INSIDE THIS ISSUE:

A YEAR IN REVIEW
2012-2013

Postcode lottery in anaesthetic training

The history of the specialty of Anaesthesia in the UK

Learn@AAGBI
Scan and learn... simultaneously.

X-PORTE
THE WORLD’S FIRST ULTRASOUND KIOSK

Ultrasound Unleashed: Scan live with on-board tutorials

View animated tutorials concurrently with live scans for in-the-moment learning.
Access integrated 3D Visual Guides designed by animation modeling experts and pioneers in medical tutorials for astronauts. Highly advanced learning modules are among the many first-ever point-of-care innovations integrated in SonoSite’s new ultrasound kiosk.

Think these are great? Wait till you see all of X-Porte’s features!
www.sonosite.co.uk/products/x-porte


Editorial

Retrospective: Goodbye and thanks for all the flowers

In this edition we publish our annual review, and some editor’s highlights from Annual Congress in Dublin. Looking further back, the history boys (and girls) have been busy, and the reproduction of a paper describing the birth of our College and Association makes interesting reading.

The phrase ‘of necessity, large numbers of routine anaesthesia and most of the emergency anaesthesia in hospitals must be administered by interns’ reflects the reality of the NHS that I joined in 1981, and we still have some way to go before consultant-delivered care is anything but a pipe-dream. Indeed, some of you may still regard it as a nightmare.

Like Iain Wilson, who wrote last month’s editorial, I am looking back on my career in anaesthesia and at the AAGBI - I will be leaving the specialty soon and left the AAGBI at Annual Congress in September. I would second Iain’s feelings about the AAGBI having been a great organisation to work with, as has the wider NHS. Despite all the negative press, the care we give to patients undergoing surgery today is so much better than it was thirty years ago, at the start of my career. Having said that, I suspect that there may be some giant leaps in our understanding in the fairly near future that will help us to improve outcomes to an extent that we have hardly dreamt of to date. That was certainly the message I heard listening to Daniel Sessler at Annual Congress in September - read more on that subject in the report from Dublin.
A younger colleague recently asked me to pass on a few tips. He felt I must have learned something that would be helpful to him over the years. I was initially flummoxed, but have returned to the question from time to time. Looking at a couple of nascent “glossies” (Fatigue and Occupational Health – both strongly recommended reads – they should be published early in the New Year), and reflecting on my own career, I have three “top tips”, not things that I think I have done well, but that I ought to have done better.

‘Have lunch’ is pretty much my No 1 tip. Really, I skipped an awful lot of meals and ate an awful lot of KitKats, and I am not sure I really did anyone any favours in doing so. We need to stay healthy to be able to do a good job.

At the risk of sounding corny, and in the light of my recent experiences as a patient, I would have to say that my No 2 tip is ‘listen to patients’. I mean this in a slightly broader sense than just listening to their responses to your questions – go a bit further and cultivate empathy.

Last but not least, my newly-retired outstanding colleague Ian Warnell offers this: ‘Take a sabbatical. You won’t miss anything’.

As much money as you can into an equity (not cash) ISA every year ‘yes’ to opportunities – you’ll be surprised what you can do; and put lessons about our behavior.

I think it is still the case that most of us learn that we too can err (for of doing this, and different kinds of knowledge. ANTS training will
turn up when you want to. This latter advice comes
from time to time. Looking at a couple of nascent ‘glossies’ (Fatigue
and Occupational Health – both strongly recommended reads –
you are extraordinary people

· A healthcare system that understands that the safety of surgical patients is best served by promoting and supporting
· A Government that does not view doctors as soft political
· Hospital managers who are motivated to put patient safety
· A pension scheme for doctors that is not downgraded at
· A system of training in hospital specialties that does not keep
· A totally new reward system to replace the current Clinical
· A new NHS Consultant Contract that recognises that there
· A Ducati Multistrada 1200 S Granturismo.
· A non-Luer spinal and epidural needle connector design that is based on ISO standards, has been appropriately

I do realise that giving me all of the above for Christmas will be a bit of a tall order, so, if you can only grant one of these wishes, I think I will opt for the Ducati Multistrada. Meanwhile, the AAGBI is working on its New Year’s Resolution, which is likely to bear a strong resemblance to last year’s: to continue to advance safety, education and research in anaesthesia and its related subspecialties.

Happy Christmas!

William Harrop-Griffiths
AAGBI President
Trainees… what can the NIAA do for you?

What is the NIAA?

The National Institute of Academic Anaesthesia (NIAA) was established in March 2008 as a response to the crisis in academic anaesthesia identified by the 2005 Pandit report1. Its aims include improving patient care by promoting the translation of research findings into clinical practice, facilitating high profile, influential research, and supporting training and continuing professional education in academia.

The NIAA trainee strategy

Supporting the training and development of trainee anaesthetists has been a core value of the NIAA since its inception and is emphasised in the 2012-2017 strategic plan3. There is a lack of formal academic posts in anaesthesia, with only seven of the advertised 268 academic clinical fellow (ACF) posts for 2013 being in the specialty4. However, many anaesthesia trainees in standard clinical training programmes are engaged in research and the NIAA activities aim to support the development of all trainees (Figure 1). The NAA trainee strategy is to introduce similar courses to research training for anaesthetists and allow participants to attend conferences during working hours, squeezed into lunch breaks or lists.

Trainee representation

The NIAA has an academic trainee coordinator and two trainee representatives, Dr Robert Saunders and Dr Eleanor Carter. Coordinator is Dr Ramani Moonesinghe assisted by two trainee representatives, Dr Robert Saunders and Dr Eleanor Carter.

Research and trainee databases

The NIAA holds a database of research-active individuals, both senior anaesthetists and trainees, that is accessible via its website. Trainees can join the database and search for other individuals working in their area of interest for networking opportunities and to identify potential research supervisors. The NIAA has also asked research-active trainees to log their details with the Institute and provide a brief summary of their current research. This information will be used to build a complete picture of the level of research participation by trainees and to publish a report on their activities.

Trainee resources

The NIAA website has a section specifically for trainees with useful information for those considering a career in academic anaesthesia. In addition, there are links to articles on routes into research and other online resources such as e-learning for health research training modules. NIAA Board members have also contributed information on research training to the GAT Handbook. The aim is to expand the online resources to further assist with research training.

Training courses

The NIAA research week earlier this year brought together research courses from the BJA, Anaesthesia Research Society and NIAA Health Services Research Centre. The aim was to facilitate access to research training for anaesthetists and allow participants to attend multiple research events if desired. The NIAA also recently hosted an Introduction to Research course for trainees in association with the London Deanery. The intention is to introduce similar courses throughout the UK, to enable anaesthesia trainees to access research training early in their careers.

Trainee representation

The NIAA has an academic trainee coordinator and two trainee representatives who attend and contribute to NIAA Board, providing a voice for trainees in the organisation. The NIAA also intends to support high quality trainee research networks, such as the South West Anaesthetic Research Matrix (SWARM) and is holding its first National Trainee Research Federation meeting later this year.

Provision of funding information

The NIAA coordinates grants, awards and fellowships offered by its founding and other funding partners. Full information regarding current opportunities, eligibility criteria and application processes are available via the NIAA website. Trainees are eligible to apply for many of these grants and should check the funding pages regularly if they are looking to fund a research project.

Summary

A core value of the NIAA is to support the training and development of the next generation of academic anaesthetists. Current activities include provision of written and online resources, organisation of training courses and trainee representation. The future aims are to expand and develop these activities resulting in high quality research exposure for all trainees ensuring a bright future for academic anaesthesia.

Figure 1

Summary of the NIAA trainee activities

There are many barriers to organising regular, structured, face-to-face revision for the structured oral examination (SOE) components of the FRCA examination, and anyone who has sat the examination will remember the intense frustration of spending valuable revision time arranging viva practice only to fail it to be cut short by extraneous factors. Candidates must contend with solving SWATS with patterns, geographical dispersion across large deaneries and placement in departments with no other trainees sitting the examination.

We observed many of these obstacles during revision for the Primary FRCA and decided to use new technology to maximise opportunities for viva practice for the Final SOE by using Skype, a free online video conferencing tool, to connect to each other for practice. Resources available to assist candidates revising for the FRCA examinations traditionally take the form of large and comprehensive textbooks supplemented by smaller revision-style texts, continuing education articles, and written question books specific to particular examination sub-sections. In the past ten years these resources are increasingly complemented by use of online question banks, smart-phone applications and revision courses of significant cost but variable quality.

For the SOE sub-part to the Primary and Final examination candidates typically revise in small groups in their spare time and with local consultants during working hours, squeezed into lunch breaks or lists.

References

2. www.niaa.org.uk

FRCR viva revision – the Skype is the limit

How long do you delay cardiac surgery if your patient is on Clopidogrel?
Since 1982 an International Symposium on the History of Anaesthesia has been held approximately every four years. The venues for the first seven were successively Rotterdam, London, Atlanta, Hamburg, Santiago de Compostela, Cambridge and Crete. These Symposia have generated a huge archival record on the development of anaesthesia, anaesthesia and intensive care worldwide. The eighth ISHA was held in Sydney, Australia from 22 to 26 January 2013 – providing an opportunity for expansion of previous research, new topics and exchange of ideas.

The delegates from the northern hemisphere had to adjust to a temperature of 40 degrees Celsius, but this was soon accomplished with the aid of local cold beverages, which came in strange measures: ‘schooner’, ‘middy’ and ‘jug’.

