The Misuse of Anaesthetic Agents through time

Pask Certificate of Honour: Members of Defence Anaesthesia who served in Afghanistan

Letter from America
Dr Bythell is away at the moment, so I am stepping into the breach. Deciding whether and when to intervene is an integral part of our everyday practice. This month’s article on Anaesthesia in Afghanistan demonstrates what can be done when good teams take joint responsibility for patient management. Nurturuous attention to detail, in which every aspect of care is reviewed and perfected, has improved survival and quality of life for people with the most extreme injuries. Much of this success depends on the culture of the organisation: amongst medical teams the culture is one of constant practice, improving speed, sharpening skills and getting the right equipment to deliver what is needed. Not all of us work in organisations with such a ‘can do’ approach. Attention to detail in the NHS is more often centred on the purchase of cheaper disposables. Leadership, in this situation – getting from an idea to an outcome involves encouraging people to understand the wider picture, to take what they see as ‘risks’, with the potential to incur the wrath of ‘management’. At last month’s AAGBI Council meeting I had the privilege of listening to Dr Stuart White explain how he had introduced recycling of plastic and paper theatre waste into his organisation. Hospitals can earn good money by recycling. Despite this, he still had to work hard to explain to hospital managers that the material was not ‘an infection risk’, and a doctor had to sign a form stating that bags did not contain contaminated waste. He struck a chord with me; my list this morning produced a large bag of plastic packaging. A recent survey showed that 94% of UK anaesthetists wanted to recycle at work. So why don’t we?

Rather than encouraging innovation, the NHS culture seems to put barriers in the way. Change comes from the top, often in the form of service reconfigurations, and major health service reorganisation costs millions. I’m left wondering what would happen if, instead of the right equipment to deliver what is needed, not all of us work in organisations with such a ‘can do’ approach. Attention to detail in the NHS is more often centred on the purchase of cheaper disposables. Leadership, in this situation – getting from an idea to an outcome involves encouraging people to understand the wider picture, to take what they see as ‘risks’, with the potential to incur the wrath of ‘management’.

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An exciting opportunity:
Editor of Anaesthesia News

Anaesthesia News is the paper newsletter of the AAGBI, and is circulated to over 10,000 members, at home and overseas.

A recent membership survey (2011) suggests that 98% of members read the newsletter at least several times a year. The Editor’s post is therefore a key role within the Association of Anaesthetists.

Key highlights and benefits for the editor include:

• The opportunity for a national leadership role for the specialty
• Join the AAGBI Board of Directors (co-opted member)
• Join an excellent production team
• Interact with a large number of colleagues
• Free registration for all AAGBI educational events
• Computer allowance

For a job description, person specification and details of the recruitment process please visit: www.aagbi.org/publications/anaesthesia-news

If you would like to chat about the post informally please contact the current editor at: anaenews@aagbi.org

Closing date for applications: Monday 23 April 2012

The Pask Certificate is a prestigious award named after an RAF anaesthetist, Professor Edgar Pask, who literally put his own life at risk during the Second World War to reduce the danger faced by aircrew bailing out of aircraft at high altitude or into the sea. His high altitude parachute descent simulations involved breathing a hypoxic mixture of gases whilst suspended in a parachute harness, becoming unconscious for several minutes. The other better-known experiments were on the design of life jackets to prevent unconscious aircrew floating face down in the water. To simulate these conditions, Pask was anaesthetised, intubated and whilst breathing either through a long circuit allowed to float or sink in a swimming pool. All without monitoring – a risky anaesthetic! Almost certainly aspiration must have occurred as well as cooling and other unpleasant side effects. The experiments were filmed in order to demonstrate to aircrew the work being done on their behalf. An excellent review about the remarkable work of Professor Pask has been published recently.

The Council of the AAGBI decided to award a Pask Certificate to each anaesthetist who has served in Afghanistan in recognition of the bravery and dedication of all those involved, from the front line battlefield rescue, the hospital at Bastion to the return journey to UK.

The work is clearly exhausting both physically and mentally. The trauma that we face in UK is of a much lesser degree and seldom inflicted deliberately by such catastrophic results. The medical expertise received by our soldiers is of the highest quality with many of the lessons from the battlefield being translated to civilian practice. Many of the local casualties are children who are in the wrong place at the wrong time, or have been targeted deliberately. Tough stuff.

Many of our young soldiers who return to UK, often only a few hours after being injured on the battlefield, face long term rehabilitation to cope with their injuries, both physical and mental. Many of these injuries are truly life-changing and support from our nation will need to go on for many years.

So, when you meet a colleague coming back from Afghanistan, remember to welcome them home, shake their hands and let them know we appreciate them – that is the spirit and the message behind the award. Also let’s not forget the loneliness faced by families in our departments left at home during lengthy detachments.

The NHS and the politics of Healthcare continue unabated. At the time of writing the Health and Social Care Bill is receiving a lot of opposition. Of particular risk to the NHS in my view, is convenient outsourcing to the independent sector for short term gain followed by fragmentation of services and future increased costs to resolve the resulting difficulties.

The BMA is due to ballot their members on industrial action on pensions. The AAGBI responded to the pension review (see website) and made a number of points including the fact that anaesthetists are more likely to work part-time or to take career breaks than doctors in many other specialties, are less likely to get Clinical Excellence Awards and if they do, they tend to receive them later in their career. An additional important factor when you consider your response to the BMA ballot is whether you believe you will feel safe working in anaesthesia until the age of 67 years? Most of my colleagues seem to prefer to retire at 60 – 62 years of age. This is a complex debate, especially given the pension problems in the private sector and our increasing longevity.

