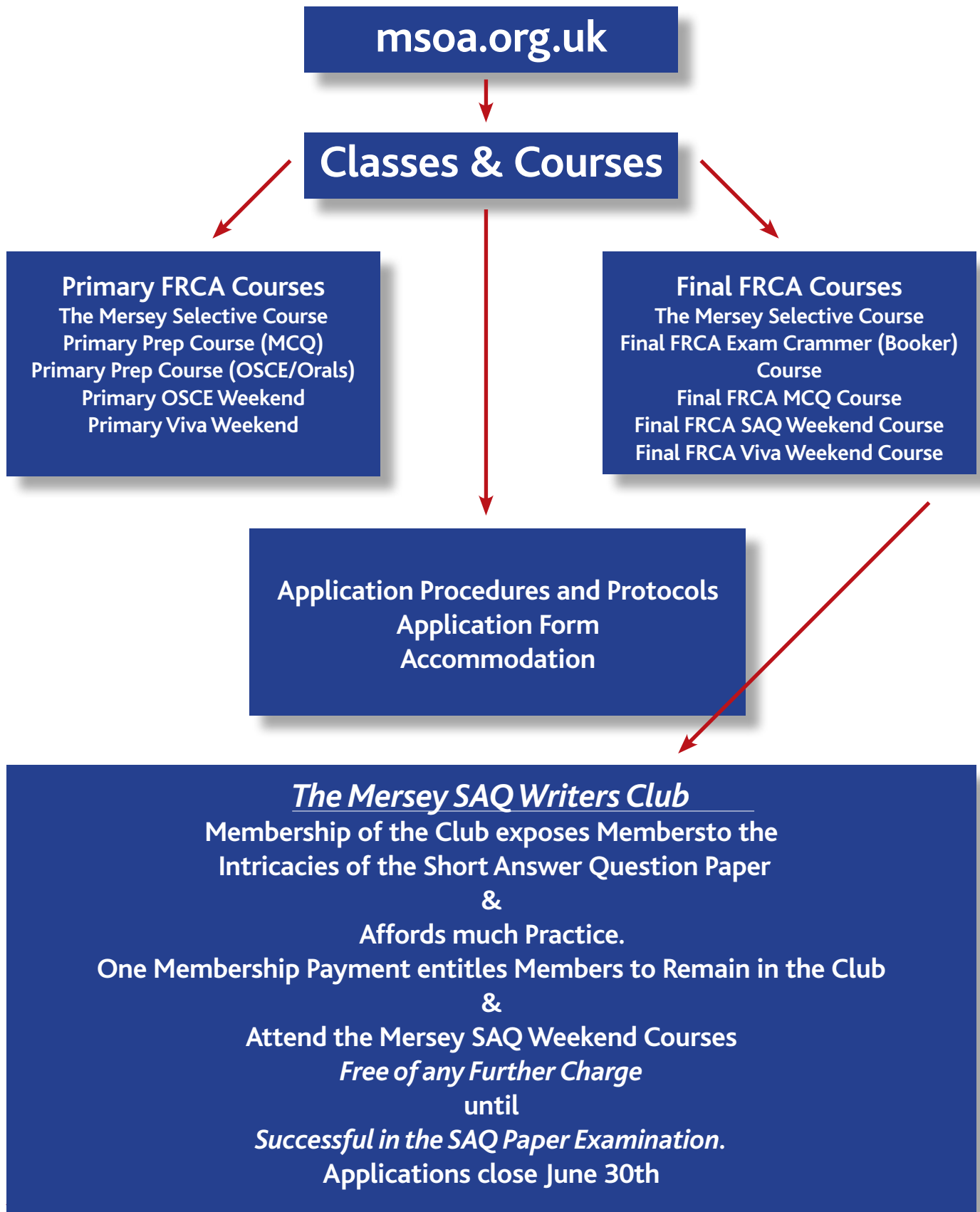
The opinion of all colleagues who have taken part in these meetings so far is that these should continue. Tradition begets substance. The meeting planned for this year will be dedicated to John Zorab. Along with Professor Feldman, John Zorab was the initiator of the concept of Anglo Serbian days of anaesthesia. It is our intention to remember John Zorab in the way we do Patrick Shackleton and Russell Davies. John truly upheld the idea that all anaesthesiologists from around the world should comprise one universal family. The forthcoming meeting will also be an occasion for us to pay tribute to him for all the help and friendship he unselfishly extended throughout the years.