There were over 150 delegates from at least 12 countries. The History of Anaesthesia Society (UK) was well represented with 14 delegates (delivering a total of 14 lectures), including the President, Dr Anne Florence.

More than 90 presentations were delivered; a particularly memorable presentation was the first French educational video on muscle relaxants, which was quite shocking. It demonstrated not only the rabbit head drop test, but administration of muscle relaxant to a human volunteer without general anaesthesia! Notable events were the Young Historians’ essay competition (12 presentations) and an anaesthetic history book-signing/sale from international authors. Alistair McKenzie represented the AAGBI in this regard. There was also a workshop on the value of reinstating the history of anaesthesia into the anaesthesia training curriculum – with a resolution to set up a website on this topic. The highlight of the non-academic program was a dinner cruise round Sydney Harbour. During this, the winner of the Young Historians’ essay competition, Dr Martin Graves was awarded the Gwen Wilson Prize for his paper on the role of the Australian anaesthetist in World War I.

At the closing ceremony the organising committee (for the Australian Society of Anaesthetists, the Australian & New Zealand College of Anaesthetists and the New Zealand Society of Anaesthetists) were congratulated for a tremendous meeting. They had convinced the delegates of the theme of the symposium: “History matters”.

Once the Trust Mandurah had been sweated out of the enterprise (which was no small feat in itself), there came the small matter of whipping up the enthusiasm of colleagues to whip up some eggs in aid of an admirable cause. Despite numerous assurances of good intentions and promises of support, there was always the worry that some of the produce would actually materialise and the whole thing would flop like a sagging soufflé.

In the event, these concerns were unfounded. By 7am on the allotted morning, Cake Mission Control was established in the Education Centre where projects ‘footfall’ would be optimum (thanks for specialist insight from Alan Sugar et al). By 8am the trusty cake trolley was wheeled into the department, from the most junior through to possibly his wife!).

Two Theatre Drugs trolleys were commandeered for the day and converted into cake dispensing trolleys, groaning with delicious tarts: these were then dispatched to every corner of the Hospital – nowhere was safe; even a Trust Board meeting was interrupted for a Granny Cake Bake Break (with excellent feedback from all concerned).

The whole day was a tremendous success on many levels: morale boosting, team-building, bridge-building with other departments, positive PR for the department and, above all, fun!

Dr Jean Horton (UK) and Dr J Rupprecht (The Netherlands).

Fig. 2: Sydney Harbour Cruise: (L to R) Dr J Wilkinson (UK), Dr W Stratling (UK) and Dr M van Wijhe (The Netherlands).

The Great Anaesthesia Bake

Monday 16th June was the day when the covert bakers of Wythenshawe Hospital Anaesthetic Department came out of the cake baking closet and answered the call to arms (or aprons), from the Association – the day of the ‘Great Anaesthesia Bake’ in aid of ‘Lifeline’ was upon them and it was time to step up to the plate and show what they were made of: and step up they did, with admirable results!

When faced with organising any event like this, the first impulse for most is to mentally envisage the hurdles that would have to be jumped in order to make it happen; the next impulse is to yawn, turn the page and move onto the next affair. Thankfuly Sarah Wheatley, an Anaesthetic Consultant at Wythenshawe Hospital, resisted those impulses and made it happen.

The delegates from the northern hemisphere had to adjust to a temperature of 40 degrees Celsius, but this was soon accomplished with the aid of local cold beverages, which came in strange measures: ‘schooner’, ‘middy’ and ‘jug’.

More than 90 presentations were delivered; a particularly memorable presentation was the first French educational video on muscle relaxants, which was quite shocking. It demonstrated not only the rabbit head drop test, but administration of muscle relaxant to a human volunteer without general anaesthesia! Notable events were the Young Historians’ essay competition (12 presentations) and an anaesthetic history book-signing/sale from international authors. Alistair McKenzie represented the AAGBI in this regard. There was also a workshop on the value of reinstating the history of anaesthesia into the anaesthesia training curriculum – with a resolution to set up a website on this topic. The highlight of the non-academic program was a dinner cruise round Sydney Harbour. During this, the winner of the Young Historians’ essay competition, Dr Martin Graves was awarded the Gwen Wilson Prize for his paper on the role of the Australian anaesthetist in World War I.

At the closing ceremony the organising committee (for the Australian Society of Anaesthetists, the Australian & New Zealand College of Anaesthetists and the New Zealand Society of Anaesthetists) were congratulated for a tremendous meeting. They had convinced the delegates of the theme of the symposium: “History matters”.

Once the Trust Mandurah had been sweated out of the enterprise (which was no small feat in itself), there came the small matter of whipping up the enthusiasm of colleagues to whip up some eggs in aid of an admirable cause. Despite numerous assurances of good intentions and promises of support, there was always the worry that some of the produce would actually materialise and the whole thing would flop like a sagging soufflé.

In the event, these concerns were unfounded. By 7am on the allotted morning, Cake Mission Control was established in the Education Centre where projects ‘footfall’ would be optimum (thanks for specialist insight from Alan Sugar et al). By 8am the trusty cake trolley was wheeled into the department, from the most junior through to possibly his wife!).

Two Theatre Drugs trolleys were commandeered for the day and converted into cake dispensing trolleys, groaning with delicious tarts: these were then dispatched to every corner of the Hospital – nowhere was safe; even a Trust Board meeting was interrupted for a Granny Cake Bake Break (with excellent feedback from all concerned).

The whole day was a tremendous success on many levels: morale boosting, team-building, bridge-building with other departments, positive PR for the department and, above all, great fun!

...and the final and most important result? Over £1000 raised for Lifelinetox to provide not just Pulse Oximeters where the need is greatest, but also an essential training package in how to use an Oximeter safely and effectively.

I would hope that The Great Anaesthesia Bake will become a regular event, and that any Departments that have considered getting involved just get on and do it!! It’s a sure recipe for a guaranteed great experience in aid of a truly worthwhile cause!!

Adam Dobson, Consultant Anaesthetist, UHSM

Not all patients respond to Clopidogrel in the same way…

Approximately 32% of Patients do not respond to Clopidogrel¹.

With the Multiplate® Analyser you can quickly and easily establish a patient’s current level of platelet function and use this to:

• Make a decision about surgical delay²,³ • Guide platelet use in surgery⁴

For more information visit: www.multiplate-analyser.co.uk or call 01444 256 782

A YEAR IN REVIEW 2012-2013

The year 2012-13 was another successful and eventful one: here we share a few highlights.

COUNCIL

At the Annual Members’ Meeting in Bournemouth in September 2012, we were pleased to welcome three newly elected council members:

• Dr Rachel Collis, Consultant Anaesthetist, University Hospital of Wales
• Dr Matthew Checketts, Consultant Anaesthetist, Ninewells Hospital
• Dr Roshan Fernando, Consultant Anaesthetist, University College London Hospitals

At the AMM in Dublin, in September 2013, we were again pleased to welcome:

• Dr Upma Misra
• Dr Paul Barker
• Dr Mike Nathanson

TRAINEES’ COMMITTEE

The GAT Committee was joined by four new elected members at the Annual General Meeting in Glasgow in June 2012:

• Dr Ben Fox, Addenbrookes Hospital
• Dr Claire Gillan, Lothian University Hospitals NHS Trust
• Dr Jonathan Price, Royal Free Hospital
• Dr Elaine Yip, Forth Valley Royal Hospital

and at AGM in Oxford 2013:

• Dr Emily Roxson, ST6, London

21 PORTLAND PLACE

Our Grade II listed building in London has attracted around 300 visitors a week and hosted numerous meetings, events and seminars during the year.

We continue to offer office space to the World Federation of Societies of Anaesthesiology (WFSA) and Lifebox, the international charity of which AAGBI is a founder member.

SPECIALIST SOCIETIES

The AAGBI staff provide secretariat and event services for 20 specialist societies, the largest being DAS, APA and OAA. Eight one-day conferences and five study days were organised for specialist societies, together with upgrades to IT systems to enhance the service provided.

MEMBERSHIP

We are pleased to report a healthy 93% retention rate and a total of nearly 10,600 members including 723 new members joining during the year.

The enhancement of membership services is a key focus. New services launched this year were: AAGBI Core Topics in Anaesthesia 2012 and the online case reports site Anaesthesia Cases launched in 2013. Additionally, we now offer an exclusive discount for members wishing to purchase the FRACQ online exam resource from Cambridge University Press.

We are pleased to report a healthy 93% retention rate and a total of nearly 10,600 members including 723 new members joining during the year.

The enhancement of membership services is a key focus. New services launched this year were: AAGBI Core Topics in Anaesthesia 2012 and the online case reports site Anaesthesia Cases launched in 2013. Additionally, we now offer an exclusive discount for members wishing to purchase the FRACQ online exam resource from Cambridge University Press.

Total members 10,592

Membership Categories

- Trainees
- Ordinary
- Overseas
- Retired
- Honorary

4% 11% 29% 56%

www.anaesthesiacases.org

ENVIRONMENT

The AAGBI continues to make progress in its drive to become more environmentally friendly, for example using more energy efficient lighting and encouraging recycling where possible. Clinical guidelines and other publications are available for download from the website and limited print runs to reduce the environmental impact.

In the last year we recycled a total of 9,330 kg of paper, making a CO2 saving of 13,060 kg – that’s equivalent to 126 trees saved!

Social Media

Our Facebook and Twitter accounts have been extremely popular and we are now connecting with our members and new audiences through these interactive means. We have over 1600 followers on Twitter.

Join us on Twitter @aagbi or Facebook aagbi

www.aagbi.org
“These young men and women are the new face of anaesthesia in Uganda. The more we can improve our numbers, the more we can develop our speciality. We are noticing better outcomes all the time.”

Dr Stephen Ttendo, Head of Department at Mbarara University Hospital, Uganda

Supporting colleagues overseas

The AAGBI Foundation maintains an active programme of support for anaesthesia worldwide, including grants towards educational projects in lower resource countries, book donations and funding of educational resources. This year 37 grants were awarded towards work in 17 countries.

Overseas Anaesthesia Fund

The Overseas Anaesthesia Fund (OAF) enables individuals and organisations to donate directly to AAGBI programmes that support training and promote safer anaesthesia in developing countries.

- Nearly 100 regular donors generated a total of £50,000 last year.

Uganda Fellowship Scheme

- Now in its seventh year, 23 doctors are currently being supported in training.
- Joint funding support is provided by RCoA, OAA, DAS and WAS.

Important Safety Initiatives

Neuraxial connectors

In February 2013, AAGBI, RCoA, OAA, RA-UK, APA, and RCoA Faculty of Pain Medicine and Patient Liaison Group released an updated statement to advise hospitals and support clinicians in the NHS in the process of introducing non-Luer connectors for neuraxial and regional anaesthesia. The AAGBI is represented on the External Reference Group established to support the safe implementation of new devices. We would like to hear of your experiences with the new non-Luer needles. Please e-mail us at neuraxial@aagbi.org.

AAGBI and the Safe Anaesthesia Liaison Group (SALG)

The AAGBI works with SALG to promote learning from incident reporting. It has two networks (with a total of 800 individuals) that disseminate information and provide valuable feedback. It publishes quarterly Patient Safety Updates to highlight reported safety incidents, the latest one relates to fire safety on intensive care and in theatre.

National Audit Project 5 (NAP5)

NAP5 was launched by the AAGBI and RCoA in June 2012 to investigate accidental awareness during general anaesthesia in the UK and Ireland. All four Chief Medical Officers endorsed the work. Cases continue to be sent in and the results will be published in Anaesthesia and the BJA. Several follow-up projects are planned.

Assistance for the Anaesthetist statement

The AAGBI released a supporting statement on assistance for the anaesthetists in September 2012 to supplement the existing Anaesthesia Team 3 guideline.

National Essential Anaesthetic Drug List (NEADL)

The WHO defines national essential medicines as ‘those that satisfy the priority healthcare needs of the population’. The AAGBI canvassed the views of delegates attending the WSM 2013 meeting on essential anaesthetic drugs and produced the first version of NEADL. At this year’s Annual Congress we will conduct another consultation with members.

Checking Anaesthetic Equipment (checklist)

The machine checklist published in June 2012 to complement the Checking Anaesthetic Equipment safety guideline will be tailored to suit the machines of a variety of manufacturers.

The AAGBI is proud to be a founder member of the international charity, Lifebox. Lifebox is a not-for-profit organisation saving lives by improving the safety and quality of surgical care in low-resource countries by ensuring that every operating room in the world has a pulse oximeter.

www.lifebox.org

Lifebox UK-registered charity (No. 1143018)
The AAGBI is committed to providing opportunities for anaesthesia professionals to keep up to date with their professional development and continues to develop new resources for its members.

Conferences and seminars

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Development of e education and online learning for CPD is a key priority. Our online video platform now offers over 200 lectures and CPD content from our conference and seminars. It attracts, on average, over 900 views a month The AAGBI is working to incorporate the video platform into a CPD zone which will allow users to record CPD for appraisal and revalidation purposes.

Feedback from a tour group visitor: “It was all very positive, one of the best visits and we have visited many places! The subject was interesting and relevant, the timings were just right and above all, your speakers were superb. They were knowledgeable, engaging and with just the right amount of humour. They were happy to answer all questions and you all made us feel very welcome.”

The Arts Council accredited AAGBI Heritage Centre hosted nearly 750 visitors in London and at events around the country.

The exhibition A Blessing in Disguise proved to be extremely popular and was extended for an additional six months. Our dedicated team of hardworking and enthusiastic heritage volunteers were joined by two new volunteers and we have developed a new internship programme this year.

“The AAGBI is committed to providing opportunities for anaesthesia professionals to keep up to date with their professional development and continues to develop new resources for its members.”

Conferences and seminars

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Development of e education and online learning for CPD is a key priority. Our online video platform now offers over 200 lectures and CPD content from our conference and seminars. It attracts, on average, over 900 views a month The AAGBI is working to incorporate the video platform into a CPD zone which will allow users to record CPD for appraisal and revalidation purposes.

Feedback from a tour group visitor: “It was all very positive, one of the best visits and we have visited many places! The subject was interesting and relevant, the timings were just right and above all, your speakers were superb. They were knowledgeable, engaging and with just the right amount of humour. They were happy to answer all questions and you all made us feel very welcome.”

The Arts Council accredited AAGBI Heritage Centre hosted nearly 750 visitors in London and at events around the country.

The exhibition A Blessing in Disguise proved to be extremely popular and was extended for an additional six months. Our dedicated team of hardworking and enthusiastic heritage volunteers were joined by two new volunteers and we have developed a new internship programme this year.

“The AAGBI is committed to providing opportunities for anaesthesia professionals to keep up to date with their professional development and continues to develop new resources for its members.”

Conferences and seminars

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Development of e education and online learning for CPD is a key priority. Our online video platform now offers over 200 lectures and CPD content from our conference and seminars. It attracts, on average, over 900 views a month The AAGBI is working to incorporate the video platform into a CPD zone which will allow users to record CPD for appraisal and revalidation purposes.

Feedback from a tour group visitor: “It was all very positive, one of the best visits and we have visited many places! The subject was interesting and relevant, the timings were just right and above all, your speakers were superb. They were knowledgeable, engaging and with just the right amount of humour. They were happy to answer all questions and you all made us feel very welcome.”

The Arts Council accredited AAGBI Heritage Centre hosted nearly 750 visitors in London and at events around the country.

The exhibition A Blessing in Disguise proved to be extremely popular and was extended for an additional six months. Our dedicated team of hardworking and enthusiastic heritage volunteers were joined by two new volunteers and we have developed a new internship programme this year.

“The AAGBI is committed to providing opportunities for anaesthesia professionals to keep up to date with their professional development and continues to develop new resources for its members.”

Conferences and seminars

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Greater numbers of educational events were provided for the profession in the form of three national conferences: GAT, AC and WSM London years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Attracting 1,800 delegates, significantly more than previous years. WSM London in January 2013 was the largest ever attracting 1,800 delegates, significantly more than previous years. 2012 and WSM London 2013.

Development of e education and online learning for CPD is a key priority. Our online video platform now offers over 200 lectures and CPD content from our conference and seminars. It attracts, on average, over 900 views a month The AAGBI is working to incorporate the video platform into a CPD zone which will allow users to record CPD for appraisal and revalidation purposes.

Feedback from a tour group visitor: “It was all very positive, one of the best visits and we have visited many places! The subject was interesting and relevant, the timings were just right and above all, your speakers were superb. They were knowledgeable, engaging and with just the right amount of humour. They were happy to answer all questions and you all made us feel very welcome.”

The Arts Council accredited AAGBI Heritage Centre hosted nearly 750 visitors in London and at events around the country.

The exhibition A Blessing in Disguise proved to be extremely popular and was extended for an additional six months. Our dedicated team of hardworking and enthusiastic heritage volunteers were joined by two new volunteers and we have developed a new internship programme this year.
As a professional association, the AAGBI is constantly active in representing the interests of anaesthetists and acting as a voice for the profession.

Over the year, the Association has supported members with the Revalidation process and has published a position statement on CPD, actively liaising with the General Medical Council (GMC).

The AAGBI has also responded to the Office of Fair Trading and Competition Commission investigations of private healthcare and contributed to the Department of Health consultations on training, manpower planning and Cork to the future consultant role.

Commission investigations of private healthcare and contributed to the Department of Health consultations on training, manpower planning and the future consultant role.

We would like to say a huge thank you to all our members for their continued support!
Postcode lottery in anaesthetic training

The first two years of anaesthetic training lay the foundations on which future practice is based. The “Basis of Anaesthetic Practice”, provides a comprehensive introduction to the principles and practices involved in anaesthetic care, with the achievement of the Initial Assessment of Competency (IAC) the endpoint. The next 21 months (“Basic Anaesthetic Training”) provides exposure to different subspecialties, with expected competencies documented in the curriculum.1 Whilst there is no prescriptive order in which training should be delivered, the Intensive Care Medicine unit of training (ICM) should be delivered in a dedicated three-month block.1

Following trainee feedback and evidence obtained at the ARCP, we undertook a survey to identify if trainees felt the timing of the ICM module was suitable. We enquired about the timing of their ICM module. We focussed on ICM training, the IAC, out-of-hours (OOH) anaesthesia and obstetrics.

Following permission from the Associate Dean for Quality Management, all CT1 and 2’s were invited to participate in the survey via email. 58 trainees were invited, 33 replied.