**Prof. Dragan Vucovic,**

President of Serbian Association of Anaesthesiologists and Intensivists

# The Mersey Website

For Details of All Courses & The SAQ Writers Club



# MERSEY COURSES

Schedule of Courses		
Course	Start	Close
Final Viva Weekend (RCA)	06/06/08 (Fri)	08/06/08 (Sun)
Primary MCQ	17/08/08 (Sun)	22/08/08 (Fri)
Final MCQ	24/08/08 (Sun)	29/08/08 (Fri)
SAQ Weekend	29/08/08 (Fri)	31/08/08 (Sun)
Primary Viva Weekend	12/09/08 (Fri)	14/09/08 (Sun)
Primary OSCE Weekend	19/09/08 (Fri)	21/09/08 (Sun)
Final FRCA Crammer (Booker)	21/09/08 (Sun)	26/09/08 (Fri)
Primary OSCE/Orals Week	26/09/08 (Fri)	03/10/08 (Fri)
Final Viva Weekend (CARCSI)	03/10/08 (Fri)	05/10/08 (Sun)
Final MCQ	05/10/08 (Sun)	10/10/08 (Fri)
SAQ Weekend	10/10/08 (Fri)	12/10/08 (Sun)
Mersey Selective	02/11/08 (Sun)	07/11/08 (Fri)
Final Viva Weekend (RCA)	21/11/08 (Fri)	23/11/08 (Sun)

PLUS

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One Question Paper per Fortnight

CLUB # 6 - Opens July 1

Introduction to 'The Mersey Method' & The Writers Club for the SAQ Paper			
Saturday	June 21	Royal College of Anaesthetists, London	10.00 – 16.00
Saturday	June 28	Aintree Hospitals, Liverpool	10.00 – 16.00

For Details regarding All Courses and The Writers Club  
Please see Website  
MSOA.ORG.UK

# Update on the new SAS grade contract

Negotiations on a new contract for SAS doctors and dentists began in May 2005. An agreement was reached with NHS Employers in 2006. The contract was ratified, with some amendments, by the Government in December 2007, following which SAS grades were asked to vote on whether they wished to accept the new contract. The BMA Staff and Associate Specialist Committee (SASC) met on 19 March 2008 to consider the results of the contract ballot, and accepted the new SAS contract on behalf of UK SAS doctors. 60.4% had voted that they supported the introduction of the new national contract for doctors and dentists in the SAS grades.

The new contract will be offered on an optional basis from 1 April 2008 to doctors / dentists in the following grades:

- staff grades
- associate specialists
- senior clinical medical officers
- clinical medical officers
- clinical assistants
- hospital practitioners

The new grade of Specialty Doctor will replace staff grade and will be offered by employers from 1 April 2008, so there will be no new appointments to the above grades after that date.

The Associate Specialist grade will be closed. There is a new Associate Specialist grade with similar structure to the Specialty Doctor. Current Associate Specialists

will have the option to express an interest in switching to this new grade. As no new appointments will be made to Associate Specialist level, the only other route to enter the grade will be to regrade from Staff Grade or Specialty Doctor, but applications will only be possible until 31 March 2009, and after that time new applications for regrading will not be accepted.