Intensive Care Medicine

As part of “Basic Anaesthetic Training”, ICM should occur after gaining of the IAC. The curriculum defines learning outcomes to be achieved during this module, including those associated with airway management.1

The importance of adequate airway training in relation to ICM was highlighted in NAP44, with a lack of training contributing to factors in 58% of reported events.2

Trainees had cited issues with ICM timing, and the impact they felt this had on training. We enquired about the timing of their ICM module.

3. Trainees that started their ICM module immediately after their IAC (month 4, all smaller DGH) felt they had inadequate time to consolidate their anaesthetic and airway skills.

Inadequate training was noted by NAP4 to be a contributory factor in many incidents1. Without their IAC, trainees are not expected to perform airway management on ICU patients unsupervised. ICM is more suited for trainees to consolidate their airway skills. The authors have a core group who would be sufficient to consolidate following a period of supervised training.

The next ICM module will be in ST3, and trainees will perform airway management on critically ill patients under constant supervision. If they are inexperienced, is this adequate both for training and more importantly, patient safety?

The authors feel the curriculum should be more prescriptive as to the timing of the ICM module, and that it should follow six months of anaesthetic training. Whilst evidence for this recommendation is lacking, it is prudent to allow a period of consolidation of newly acquired skills. However, rotula obligations in smaller DGH’s trainees rotate to ICM before this time (10 of 20 prior to month 6).

Initial Assessment of Competency

The IAC is a requirement prior to trainees anaesthetising without direct supervision. It is prescriptive for all trainees and the timeline is stipulated.1

In Wessex, training during the IAC varies. We questioned how their IAC could have been achieved. In Wessex, for example, CT1s providing OOH cover for emergency theatre lists.

From these results trainees find a core group of mentors; consultants; essential. Benefits include monitoring of progress, provision of consistent feedback and identification of the trainee in trouble. Those trainees not attaining skills, as highlighted in a recent audit3, such as endotracheal intubation and facemask anaesthesia, will be identified early. It is well established that inadequate supervision can contribute to stress and has a negative impact on learning in doctors.3

Trainees also benefit4. Consistent observations by regular supervisors enable fair and reliable assessments over a period of time.

Out of Hours Anaesthesia

OOH anaesthesia offers many training opportunities, with trainees often providing anaesthesia with distant supervision. Anaesthetists often undertakes OOH anaesthesia in their training. They may not therefore have undertaken OOH anaesthesia within the curriculum.

The opportunity to perform OOH anaesthesia varied with training location. 31 of 32 respondents had performed OOH anaesthesia in their training. Of these, 15 had performed three or more OOH shifts. The next 22 were neutral or not very confident that their current post will help them build the competencies they need at that particular stage of training.5

We have highlighted potential solutions to the issues we have identified:

Summary

A postcode lottery does exist in basic anaesthetic training, and we have shown areas of training in our Deanery that may need improvement.

We have highlighted potential solutions to the issues we have identified:

• undertaking ICM after month 6 of training;
• CT1s providing OOH cover for emergency theatres with local supervision;
• a dedicated group of consultants for continuity of supervision during the IAC;
• a dedicated obstetric training block for CT2 trainees.

We recognise this is the ideal training programme and realistically would be difficult to achieve in most hospitals. Undesirable consequences include:

• rota gaps, and difficulty providing daytime list cover, especially if resident OOH consultant cover is introduced;
• a further shift in balance between in hours versus out of hours caseload by higher trainees (previously noted following the implementation of the European Working Time Regulation).

Concerns with regards to the adequacy of training are not unique to our region, and have been highlighted in the 2012 and 2013 GMC National Training Survey. 8% of CT1s and 15% of CT2s were neutral or not very confident that their current post will help them build the competencies they need at that particular stage of training.6

Dr Patrick Tapley
Anaesthetic Registrar, North Shore Hospital, New Zealand

Dr Kathy Torlot
Anaesthetic Consultant, Portsmouth Hospitals NHS Trust

References


Figure 1 shows the ICM start date month relative to the size of hospital, and highlights some issues:

1. Of the 6 trainees undertaking ICM in month one felt this was detrimental to their training. Potentially they may not accrue adequate experience in the complexities of airway management in the critical care, with the frequent combination of airway abnormalities, hypoxaemia and cardiovascular instability.

2. ICM forms part of “Basic Anaesthetic Training” in the curriculum, therefore is undertaking ICM in month one against the curriculum guidance.

3. Trainees that started their ICM module immediately after their IAC (month 4, all smaller DGH) felt they had inadequate time to consolidate their anaesthetic and airway skills.

4. Inadequate training was noted by NAP4 to be a contributory factor in many incidents.1 Without their IAC, trainees are not expected to perform airway management on ICU patients unsupervised. ICM is more suited for trainees to consolidate their airway skills. The authors have a core group who would be sufficient to consolidate following a period of supervised training.

5. The next ICM module will be in ST3, and trainees will perform airway management on critically ill patients under constant supervision. If they are inexperienced, is this adequate both for training and more importantly, patient safety?

6. The authors feel the curriculum should be more prescriptive as to the timing of the ICM module, and that it should follow six months of anaesthetic training. Whilst evidence for this recommendation is lacking, it is prudent to allow a period of consolidation of newly acquired skills. However, rotula obligations in smaller DGH’s trainees rotate to ICM before this time (10 of 20 prior to month 6).

The main aims of basic obstetric training are to become competent in essential obstetric anaesthetic skills, and obtain the IAC in obstetric anaesthesia (ACOA). The curriculum does not stipulate how obstetric training is delivered, but suggests an obstetric block is beneficial.1

We supported trainees with, or undertaking, the ACOA (n=26) regarding how their obstetric training was delivered.

All trainees at larger hospitals had a dedicated obstetric block and practised OOH obstetric anaesthesia. Only one of smaller hospitals provided a dedicated obstetric block, and of 9 respondents in smaller DGH’s, 6 had other commitments that prevented them from gaining experience in OOH obstetric anaesthesia.

To see if trainees were accruing enough obstetric experience, a predetermined caseload (100 cases, 50 epidurals, extrapolated from the college audit standard for airway experience during the IAC) was stipulated. Trainees were asked whether they felt they would achieve this by the end of CT2.

Dr Patrick Tapley
Anaesthetic Registrar, North Shore Hospital, New Zealand

Dr Kathy Torlot
Anaesthetic Consultant, Portsmouth Hospitals NHS Trust

References


Achievement of Obstetric caseload

One solution to the problem encountered by trainees at smaller DGH’s is to provide obstetric training as a dedicated block in the larger hospitals. However this would lead to inevitable manpower issues at the smaller DGH’s for both daytime theatre lists and out of hours shifts.

Figure two breaks this down dependent on whether a dedicated obstetric block was provided. From our limited numbers, the provision of a dedicated obstetric training block (including OOH) would be beneficial for accrual of experience.
The history of the specialty of Anaesthesia in the UK

Since the RCoA’s launch of a new video made to celebrate the 65th anniversary of the NHS in July this year, the AAoB has received a number of queries about the history of the specialty of Anaesthesia. In the video, Dr Peter Venn says that: “the specialty of Anaesthesia is widely regarded as being the same age” as the NHS itself, implying that the creation of the Faculty of Anaesthetists of the Royal College of Surgeons, later to become the College of Anaesthetists (in 1948) and later still the Royal College of Anaesthetists, marked the start of the specialty of Anaesthesia in the UK. As can be imagined, the RCoA was of the opinion that it was not justified in awarding the RCoA the credit which was due to the AAoB, and indeed to the creation of the Faculty. The first Dean of the Faculty was Dr Archibald Morant (Dean 1948 – 1952) who had shortly before this demitted office as President of the AAoB (1944 – 1947). We reproduce this article in full with the permission of Anesthesia & Analgesia. We hope you will enjoy it.

“History Boy”


Royal College of Surgeons England - Featherstone

The Faculty of Anaesthetists of the Royal College of Surgeons England

(A Note on its Origin and Purpose)


University Lecturer in Anaesthetics, Birmingham University, Senior Anaesthetist, United Birmingham Hospitals

HERE ARE TWO ASPECTS of anaesthesia which I should like to discuss: first, the organization and status of the specialty of Anaesthesia; and, second, in a later part of this article, a consideration of the relationship between the specialty and the hospitals in which surgery is performed. As an introduction to these two problems, let me briefly refer to the training of anesthetists on this side of the Atlantic since it has led to the formation of the Faculty of Anaesthesia and, secondly, in a later part of the article, to the formation of the Faculty of Anaesthetists of the Royal College of Surgeons England. The reasons for these two problems have been discussed elsewhere; although these problems are of course affected on this side of the Atlantic by the training of anesthesiologists in the United States, very closely, and indeed have received most important attention from the International Anesthesia Research Society and other similar bodies of anaesthesiologists in this continent, nevertheless I hope you will find it instructive to receive a report on the history of anaesthesia in the United Kingdom.

There are also several more or less local societies or associations of anaesthetists in different parts of the British Isles. The three principal bodies, however, which deal with the specialty of anaesthesia in the United Kingdom are those which I mentioned first: the Section of Anaesthetics, the Association of Anaesthetists, and the Faculty of Anaesthetists. These three bodies are in close cooperation, and members of each are on the Councils of any of the other two. It should be clearly understood that each organization deals with a different aspect of anaesthesia, and a description of the origin and development of each will show how the three bodies are able to strengthen each other in afield which itself is an extremely important one. The organization of surgery in hospitals must be administered by interns. Formerly, the interns who carried out the work of hospital anaesthesia were not required to have any special training in the special study and practice of anesthesiology, but they were required to have obtained an examination to show that they were fit to administer anaesthesia. The examination, which was greatly in demand, was a very successful one, and there were many applicants for it. But there was a need for a voluntary body of surgeons who were interested primarily in the practice of anaesthesia in order to represent this body in the British Medical Association.

The Section of Anaesthesia of the Royal Society of Medicine is concerned entirely with the point of view of science and research in anaesthetics. The Section provides the forum where British anaesthetists describe their work and their views. Moreover, during the War, many anaesthetists from Canada, the United States and other allied countries took a very active part in discussions of the Section at the House of the Royal Society of Medicine in Wimpole Street. Dr. Ronald Jarman is now President of the Section.

Eights years ago, in 1930, when I was President of the Section, the Section was the only “central” organization of anaesthetists which they could join, but we found that the strict limitation of its powers, solely to the functions of a central association, was not sufficient. In an era when surgery was performed in the main voluntary hospitals, either attached to medical schools or situated in the larger cities and towns. The Poor Law Infirmary at the time of the first faculty examination was entirely for the chronic sick, but in 1928, by Act of Parliament, the Infirmaries came under the Minister of Health and they were then gradually improved both in medical and surgical points of view. The War many years ago was offering a standard of surgical work at a high order. This process has been expedited during the past ten years with the result that many more posts for anaesthetists have been created. Accordinly the demand for further education has shown an increase. Many anaesthetists have become interested in research in anaesthetics; the Association is the independent deliberative body which represents anaesthetists, and the new Faculty will provide for the training anaesthetists.  

Drugs and technique provided better and safer anaesthesia, but they demanded the riper experience and sound training of specialists. In order to enable the Section to carry out this new function it was evident that considerable numbers of practitioners would be required. But although the demand was obvious, the conditions for the workers had become so standardized, that Anaesthetic practitioners were to be considered financially, and the status of those who had undertaken the special study and practice of anaesthesiology had been so much improved that they were satisfied to remain in private practice of the surgeons with whom they worked, than upon their skill and industry. The large voluntary hospitals, where at that time most of the operative surgery was performed, were perfectly satisfied with the anaesthetists who were indeed for the most part, at that time, they preferred to attend on an honorary basis, but the post of remunerative work in private practice was too unattractive to meet the needs of all the workers whom the anaesthesia service required.

It was clear that the status of specialists in anaesthesia urgently needed a hallmark or test to indicate that they had attained a proper standard of training and skill. And so, they would require an autonomous body of their own through which their views could be collected and represented in negotiations with outside bodies, such as departments of the Government, universities, examining bodies and hospital authorities.

Dr. Ronald Jarman is now President of the Royal College of Surgeons England, and he will be President of the Association, has achieved remarkable success. The Diploma in Anaesthetics soon came into being through the ready response of the many anaesthetists who realized the significance of the diploma and its value in establishing the specialty. During the War, not only did the enhanced position of anaesthetists receive consideration, but also the diploma was developed through the appointment of specialists and graded specialists on conditions similar to those of other departments of medicine; but the diploma was of particular value in assessing the capabilities of candidates for these posts.

From another angle the diploma was very useful. Of necessity large numbers of routine anaesthesia and most of the emergency anaesthesia in hospitals must be administered by interns. Formerly, the interns who administered the anaesthesia were not required to have any special training in the special study and practice of anesthesiology, but they were required to have obtained an examination to show that they were fit to administer anaesthesia. The examination, which was greatly in demand, was a very successful one, and there were many applicants for it. But there was a need for a voluntary body of surgeons who were interested primarily in the practice of anaesthesia in order to represent this body in the British Medical Association.

In the course of the development of the specialty of Anaesthesia in the United Kingdom, I would like to draw attention to the fact that the Section of Anaesthetics is concerned entirely with the point of view of science and research in Anaesthesia. The Section provides the forum where British Anaesthetists describe their work and their views. Moreover, during the War, many anaesthetists from Canada, the United States and other allied countries took a very active part in discussions of the Section at the House of the Royal Society of Medicine in Wimpole Street. Dr. Ronald Jarman is now President of the Section.

Eights years ago, in 1930, when I was President of the Section, the Section was the only “central” organization of anaesthetists which they could join, but we found that the strict limitation of its powers, solely to the functions of a central association, was not sufficient. In an era when surgery was performed in the main voluntary hospitals, either attached to medical schools or situated in the larger cities and towns. The Poor Law Infirmary at the time of the first faculty examination was entirely for the chronic sick, but in 1928, by Act of Parliament, the Infirmaries came under the Minister of Health and they were then gradually improved both in medical and surgical points of view. The War many years ago was offering a standard of surgical work at a high order. This process has been expedited during the past ten years with the result that many more posts for anaesthetists have been created. Accordinly the demand for further education has shown an increase. Many anaesthetists have become interested in research in anaesthetics; the Association is the independent deliberative body which represents anaesthetists, and the new Faculty will provide for the training anaesthetists.  

Drugs and technique provided better and safer anaesthesia, but they demanded the riper experience and sound training of specialists. In order to enable the Section to carry out this new function it was evident that considerable numbers of practitioners would be required. But although the demand was obvious, the conditions for the workers had become so standardized, that Anaesthetic practitioners were to be considered financially, and the status of those who had undertaken the special study and practice of anaesthesiology had been so much improved that they were satisfied to remain in private practice of the surgeons with whom they worked, than upon their skill and industry. The large voluntary hospitals, where at that time most of the operative surgery was performed, were perfectly satisfied with the anaesthetists who were indeed for the most part, at that time, they preferred to attend on an honorary basis, but the post of remunerative work in private practice was too unattractive to meet the needs of all the workers whom the anaesthesia service required.

It was clear that the status of specialists in anaesthesia urgently needed a hallmark or test to indicate that they had attained a proper standard of training and skill. And so, they would require an autonomous body of their own through which their views could be collected and represented in negotiations with outside bodies, such as departments of the Government, universities, examining bodies and hospital authorities.

Dr. Ronald Jarman is now President of the Royal College of Surgeons England, and he will be President of the Association, has achieved remarkable success. The Diploma in Anaesthetics soon came into being through the ready response of the many anaesthetists who realized the significance of the diploma and its value in establishing the specialty. During the War, not only did the enhanced position of anaesthetists receive consideration, but also the diploma was developed through the appointment of specialists and graded specialists on conditions similar to those of other departments of medicine; but the diploma was of particular value in assessing the capabilities of candidates for these posts.

From another angle the diploma was very useful. Of necessity large numbers of routine anaesthesia and most of the emergency anaesthesia in hospitals must be administered by interns. Formerly, the interns who administered the anaesthesia were not required to have any special training in the special study and practice of anesthesiology, but they were required to have obtained an examination to show that they were fit to administer anaesthesia. The examination, which was greatly in demand, was a very successful one, and there were many applicants for it. But there was a need for a voluntary body of surgeons who were interested primarily in the practice of anaesthesia in order to represent this body in the British Medical Association.

In the course of the development of the specialty of anaesthesia in the United Kingdom, we have evolved a body in the form of the Section of Anaesthetics. Although these two problems have of course afflicted anaesthetists on this side of the Atlantic very closely, and indeed have received most important attention from the International Anesthesia Research Society and other similar bodies of anaesthesiologists in this continent, nevertheless I hope you will find it instructive to receive an exposition from the point of view of British anaesthetists.

In the sixteen years after the beginning of War I, surgery and anesthesia had undergone important advances. The operations of routine surgery had increased, but many patients were still being carried out, and surgical team work had become everyday practice. A skilled anaesthetist was regarded as an essential member of the team.
I have chosen Dan Sessler’s talk for special mention, because it seems to me that he has done more work that has directly changed my clinical practice than any other single figure during my clinical career, and that the breadth and simplicity of his insights are totally inspiring.

Diagnostic tool: the BIS MAC product

The 3rd trimester of pregnancy is a time of significant change for the mother. The discovery of a significant intrauterine growth restriction raises diagnostic and management dilemmas. During this period, the anaesthetist may need to consider the possibility of a missed abortion. This raises the question of what to do in this situation and whether to use imaging. This is a challenging time for the anaesthetist. The patient may be anxious and concerned about the possibility of losing the baby. It is important to communicate with the patient and to explain the situation clearly. The decision to use imaging should be made in consultation with the obstetrician. If imaging is performed, the results should be discussed with the patient and explained in a clear and straightforward manner. The patient should be reassured that the imaging is being done to assess the pregnancy and to determine the best course of action. 

The use of imaging in this situation is controversial. Some experts believe that imaging is unnecessary and that the diagnosis can be made without it. Others believe that imaging is necessary to make an accurate diagnosis. The decision to use imaging should be based on the individual case and the preferences of the patient and the obstetrician. 

It is important to reassure the patient that the decision to use imaging is being made in their best interests. The patient should be informed about the risks and benefits of imaging and the potential outcomes. The patient should be supported throughout the process and given the opportunity to ask questions. The patient should be encouraged to express their feelings and concerns. The patient should be informed about the availability of support and resources.

I have chosen the John snow lecture, given by Dr Rhona Mahony. For me, this provided a fascinating insight into events and beliefs that surround the very different attitudes the UK and Ireland has had to women’s health and childbirth. Dr Rhona Mahony is an obstetrician, Master at the National Maternity Hospital, Dublin, the first woman appointed to this role since its foundation in 1894. With 9,000 deliveries per year, one-in-eight of all Irish children are delivered in the hospital.