Work has begun on implementation and employers will write to all SAS doctors asking for expressions of interest. SAS grades will have 12 weeks from receipt of the letter from employers to express an interest in the new contract. This does not commit doctors to accepting the new contract but guarantees back pay to 1 April 2008 once a job plan has been agreed. Written offers of an agreed job plan need to be accepted within 21 days (28 days in Scotland).

- Current SAS doctors must consider whether they would like to apply for the new contract. Consideration of individual circumstances will be essential.
- If expressing an interest, it is advisable to begin a diary planning exercise to aid you in job planning discussions. This should last for a minimum of 6 weeks, or one rota cycle (whichever is longer), though a longer period of time would be helpful.
- Staff grades eligible to apply to regrade to the AS grade should do so as soon as possible, as applications will not be accepted after 31 March 2009

- BMA SASC is working on producing further guidance to assist in assimilation. This will be available as soon as possible.

The contract is based on a 10 Programmed Activity (PA) contract, most of the work being for Direct Clinical Care (DCC) with a minimum of one PA for Supporting Professional Activities. A PA is of 4 hours duration. The job plan in the new contract should be based on the current job plan, so SAS doctors who currently have more than one NHD/ session for SPA activity should continue to receive this.

Contracts can be for up to 12 Pas but only the basic 10 PAs are superannuable.

There is a supplement for on-call work, payable as a percentage of the basic salary with the percentage being dependent on the frequency of the on-call. This will not be payable for a shift pattern.

Work actually carried out as Out of Hours work (OOH), as demonstrated by diary exercise, will be payable at an enhanced rate where the rate of pay will be time and a third. OOH work is work done between 19:00 and 07:00 on weeknights and all work at weekends and on public holidays. Where OOH work is included within the 10 session job plan this will be superannuable. If it forms part of additional PAs above the basic ten PAs it will not be superannuable.

Optional and Discretionary point awards will no longer exist in the new contract, but will continue to be available for those SAS doctors who chose to remain in their old contracts.

This new contract should hopefully create opportunities for SAS grades to have proper recognition of their skills and experience.

**Anthea Mowat, Associate Specialist,  
Lincolnshire  
BMA SASC Conference Chair**

**Christine Robison, Associate Specialist,  
Edinburgh  
BMA SASC**



THE ASSOCIATION OF ANAESTHETISTS  
of Great Britain & Ireland

## Evelyn Baker Medal

### An award for clinical competence

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the 'unsung heroes' of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontypridd) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Brian Steer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005, Dr Martin Coates (Plymouth) in 2006 and Dr Gareth Charlton (Southampton) in 2007.

Nominations are now invited for the award to be presented at the WSM in January 2009 and may be made by any member of the Association to any practising anaesthetist who is a member of the Association.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at [honsecretary@aagbi.org](mailto:honsecretary@aagbi.org) by Friday 3 October 2008.

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Details of events and meetings will also be listed free of charge, in the Calendar of Events and International Meetings on the AAGBI website: [www.aagbi.org](http://www.aagbi.org)

Contact: Claire Elliott on 020 7631 8817 or e-mail: [claireelliott@aagbi.org](mailto:claireelliott@aagbi.org)

# Preoperative The Association

**Annual Conference –  
“A Risky Business”  
6th November 2008  
at  
Royal Court Hotel, Coventry**

A inter-professional meeting designed for anaesthetists and all healthcare workers involved in the preoperative process.

**CALL for ABSTRACTS – 31st July Deadline**

**Registration: £190 (members of the POA)  
£225 (non-members)**

For further details including registration forms, please visit [www.pre-op.org](http://www.pre-op.org) or contact [meetings@pre-op.org](mailto:meetings@pre-op.org)  
**5 CEPD POINTS**

## Vascular Anaesthesia Society Of Great Britain and Ireland

**ANNUAL SCIENTIFIC MEETING**  
8th AND 9th SEPTEMBER 2008  
UNIVERSITY OF EAST ANGLIA, EARLHAM ROAD  
NORWICH, NR4 7TJ

### CALL FOR ABSTRACTS

- RESEARCH
- AUDIT
- CASE REPORTS

Have you performed any research or audit, or do you have an interesting case report that you would be interested in presenting?