She chose as her title ‘The Road to Perdition’ and gave a well-researched and moving account of the role of women in Ireland over the last 100 years and of attitudes to childbirth and the rights of the mother and fetus. The description of Dublin’s abject poverty, overcrowding, maternal mortality from pre-eclampsia, haemorrhage and infection, coupled with high perinatal mortality, would have been true of many Edwardian cities. The effect the 1914-18 war had on women, liberating them to work outside the home as nurses and in other roles, was not unique to Ireland. But the next 50 years were remarkably different on the two sides of the Irish Sea. There were no roaring twenties. Women were compulsorily retired as soon as they married, they couldn’t take the civil service exams or serve on juries. Many of those who found themselves pregnant out of wedlock were incarcerated in the now infamous Magdalene laundries. For some, the only option seemed to be infanticide; until 1952 there were no arrangements for formal abortion.

Underpinning what now seems an archaic attitude was Ireland’s desire to be a pure society. In pursuit of this aim, seemingly useful innovations such as a free antenatal care package and free healthcare for children were opposed. lest Catholic women went to Protestant doctors who might discuss contraception and sex education. Termination of pregnancy was illegal and in 1935 use or distribution of contraception was made a criminal offence. It has only been since the 1990s that people spoke openly about sexual abuse in Catholic institutions, repression and its impact on peoples’ lives.

History shapes our culture. Dr Mahony gave a straightforward and dispassionate explanation of events and the beliefs that underpinned them. For me this was both captivating and disturbing. Hearing this account has made me look at people like Mary Robinson and our own Ellen O’Sullivan, President of the College of Anaesthetists of Ireland in a new light. See what you think.

Nancy Redfern
Learn@AAGBI was launched at Annual Congress in Dublin in September this year, and already many of you have used this site to record your many and varied CPD activities.

Learn@AAGBI is the equivalent of your ‘bottom drawer’, a place to store your reflective notes on a variety of activities, and a vehicle to access our video platform. This platform has over 250 videos, and once you have watched a video, the system will produce a CPD certificate for you, which automatically populates your CPD area.

As WSM is round the corner and we are expecting >1000 attendees, I thought I would give those of you who haven’t used Learn@AAGBI before a few top tips:

Step 1: Go to www.aagbi.org
Step 2: Click on Education and Meetings
Step 3: Click on Learn@AAGBI, in all its pink glory!

Here you will find written instructions on what to do, a video of me reminding you what to do (!), 6 topical talks and most importantly the log in area at the top right hand corner. That’s the easy part!

Step 4: Click on ‘log in’

You will now have to remember where you put your AAGBI membership card, or look on the front of your unopened Anaesthesia journal for your membership number on the address label. If you have forgotten your password, just click the appropriate buttons and your password will be sent to you within seconds. This ONLY works if you have registered your correct email address with us. If in doubt email membership@aagbi.org or call 0207 631 8801/8866. When using the system for the first time, you will be asked to enter your name and surname. Once logged in, this is the first thing that you see:

1. THE AAGBI VIDEO PLATFORM

This is an ever growing resource of videos from our conferences, seminars and interviews. You search videos by:
- List of Categories (e.g. Airway Management, Burns)
- AAGBI Conference (e.g. AC 2013) or Seminar
- One of the 4 GMC Domains ((Knowledge, skills and performance) Safety and quality/Communication, partnership and teamwork/ Maintaining trust
- Primary/Final/Pre Consultant interviews content

When you choose a video, you will see which GMC domain and CPD code is covered. I have chosen to watch the video ‘Detecting research fraud’ by John Carlisle.

You will be provided with information about the author and a short summary of the video and the length of the video. When you have seen the video, click on the words at the bottom of the page which state ‘Finish video to access the reflective learning form’ and start filling in your reflective form. The feedback form will automatically contain the title of the video and the meeting at which it was presented. You can reflect and save the form as a draft which you can modify later or submit the form which cannot be modified further.

Once you have submitted this form, you will be provided with a CPD certificate.

2. MY CPD AREA

If you click onto the ‘my CPD area’, you can see how your CPD is progressing.

You will be provided with information about the author and a short summary of the video and the length of the video. When you have seen the video, click on the words at the bottom of the page which state ‘Finish video to access the reflective learning form’ and start filling in your reflective form. The feedback form will automatically contain the title of the video and the meeting at which it was presented. You can reflect and save the form as a draft which you can modify later or submit the form which cannot be modified further.

- You can view all your CPD content from any time length on the screen or hide it to show current activity
- You can download all selected reflection and CPD certificates
- You can click on ‘Register a reflective activity’ at the top of the page. This is really useful as it allows you to reflect on any meeting, journal club, departmental meeting, M and M, critical incident, quality improvement activity etc. and store it in your CPD area. You can register this activity anytime, but it is particularly good if, like me, you like to reflect whilst or as soon after an event as possible,
Dr Samantha Shinde
Honorary Secretary Elect

in order not to add it to the growing list of things I need to do! The key is to put as much information about the activity you are recording in the title area, as this is what flags up on your CPD page e.g. Lecture on Rotem, by Dr Tim Hooper. Frenchay 18.07.13.

My LearntoAAGBI logo is now bookmarked on my iPad and iPhone ready for me to reflect at a moments notice.

All of my educational activities and learning relevant to all 4 of the GMC domains can be recorded, reflected on, and will then automatically populate my CPD area.

All that leaves me to do is to just download it all into my Trust appraisal e-portfolio whenever I want to. Easy peasy... and this is just Phase 1, wait till you see what we have planned for Phase 2 in 2014!

When you next have an opportunity, try
LearntoAAGBI (www.aagbi.org/education), it will make appraisal, revalidation, reflecting and learning more interesting, fun and make you think you are an incredibly organised person... at least that’s my New Years’ resolution, hopefully it should last until 15th January for the beginning of WSM 2014!

The International Relations Committee (IRC) offers travel grants to individuals who are seeking funding to work, or to deliver educational training courses or conferences, in low resource countries.

Please note that the grant application forms were revised in April 2013 and only these updated forms will be accepted. Grants will not normally be considered for attendance at congresses or meetings of learned societies. Exceptionally, they may be granted for extension of travel in association with such a post or meeting. Applicants should indicate their level of experience and expected benefits to be gained from their visits, over and above the educational value to the applicants themselves.

For further information and an application form please visit our website: http://www.aagbi.org/international/IRC-FUNDING or email secretariat@aagbi.org or telephone 020 7631 8807.

Closing date: 13 December 2013

The Development of a Block Room

Block rooms are increasingly being used and developed in the UK having been successfully used in North America and Scandinavia. In this article we review our experience of setting up and working in a block room at the Sunderland Royal Hospital.

The patient centered benefits of regional anaesthesia are well known. Indeed regional anaesthesia is advocated by the department of health document Delivering Enhanced Recovery1, by the PROSPECT group for total knee replacements2 and by the UK Hand Surgery Report3.

"3.15 Anaesthetic support should include facilities for regional anaesthesia by brachial plexus block, which is the optimum mode of anaesthesia for many hand trauma cases. It provides excellent postoperative analgesia and avoids the risk of disruption of repairs during a restless recovery from general anaesthesia."

A commonly quoted disadvantage of regional anaesthesia is its perceived effect on patient throughput. Regional anaesthetic techniques require a significant time for administration and onset of effective anaesthesia, with a high degree of skill and expertise required to use modern ultrasound guided techniques. The use of a block room takes away some of the time pressure for the anaesthetist, and provides as relaxed environment where the patient can await surgery.

A major advantage of using a block room to administer regional anaesthesia, is that the block can be performed, and established whilst a case is currently on going. so called ‘parallel processing’ Regional anaesthesia is commenced, in a dedicated block area, within the theatre suite, while the previous case is still taking place. The patient is monitored, in a dedicated ‘cooking area’, until the operating theatre is vacated. Then they are moved into the prepared theatre with very minimal downtime and surgery commenced seamlessly. Time can be built in for any change of anaesthesia plan e.g. rescue blocks, and importantly teaching time can be accommodated whilst operating continues. Procedures such as tumour ablation, patient positioning and the timely administration of antibiotics may also be performed.

Parallel processing removes the large variability of time needed for anaesthesia. This changes the rate-limiting step of patient throughput to that of theatre preparation. This is shorter and less variable than that of anaesthesia, the result being a gain of operative time within a theatre session available for additional cases.

One of the criticisms of parallel processing is the cost of employing extra staff to run a block room system. A major advantage of this system of working, however, is its ability to increase efficiency and generate additional income. This potential for additional income generation outweighs the modest increase in staffing costs. This is especially the case if, as in Sunderland, the anaesthetic cover can be removed from upper-limb orthopaedic lists, with patients on these lists receiving regional anaesthesia in the newly created block room.

As can be seen in figure 2, in theory it may be possible to perform additional cases without overruning a theatre list. But does this work in practice? We ran a pilot over a 5-day period in early 2010, serving two primary lists and an effort was made to service other lists as required. This
Further to this, it allows for a greater utilization of the skill mix available along the theatre corridor. Previously it may have been difficult to allocate a part of the guideline is pre-operative airway equipment check (which is available to all patients and provides an easy point of contact for theatre corridor. Previously it may have been difficult to allocates a part of the guideline is pre-operative airway equipment check (which is available to all patients and provides an easy point of contact for)

For a rapid sequence induction for an emergency category one neurosurgical craniotomy. We would like to report an incident involving a reinforced endotracheal tube that was used for a rapid sequence induction for an emergency category one neurosurgical craniotomy.