This would also be an ideal opportunity for your trainees to get involved.

**There is a prize of £200 for the best verbal presentation and £100 for the best poster presentation.**

For further information please contact:-

Dr Andy Lumb, Chairman of the Education Committee, Consultant Anaesthetist, St James University Hospital, Beckett Street, Leeds, LS9 7TF

Tel: 0113 2065789  
E-mail: [Andrew.Lumb@leedsth.nhs.uk](mailto:Andrew.Lumb@leedsth.nhs.uk)

Closing Date: 5 July 2008

University of Oxford



**Courses on  
Anaesthesia for Developing Countries**  
Oxford ( Friday July 18<sup>th</sup> 2008)  
Uganda ( Nov 2<sup>nd</sup> - Nov 7<sup>th</sup> 2008)

*Courses will again be held in 2 centres this year:*

The July (Oxford) one-day primer course will cover the basic clinical and logistic features of working in a Developing Country, including hands-on technical demonstrations. Registration fee £120.



*Repairing your oximeter*

The November (Uganda) course will complement and amplify this in a clinical setting, with additional teaching on Draw-over, ketamine, oxygen concentrators, logistics, obstetric & paediatric anaesthesia, trauma management, drug supplies and training issues. Registration (includes accommodation & all meals) £390/£450 (shared/single).



*Hospital visit - Kampala*

Registrants will need to make their own flight arrangements, but will be met at Entebbe airport.

For further details & booking form contact Mrs. Pat Millard, Nuffield Dept of Anaesthetics, John Radcliffe Hospital, Oxford OX3 9DU.

Tel 01865 221590 Email: [pat.millard@nda.ox.ac.uk](mailto:pat.millard@nda.ox.ac.uk)

or see website [www.nda.ox.ac.uk](http://www.nda.ox.ac.uk) for further details & application form

## Vascular Anaesthesia Society Of Great Britain and Ireland

**TWELFTH ANNUAL SCIENTIFIC MEETING**  
MONDAY 8TH & TUESDAY 9TH SEPTEMBER 2008  
THE UNIVERSITY OF EAST ANGLIA  
EARLHAM ROAD, NORWICH

### Guest Speakers to include:-

Dr Mike Swart	"Management of intraoperative myocardial infarction"
Dr Trevor Wistow	"Management of atrial fibrillation"
Dr Graeme McLeod	"Making thoracic epidurals work"
TBC	"Management of aortic cross clamping"
Professor Mike James	"What's new in perioperative fluid management?"
Dr Sue Mallett	"Near patient testing of haemostasis"
Professor Nigel Webster	"Clinical value of biomarkers"
Mr M Armon	"Should surgeons publish their results"
Dr D Prytherch	"Prediction of risk"
Dr Don Poldermans	"Reducing risk, medical interventions"

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- Cardiopulmonary exercise testing
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### Additional topics to include:

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### Free Papers

REGISTRATION FEE: £320 (members) £375 (non-members) £275 (trainees) (inclusive of lunch, conference dinner and Monday evening en-suite accommodation)

For registration details please visit our website [www.vasgbi.com](http://www.vasgbi.com)

Contact us: Mrs J Heppenstall Telephone: 07897 556056 Fax: 0114 2464965  
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## Naked Gasman

# Be aware, be very aware

I was delighted to see my Trust taking the problem of awareness under anaesthesia so seriously. It had actually set up a number of half days on awareness training, and even made them compulsory, calling them Mandatory Awareness Training for Consultants. Furthermore, to my surprise, when I turned up for one, I found not only some of my anaesthetic colleagues, but also consultants from almost every other discipline. The penny quickly dropped as I realised the session was on topics that the Trust thought we should be “aware” of. Still I was very impressed with the high turnout at the session, but then as attendance was conditional for being considered for Clinical Excellence Awards, it was hardly surprising! One of the topics covered was the latest infection control policy or the instruction to be “naked from the elbow down” when undertaking direct patient care. This gave me the idea of putting a tray at the entrance to ICU for orthopaedic surgeons to slip their Rolex watches into before seeing their patients, with the proceeds going to the Intensive Care fund. So far all we’ve had is a broken Swatch and a copper bracelet – must have been a passing rheumatologist.

One of the Trusts in my region had the distinction of having the largest debt of any Trust a few years ago. It has struggled under the threat of paying this off year on year, at the same time as having to meet the latest government targets on waiting times and further savings. There was a recent jubilant announcement from the Trust that the debt was finally going to be written off, on condition the Trust repaid £4 million per year for the next 5 years. To me, that is £4 million per year less to be spent on clinical care of patients. The Trust has already pared costs by the usual methods of not replacing staff who leave, not updating equipment, using cheaper (and often inferior) alternatives for disposables etc. This Trust is also planning to move into a brand new hospital within the next 5 years, and coincidentally the CEO is frantically applying for other jobs even though one of the Trust’s aims is to ‘make it a great place to work!’ There were recently some Consultant interviews at this Trust, and when candidates were asked at the end if they had any questions, the local consultants on the appointments committee were waiting for one of the candidates to ask why, if it was such a good place to work with the



excitement and opportunities of a brand new hospital, was the chief executive trying to leave? I am reminded of a scene from the film 'The Queen', when Helen Mirren reminds the newly appointed Tony Blair that whilst she is, and has always been, his Queen, he is but her 10th Prime Minister and drops in for good measure that her first was Winston Churchill. Not that I'm suggesting that consultants are the royalty of the health service whilst chief executives are the government of the day – or am I? For one thing most chief executives don't last as long as government ministers (not even health ministers), and most of my consultant colleagues have never met our chief executive, even though she has been in post for four years.

Many readers will be aware of a recent problem of supply of premixed ampoules of glycopyrrolate and neostigmine, which had a mixed reception in my Trust. Some of my colleagues claimed to never use it as they either never paralysed their patients or else allowed the relaxant to wear off, whilst others foresaw cancelled operations and recovery units full of ventilated patients. One attempt to cope with the shortage was to ration the supplies to all hospitals, although no attempt was made to consider each hospital's usage of pre-mixed 'reversal'. This led to some smaller hospitals having stockpiles of the drugs, and others rapidly running out. One nearby Trust reported two incidents of profound bradycardia following the administration of unopposed neostigmine, and has now removed all boxes of neostigmine from operating theatres. My Trust bought in supplies from other suppliers, including a brand from a South African manufacturer with the instructions written in German. As the packaging is unlike our normal presentation nobody realised it was

available in our drug cupboards for some weeks. Just as well, as it cost five times as much as the usual preparation!

It reminded me of my very first drug near-miss which happened in my first week as a trainee anaesthetist. In those far off days we were given a list of our own to get on with, and a consultant in the next door theatre to call if there were problems. My assistant was a trainee ODA, on about his second week, with (you've guessed it!) an experienced ODA next door with the consultant anaesthetist that he could call on if he had problems. Preoperative visiting and premed prescribing had been done the night before by the on-call anaesthetist. The first patient was fairly unremarkable except that as I was squirting in the thiopentone I commented that he looked familiar to me. "I should do" came the patient's reply, "I was in the year below you at med school!" I contemplated calling in the consultant but it was too late for that - I was committed to my course of action. The list progressed and the next patient was having a laparotomy. As the case approached its conclusion, the trainee ODA brought in a syringe of 'reversal drugs' as it was common practice then for the assistants to draw up drugs, and the usual mixture was atropine and neostigmine. My request to be shown the ampoules, which I considered to be reasonable, was met with a surly stare and muttered comment that if consultants trusted him to draw up their drugs, why shouldn't I. He returned a moment later with what he thought were 2 empty ampoules each of atropine and neostigmine, but instead of atropine he had drawn up 2mls of 1 in 1000 adrenaline. Oops! One way of avoiding bradycardias with neostigmine!