The incident occurred in our hospital, whilst transporting a ventilated intensive care patient to the CT scanner. The oxygen cylinder was knocked, causing damage to the cylinder neck and valve. The oxygen cylinder began to leak very noticeably and loudly and the Oxylog portable ventilator stopped ventilating the patient. The patient was therefore intubated via a sidestream bag on room air, the oxygen cylinder turned off and the patient returned quickly to the intensive care unit. The patient did not come to any harm.

What about the anaesthetists looking after the patients who receive regional anaesthesia from the block room staff? There certainly is the potential for deskilling the non-block room anaesthetists. However, the presence of a block room has increased the profile of regional anaesthesia within the department and increased the total number of regional blocks performed. This has allowed us the opportunity to cover block room sessions and also continue to perform our own blocks, especially at busy times and when use of the block room will not lead directly to increased efficiency. There are obvious advantages in the system for the occasional orthopaedic anaesthetist. The Sunderland block room experience has been a positive one, for the anaesthetists, trainees and the trust. It has improved the service provided to patients and leaves them with high levels of satisfaction. It has improved the quality of regional anaesthesia training and we have been able to demonstrate a significant improvement in theatre productivity and efficiency. We hope to continue to develop the block room service and ensure the block room system of working may be a useful model for other NHS trusts.

The Sunderland block room experience has been a positive one, for the patients, consultants, trainees and the trust. It has improved the service provided to patients and leaves them with high levels of satisfaction. It has improved the quality of regional anaesthesia training and we have been able to demonstrate a significant improvement in theatre productivity and efficiency. We hope to continue to develop the block room service and ensure the block room system of working may be a useful model for other NHS trusts.

The Sunderland block room experience has been a positive one, for the patients, consultants, trainees and the trust. It has improved the service provided to patients and leaves them with high levels of satisfaction. It has improved the quality of regional anaesthesia training and we have been able to demonstrate a significant improvement in theatre productivity and efficiency. We hope to continue to develop the block room service and ensure the block room system of working may be a useful model for other NHS trusts.

The Sunderland block room experience has been a positive one, for the patients, consultants, trainees and the trust. It has improved the service provided to patients and leaves them with high levels of satisfaction. It has improved the quality of regional anaesthesia training and we have been able to demonstrate a significant improvement in theatre productivity and efficiency. We hope to continue to develop the block room service and ensure the block room system of working may be a useful model for other NHS trusts.

The Sunderland block room experience has been a positive one, for the patients, consultants, trainees and the trust. It has improved the service provided to patients and leaves them with high levels of satisfaction. It has improved the quality of regional anaesthesia training and we have been able to demonstrate a significant improvement in theatre productivity and efficiency. We hope to continue to develop the block room service and ensure the block room system of working may be a useful model for other NHS trusts.

The Sunderland block room experience has been a positive one, for the patients, consultants, trainees and the trust. It has improved the service provided to patients and leaves them with high levels of satisfaction. It has improved the quality of regional anaesthesia training and we have been able to demonstrate a significant improvement in theatre productivity and efficiency. We hope to continue to develop the block room service and ensure the block room system of working may be a useful model for other NHS trusts.
Anaesthesia December 2013

T. Heidegger, D. Saal and M. Nübling

Patient satisfaction with anaesthesia – Part 1: Satisfaction as part of outcome – and what satisfies patients

M. Nübling, D. Saal and T. Heidegger

Patient satisfaction with anaesthesia – Part 2: Construction and quality assessment of questionnaires

E. McGrady

Patient feedback and anaesthetists: what are patients assessing and why?

One of the elements now required for revalidation is patient feedback. At best, the additional workload required is often regarded as a nuisance, especially if the tools are not validated. At worst, the outcomes of any feedback can be misleading. One of the pertinent questions is: “what is the patient feeding back on, in the case of anaesthesia?” There are clear dangers that, in cases where the primary dissatisfaction is with surgical outcomes, the anaesthetist who has delivered a high-quality, pain- and nausea-free experience will nonetheless be tarred with the same brush as surgical or other colleagues. Equally, attempts at venous access, poor blood pressure control, giving a ‘terrible’ (to our own high standards) anaesthetic (with apparently traumatic airway management, multiple attempts at venous access, poor blood pressure control, abandoned epidural replaced with IV opiates, etc) can still leave the patient (unaware of any difficulties) entirely contented, with a pain free and excellent outcome and (with apparently traumatic airway management, multiple attempts at venous access, poor blood pressure control, abandoned epidural replaced with IV opiates, etc) can still leave the patient (unaware of any difficulties) entirely contented, with a pain free and excellent outcome and positive feedback.

In the November issue of the journal, two articles by Heidegger’s group analysed ‘patient satisfaction’ in relation to anaesthesia in some detail and the work provides resource material for anyone wishing to study and develop this important topic. Further, McGrady’s accompanying editorial offered some very helpful and pragmatic advice for those colleagues facing the perhaps daunting task of collecting patient feedback. She makes the helpful point that the emphasis really is on communication, and outlines how forms might be distributed and collected. There is one small aspect which, in my ignorance, I did not previously know; namely that the distribution of forms to patients should be ‘random’.

She makes the helpful point that the emphasis really is on communication, and outlines how forms might be distributed and collected. There is one small aspect which, in my ignorance, I did not previously know; namely that the distribution of forms to patients should be ‘random’. This is surprising because nobody really knows what ‘random’ means, or how to achieve it (e.g. even the proper ‘randomness’ of a randomised controlled trial is often hotly debated). Pragmatic alternatives might be ‘universal’ (especially where response rates are low), or ‘consecutive’ or ‘representative’. What will almost inevitably be near to random is whether or not the patient actually completes or ‘representative’. What will almost inevitably be near to random is whether or not the patient actually completes or ‘representative’. What will almost inevitably be near to random is whether or not the patient actually completes or ‘representative’.

One of the pertinent questions is: “what is the patient feeding back on, in the case of anaesthesia?” There are clear dangers that, in cases where the primary dissatisfaction is with surgical outcomes, the anaesthetist who has delivered a high-quality, pain- and nausea-free experience will nonetheless be tarred with the same negative brush as surgical or other colleagues. Equally, attempts at venous access, poor blood pressure control, giving a ‘terrible’ (to our own high standards) anaesthetic (with apparently traumatic airway management, multiple attempts at venous access, poor blood pressure control, abandoned epidural replaced with IV opiates, etc) can still leave the patient (unaware of any difficulties) entirely contented, with a pain free and excellent outcome and positive feedback.

In the November issue of the journal, two articles by Heidegger’s group analysed ‘patient satisfaction’ in relation to anaesthesia in some detail and the work provides resource material for anyone wishing to study and develop this important topic. Further, McGrady’s accompanying editorial offered some very helpful and pragmatic advice for those colleagues facing the perhaps daunting task of collecting patient feedback. She makes the helpful point that the emphasis really is on communication, and outlines how forms might be distributed and collected. There is one small aspect which, in my ignorance, I did not previously know; namely that the distribution of forms to patients should be ‘random’. This is surprising because nobody really knows what ‘random’ means, or how to achieve it (e.g., even the proper ‘randomness’ of a randomised controlled trial is often hotly debated). Pragmatic alternatives might be ‘universal’ (especially where response rates are low), or ‘consecutive’ or ‘representative’. What will almost inevitably be near to random is whether or not the patient actually completes the form.

©2013 FUJIFILM SonoSite, Inc. All rights reserved. 1839 10/13

For further information and to register logon to www.sonositeeducation.co.uk
Comparison of Hypothermia and Normothermia after Severe Traumatic Brain Injury in Children (CoolKids): A Phase 3 Randomised Control Trial

The Lancet 2013; 12: 545-53

Introduction
Severe traumatic brain injury (TBI) remains a leading cause of paediatric death and permanent disability around the world. Evidence from previous trials investigating the role of therapeutic hypothermia in TBI in children has been conflicting.1-3 Following a phase 2 trial showing reduced mortality using hypothermia in children after severe TBI, the authors aimed to assess whether therapeutic hypothermia (32-34°C) with slow rewarming over 48-72 hours improved mortality at 3 months.

Methods
This randomised controlled, multicentre, multinational trial was conducted in the USA, Australia and New Zealand. Children, aged 0-17, were enrolled within 6 hours of injury and were included if they had sustained a non-penetrating head injury, a GCS of 3-8 and a motor score of less than 6 following resuscitation. Randomisation was via a web-based assignment algorithm, and children who assessed outcome were masked to treatment allocation. Patients were randomised in a 1:1 ratio with a standardised, two-tiered head injury management protocol.

The primary outcome measure was mortality at three months post-injury. Secondary outcome measures were global function at 3 months postinjury (using the Glasgow outcome scale - extended paediatric) and occurrence of adverse events. Based on a previous randomised controlled study, the authors planned to enrol 340 children. This would allow detection of a 10% difference in mortality with 80% power.

Results
389 (39 in the hypothermia group, 38 in the normothermia group) were recruited into the study between November 2007 and Feb 2011. An interim data analysis on these patients led the authors to terminate the study on the grounds of futility. The mortality rates at 3 months were 63/39 (16%) in the hypothermia group vs. 23/38 (6%) in the normothermia group. Post-outcome did not differ between groups and there was no between group difference in the occurrence of adverse events.