My early experience of drug errors continued during my second week of anaesthesia training when I started obstetric anaesthesia. The elderly anaesthetist teaching me was not much more experienced than I was. He had been a fighter pilot in the war (WW2), a very late, mature entrant into medicine, tried his hand at general practice and was now the equivalent of a second year SHO. The operating list was an elective section list, all under GA (that gives you an idea of how long ago this was!) and the first patient was duly pre-oxygenated for a full 5 minutes before it was realised that the halothane had been left 'on' from the morning list. So now I'd had experience of inhalational induction! The next case was also very instructive. I learnt that it is not a good idea to give a long acting muscle relaxant as the first iv drug at induction for caesarean section. In his defence I must say that all these different size syringes can be quite confusing, especially if you have a severe tremor. He was also infamous for an ECT session in which he had forgotten to mix up methohexitone with water and had 'anaesthetised' the whole list with sterile water and suxamethonium. Strangely enough neither the staff nor the patients had noticed any difference from normal. Needless to say, my early experience has taught me to personally check every drug that I give, but this was not enough to prevent me giving sterile water instead of vecuronium recently. An easy mistake to make when interrupted as one is drawing up drugs. Be warned though – the NPSA and other 'stakeholders' have suggested that all drugs given by anaesthetists should be checked and signed for by the anaesthetist and another trained person. Looks like it will be time to hang up my clogs when that happens.

## Translation difficulties

I was very interested to read the article 'Language Barrier', by Dr Sodhi<sup>1</sup>, published in March 2008, as this is a subject that has vexed me with increasing frequency recently.

It is departmental policy where I work to obtain written consent before siting labour epidurals. I believe this is a contentious issue at the best of times; can a woman in the throes of labour really give informed consent? When a language barrier is introduced it adds yet another layer of uncertainty. In recent months I have been called to an increasing number of labouring women who have very little command of English, particularly from Eastern Europe. As Dr Sodhi wrote, it is impossible to know how much these patients understand of what has been explained to them. Most of the obstetric work-load is carried out at night and so the luxury of an official translator is not available; often partners fill the gap, but in no way can they be seen as an objective third party, and I often wonder how much of what we say is lost in translation.

This situation is less than ideal for the patient and it must surely lay us open to criticism and possible consequences? If it is considered necessary to take consent for labour epidurals, then surely it cannot be correct to carry out the procedure on a patient whom we have no real idea whether or not they have understood and accepted the inherent risks. And if we go ahead with the procedure anyway, why do we bother wasting time with the consent process? To me it seems a frustrating hypocrisy; we should either do it properly, or not at all. Should we be consenting these, and perhaps all, pregnant women for procedures during labour in the ante-natal clinic, where consent could be better informed and translators could be present where necessary? I suppose this may raise other issues - what about the woman who refuses an epidural, only to change her mind once labour starts; would we then refuse her the pain relief? I believe that this is a difficult subject and I for one am often left feeling uncomfortable following these difficult and ultimately flawed interactions. I would be interested to hear what others think and how they overcome these difficulties.



**Kate McCombe**

SpR in anaesthesia, Surrey

### Reference

1. Language Barrier. Puja Sodhi, *Anaesthesia News* March 2008, P 32

## Help with informed consent

Dr Puja Sodhi wrote about the difficulty of providing anaesthesia for patients who do not speak English, as well as empathising with the patients themselves.

This is a common situation in obstetric anaesthesia, as women cannot inform themselves about all possible eventualities that might occur during childbirth, even if they choose to seek out the information.