Discussion
The authors conclude that hypothermia for 48hrs with slow rewarming does not reduce, mortality or improve global functional outcome after paediatric severe TBI. However, the study only recruited 77% of the projected 340 patients required to show a statistical difference. The study was terminated at 3 months as an interim futility analysis showed that there was less than 20% chance of confirming the primary hypothesis. This futility analysis was performed due to slow accrual of patients into the study and due to safety concerns from another randomised controlled trial, which showed that hypothermia in children with TBI might be associated with worse outcome. The authors highlight several of the difficulties of performing studies in this field and the need for further studies to determine the role of hypothermia in TBI in children.

Tajine Fregene
Research Fellow, London Deanery

References

Fuiler et al. for the IMPROVE study group
A Trial of Intraoperative Low-Tidal-Volume Ventilation in Abdominal Surgery
NEJM 2013; 369: 428-43

Introduction
Lung-protection ventilation utilizing low tidal volumes and positive end-expiratory pressure (PEEP) is considered best practice in critically ill patients. Its role in general anaesthesia for major surgery is unknown. This patient group includes 238 million patients worldwide. Large cohort studies have shown that 20-30% of this group is intermediate to high risk for postoperative pulmonary complications.

Methods
This was a multicentre, double blinded, parallel-group trial. Patients were randomised to either lung protective ventilation (LPV) or non-protective ventilation (NPV)4. Inclusion criteria were age >40 years old, elective major abdominal surgery, duration >2 hours, preoperative risk index for pulmonary complications of >2. Exclusions included emergencies, recently unrepaired obstructive and obese subjects.

Primary protection was defined as complete of major pulmonary and extrapulmonary complications at 7 days post surgery. Secondary outcomes were followed up to 30 days.

Results
On 186 months 400 patients were randomised. There were no differences in groups in type and duration of surgery, epidural use or fluid use. Primary outcome occurred in 19.5% in the LPV group versus 27.5% in the NPV group (RR: 0.69; 95% CI: 0.48-0.98; P=0.02). When 7 post-operative days 5.0% of the LPV group required non-invasive ventilation or intubation for respiratory failure compared to 17% assigned to NPV (RR: 0.39; 95% CI: 0.14-0.61; P<0.001). Length of hospital stay was shorter among patients receiving LPV compared to NPV (mean difference -2.45 days; 95% CI: -4.11 to -0.78; P<0.001).

Discussion
Accurate sizing of this study LPV resulted in a 69% reduction in the number of patients requiring ventilator support within 7 days of surgery. The observed rate of postoperative complications was lower than predicted. This may have been due to exclusion of patients with a low risk of complications. They suggest that this improvement is due to reduction in ventilator-associated lung injury. The tidal volumes in the NPV group were 10-12 ml/kg (predicted) with no PEEP or recruitment.

In conclusion we have demonstrated of major pulmonary and extrapulmonary complications at 7 days post surgery. Secondary outcomes were followed up to 30 days.

Discussion
This review included 10 randomised controlled trials, which showed that hypothermia in children with TBI might be associated with worse outcome. The authors highlight several of the difficulties of performing studies in this field and the need for further studies to determine the role of hypothermia in TBI in children.

James Day
S76 Oxford Deanery

References

Ashton-Cleary DT
Is thoracic ultrasound a viable alternative to conventional imaging in the critical care setting?
British Journal of Anaesthesia 2013:111 (2): 153-60

Introduction
Thoracic ultrasound has been dismissed as a useful investigation, but with renewed enthusiasm in its uses, opinion is changing. This review examined relevant studies between 1980 and 2012, focusing on four common conditions that require repeated imaging to diagnose and monitor treatment.

Review
Pleural effusion: Using computed tomography (CT) as the reference standard, several studies demonstrated the superior ability and reliability of critical care ultrasonography (CCUS) to detect pleural effusions over chest X ray (CXR). Of more clinical relevance is the identification of effusion characteristics. Echogenicity is heterogenous but suggestive that useful estimations of effusion volume may be derived. Further work is required to identify one single, simple method of volume estimation that would validate current evidence.

Consolidation & atelectasis: Distinguishing between alveolar oedema, interstitial oedema and consolidation on CXR is difficult. From alveolar consolidation studies, Lichtenstein and colleagues show that CCUS can provide an accurate lung assessment by combining four ultrasound features. This was with comparable diagnostic performance to CT. However many subsequent studies by other groups failed to reproduce such findings.

Extravascular lung water: There may be an emerging role for ultrasound here, however evidence is conflicting. CCUS may enable differentiation between pulmonary and perimediastinal oedema through specific ultrasound features. It performs well at identifying cardiogenic pulmonary oedema compared to echocardiography and functional cardiac testing.1 More research is required to support the role of ultrasound in this area.

Pneumothorax: CCUS is considered valuable in detecting pneumothorax. Diagnosis is defined by the absence of B-lines, lung sliding and the presence of A-lines. If lung movement is likely to be absent, A-lines themselves can be used to differentiate between diagnoses. The largest study of critical care pneumothorax excluded ventilated patients due to reduced ultrasound sensitivity - an anomaly not mentioned in other studies. In general, CCUS outperformed CXR in diagnosis and monitoring, with CT used as the reference standard.1

Discussion
The four reviewed conditions have a varying evidence base to support the role of thoracic ultrasound. Overall CCUS appears to approach the quality of CT and surpasses that of CXR. CCUS can potentially save time and provide cost savings, however the difficulty for implementation is that of training. Guidance is available regarding core competency, however the accreditation of CCUS is still largely undecided.

Emma McLoughlin
South-East Scotland Deanery

References
1. Lichtenstein DA, Meziere GA. Relevance of lung ultrasound in the critical care setting by combining four ultrasound features. This was with comparable diagnostic performance to CT. However many subsequent studies by other groups failed to reproduce such findings.
2. Galbois A, Ait-Oufella H, Baudel JL et al. Pleural ultrasound compared to chest radiography in the symptomatic evaluation of pneumothoraces excluded ventilated patients due to reduced ultrasound sensitivity - an anomaly not mentioned in other studies. In general, CCUS outperformed CXR in diagnosis and monitoring, with CT used as the reference standard.1
3. Galbois A, Ait-Oufella H, Baudel JL et al. Pleural ultrasound compared to chest radiography in the symptomatic evaluation of pneumothoraces excluded ventilated patients due to reduced ultrasound sensitivity - an anomaly not mentioned in other studies. In general, CCUS outperformed CXR in diagnosis and monitoring, with CT used as the reference standard.1
4. Lichtenstein DA, Meziere GA. Relevance of lung ultrasound in the critical care setting by combining four ultrasound features. This was with comparable diagnostic performance to CT. However many subsequent studies by other groups failed to reproduce such findings.
5. Lichtenstein DA, Meziere GA. Relevance of lung ultrasound in the critical care setting by combining four ultrasound features. This was with comparable diagnostic performance to CT. However many subsequent studies by other groups failed to reproduce such findings.

Anaesthesia News December 2013 • Issue 317

Anaesthesia News December 2013 • Issue 317
If you’re going to San Francisco...

As the 1967 song by Scott McKenzie goes, be sure to wear some flowers in your hair. And, although there are still many flower children and hippies to be seen in the city, this was not actually the dress code for the American Society of Anesthesiologists (ASA) annual meeting in San Francisco where the AAGBI was represented by our President William Harrop Griffiths, Vice President Isabeau Walker and Executive Director Karin Pappenheim. There were also around 130 UK delegates amongst the 15,000 anaesthetists, industry reps and others attending this major five day event in October.

With a packed multi stream programme starting at 7.30 am on many days, finding your way to the right session at the right time was often challenging. Highlights included:

- Dr Jane Fitch taking up her role as new ASA president, only the second woman to hold this office in the organisation’s history. Dr Fitch is professor and chair of the Department of Anesthesiology at the University of Oklahoma Health Sciences Centre in Oklahoma City.
- The launch of ASA’s public affairs campaign ‘When seconds count’ promoting the role of anaesthetists. [http://www.asahq.org/whensecondscount.aspx](http://www.asahq.org/whensecondscount.aspx)
- A debate on the death penalty linked to ASA action to persuade policy makers not to use anaesthetics for executions. ASA successfully lobbied the State Governor of Missouri to stop possible use of Propofol for this purpose, so averting the threat to anaesthetic treatment from this move.
- Lifebox fundraising and workshop.
- Patient Safety as the theme of the conference with Hollywood actor Dennis Quaid taking part by video in a plenary session on the Chasing Zero Project promoting safety and quality.

An important discussion on drug shortages took place at a World Federation of Societies of Anaesthesiologists (WFSA) session - where the ongoing work by AAGBI on the national essential anaesthetics drug list (NEADL) was a focus and joint action by the Association, WFSA and European Society of Anaesthesiologists was agreed as a follow up.

As always at such events, there are many opportunities for networking with colleagues and a meeting was held between CEO’s of national societies for information sharing as well as a lunch for Presidents of member organisations from around the world.

Karin Pappenheim
Executive Director, AAGBI

---

[Photography © Sarah Kessler, Lifebox]
WSM London is one of the AAGBI’s largest conferences. It takes place over 3 days and offers a mixture of updates, leading edge topics, a poster competition, an extensive Industry exhibition and the opportunity to network.

BOOK YOUR PLACE NOW!

For further information please visit

www.wsmlondon.org