The Obstetric Anaesthetists' Association have produced two information booklets on pain relief in labour and anaesthesia for caesarean section, and a card with brief information on epidurals for use especially during labour. There are currently a number of translations of these on the OAA website ([www.oaformothers.info](http://www.oaformothers.info)) with several more having been commissioned.

We are also developing cards with words, phrases and pictures relevant to regional and general anaesthesia, with script and phonetic translations. These can be used to help communication especially in the emergency situation when there is no interpreter available.

We would commend these resources to anaesthetists who deal with non-English speaking women in pregnancy and labour.

**Dr Michael Kinsella**

Information for Mothers Sub-committee, OAA

## Instant headache!

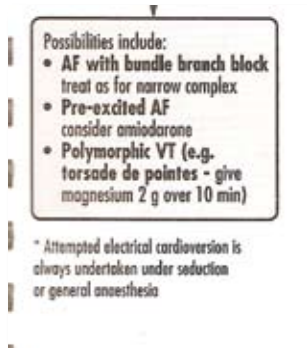
I was asked to provide a labour epidural for an extremely anxious lady.

After explaining in detail about the technique and all the side effects, including post dural puncture headache and its management, I infiltrated local anaesthetic into the skin. Just before introducing the Tuohy needle, the lady screamed "Doctor, I am getting a terrible headache"!

**Dr.K.B.Dasari**  
FTSTA Anaesthetics  
Royal Cornwall Hospital  
Truro

## Making cardioversion interesting

I came across this novel anaesthetic technique in a published tachycardia algorithm. Despite attempting personal study of this art, I have never received any formal teaching. I wonder if it is now examinable as part of the FRCA syllabus, and if so, should I bring flowers?



**Malcolm Broom**  
Anaesthetic SpR, Glasgow

## More on allergies...

The incidence of unusual allergens<sup>1,2,3</sup> does seem to be increasing. Although an allergy to the colour red<sup>3</sup> would win the prize for most unusual allergen, I would like to report a close second. On pre-operative assessment for a gynaecology list, I met a very nice lady who had previously had a carpal tunnel repair. Unfortunately during this procedure she had experienced a nasty iodine burn under the tourniquet., which had subsequently required skin-grafting to the injured area. During routine questioning I enquired about allergies, to which she replied "tourniquets". This had even been dutifully written on her red patient ID band.

**Chris Jones, Anaesthetic SpR**  
Epsom and St. Helier NHS Trust

1. Lomax S. Anaesthesia News December 2007, 245:25
2. Stoddart A. Anaesthesia News September 2007, 242:26
3. Boswell O, Al-Rawi S. Anaesthesia News April 2008, 249:30

*Editor's note: Thank you for all your allergy stories – this correspondence is now closed.*

## For the nervous anaesthetist?

Recently, I attended a course in an English hospital which shall remain nameless. During a relief break as I went to the men's room, to my utmost surprise I found ....



A very old Boyle's machine [Fig 1] was decoratively perched next to the two urinals. I had to physically move it aside to squeeze in for the original purpose of my visit. I wondered, did someone actually have to provide anaesthesia there, or was it just dumped for lack of space.

I certainly can think of few other places where a Boyle's machine would be useful for providing 'anaesthesia outside theatre' - like the dining room, locker rooms, outside pubs, football stadiums, next to an ATM machine, library etc.

Is this a missing aspect of our training?

**Dr Deepak Malik**  
Specialty Registrar, Anaesthetics  
The Royal Hallamshire Hospital,  
Sheffield Teaching Hospitals NHS Trust

## Is that what they really meant...?

Spotted in a flyer for an anaesthesia CPD meeting (not one organised by AAGBI!)

*Session 5*  
*Non technicals kill in the operating theatre*

Support for a physician-only service, or a misplaced space?

*DUE TO THE VOLUME OF CORRESPONDENCE RECEIVED, LETTERS ARE NOT NORMALLY ACKNOWLEDGED.*

# FILM REVIEW

# AWAKE

## PASSING GAS ON THE SILVER SCREEN



As you address yourself over the forthcoming months to the umpteenth patient who's asked you if he's going to wake up in the middle of the operation "like that bloke in the film", spare a thought for the unfortunately-named Dr Larry Lupin. Larry, the anaesthetist whose practice is the subject of the recent Hollywood blockbuster, 'Awake', is going to have rather a difficult time if the shadow of revalidation ever falls on our colleagues in New York.

"It seems, Dr Lupin", begins the assessor, "that your pre-operative assessment leaves something to be desired. I believe that you first met the index patient, who was scheduled for heart transplantation, on the operating table. Indeed, you only asked him about his fasting status during the act of pre-oxygenation. Pre-oxygenation, I might add, which was achieved by securing the mask to his face with a Clausen harness, incorrectly attached. You then induced anaesthesia while monitoring nothing but central venous pressure, the line having presumably been inserted by a passing surgeon in some location other than the neck."

"I say induced anaesthesia, of course, but that is perhaps something of an exaggeration. He never actually went to sleep at all, did he? But then, you may not have known that, as you were apparently out of the theatre most of the time during the procedure".

"Ah", protests the beleaguered Dr Lupin. "But that's pretty standard during cardiac surgery, you know".

"Not *before* the patient goes on bypass!", thunders the assessor. "And, it must be said, that it is hardly standard practice for

an anaesthetist to carry a hip flask in his scrubs, let alone to take surreptitious sips from it during the operation".

Larry raises his grizzled and drink-sodden head from the edge of the desk, where it has come to lie. "Give us a break. I'm a shining example of virtue compared to the surgeons. At least I didn't plot to kill the patient by injecting adriamycin into the donor heart, having tricked him into marrying one of my nurses, thus ensuring that she'll inherit his millions, allowing me to pay off all my malpractice claims".

The assessor concedes this point, suggests a programme of counselling to allow Dr Lupin to confront his issues, and tells him she'll see him in five years' time. Larry heads off to find himself a new cardiac team, the last one having presumably been struck off, imprisoned, executed, sent to practice in South Dakota or whatever happens to homicidal surgeons in the USA.

'Awake', the first – and hopefully only – foray by Hollywood into the complications of anaesthesia, has a few surprises up its sleeve. The anaesthetist isn't the villain of the piece, just incredibly incompetent. Indeed, he's not even played by the only British character, usually a shoo-in for the guy in the black hat. Another anaesthetist, who we don't get to meet, has defaulted from the case because he can't bring himself to murder his patient – that's what I call 'probity'. And, in the spirit of suspense, I'll leave you guessing where the good guys find a new heart for our temporarily bypass-dependent hero.

You even get to feel a little sorry for the mad surgeon. After all, he's pulling an 80-hour week, everyone's trying to sue

him, and his chief assistant is a malign, rat-faced dwarf. And, heck, it's not every day that fate gives the wealthiest man in New York cardiomyopathy and then places him, trusting and needy, into your hands. Plus, and this will always be the clincher for any red-blooded male, he's had the good taste to employ Jessica Alba as his scrub nurse.

Could this be the beginning of a new trend in entertainment? Surgeons, A&E docs, even GPs and psychiatrists have all had their day in the sun. Now we're up there with the greats. What next? 'Skin Flick', a film about a deranged dermatologist who mistakenly treats a nasty fungal infection with steroids? 'Sickly Sweet', in which a debt-ridden diabetician boosts his private practice by putting glucagon in the punch at the country club social? You may think I jest but, while settling into my seat, I nearly dropped the popcorn as a trailer came on for a film in which two trainee pathologists compete to murder innocents in increasingly bizarre ways, challenging the other to discover how it was done at post-mortem. The title? 'Pathology'. Who said they don't have imaginations in Hollywood?

**David Bogod**