By the time you receive Anaesthesia News this month, the NPSA deadline to change to new neuraxial connectors will have passed. Many hospitals will use the risk register while waiting for independent testing of the new products. The new connectors will reduce risks to patients and medical staff.

The Association of Anaesthetists – check the remarkable GAT conference offer this year – 3 days of education for only £195 – see you there!

Trainee – check the remarkable GAT conference offer this year – 3 days of education for only £195 – see you there!

Dr Iain Wilson, AAGBI President

The UK armed forces have been involved in conflict in the Middle East and Afghanistan for over a decade and, during this time, medical care has seen huge changes, some of which are applicable to civilian trauma practice. Despite this, many anaesthetists will be unaware of the work of their colleagues in the Defence Medical Service (DMS).

**General Casualty Care**

The concept of a “golden hour” is of limited validity in military trauma, where traumatic injuries may lead to exsanguination within minutes. The current paradigm of “the platinum ten minutes” reflects this, and has driven first responder care and equipment design. A wounded soldier may self-aid, or receive ‘buddy aid’ from an immediate colleague using tourniquets and elasticated field dressings within a few moments of being wounded. Soon after, a more highly trained Team Medic may use additional equipment such as Celox® haemostatic dressings or chest seals to address the C-ABC of trauma: catastrophic haemorrhage, airway, breathing, circulation. Increasingly, the aspiration for field units is to have 50% of front line soldiers trained to a Team Medic level.

Historically, patients are then evacuated through echelons of care, each having greater capability to stabilise and treat patients (see Table 1). Typically, Roles 1 & 2 are relatively basic facilities, Role 3 is the most capable in-country asset, and Role 4 is the NHS in the UK. The exact structure varies between different strategic situations, but in the most capable in-country asset, and Role 3 is the NHS in the UK. The exact structure varies between different strategic situations, but in the most capable in-country asset, and Role 3 is the most capable in-country asset, and Role 4 is the NHS in the UK.

Pre-hospital care is provided by the Medical Emergency Response Team (MERT), a team of four—two paramedics, an anaesthetist or emergency physician, flown to the point of wounding in a Chinook helicopter. Less severely injured casualties may be retrieved in smaller aircraft e.g. Skynysk Pav Hawk helicopter staffed by American paramedics, but the configuration of the Chinook, with large floor space and equipment stores allows many casualties to be collected, and for early aggressive treatment of the more complex casualties. It is not unknown to have six stretcher cases and a similar number of less injured patients in a single trip.

**Pre-Hospital Care**

The involvement of anaesthetists occurs from the point of wounding onwards. Pre-hospital care is provided by the Medical Emergency Response Team (MERT). Although MERT is a concept (forward delivery of care) rather than a place, the current MERT configuration is a team of four—a nurse, two paramedics and an anaesthetist or emergency physician, flown to the point of wounding in a Chinook helicopter. Less severely injured casualties may be retrieved in smaller aircraft e.g. Skynysk Pav Hawk helicopter staffed by American paramedics, but the configuration of the Chinook, with large floor space and equipment stores allows many casualties to be collected, and for early aggressive treatment of the more complex casualties. It is not unknown to have six stretcher cases and a similar number of less injured patients in a single trip.

**Table 2: Typical MERT Interventions**

- **Rapid Sequence Intubation**
- **Application of cervical collar & pelvic splint**
- **Elasticated field dressings, tourniquets & Celox gauze**
- **Intraosseous access, transfusion of blood and plasma**
- **Administration of analgesia, muscle relaxant & sedative**
- **Thrombocytopenia (intracranial drainage**

At all times, a dedicated Chinook is available in Camp Bastion, equipped with MERT stores—such as stretchers, fluids (including blood and FFP), monitors (MRL, PIC), oxygen cylinders, pneuPAC ventilator etc. Emergency and controlled drugs are carried separately by the MERT doctor.

The role of the MERT doctor is a challenging one—delivering simultaneous, time critical decision making for multiple seriously ill casualties requires mature judgement, a strong team ethos, and good practical skills, especially since the helicopter is frequently flying tactically to avoid potential or actual hostile ground fire. Despite this, first time successful intubation rates are over 95%, and it is possible to carry out multiple, high quality interventions in a much shorter timescale than is usually possible in civilian environments.

**Emergency Department (ED) & Operating Room (OR) Management**

Once the helicopter lands on HLS Nightingale at Camp Bastion, patients are transferred briefly to a land ambulance for the two hundred metre journey to the Role 3 hospital. Generally, the MERT medical officer will accompany this transfer, and continue appropriate resuscitation as required.

Patients are assessed in ED by a trauma team consisting predominantly of senior experienced decision makers. Digital radiology provides images within seconds, while a consultant radiologist concurrently carries out a FAST scan (Focused Assessment with Sonography for Trauma) and limited echocardiography. Surgical specialists are immediately to hand, with their approach to the patient controlled by the ED consultant. Dedicated runners carry blood samples and blood products to and from the lab, which is only a few metres from the ED.

Often, the MERT give advance warning of the need for a massive transfusion before the patient arrives, so blood is already primed and ready for use. Patients are then transferred to the OR, where the patient is anaesthetised by a theatre anaesthetist. Reperfusion of tissues with pressurised air and fluid is initiated, and the patient is haemodynamically stabilised, before being transferred to the intensive care unit.

**Figure 1: Echelons of Care**

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<th>Role</th>
<th>1</th>
<th>2</th>
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<tr>
<td>Typical Capability</td>
<td>Primary Care, First Aid, triage, immediate life saving measures. No holding or transport capacity.</td>
<td>Treatment, limited holding capacity (&lt;20 beds). Limited transport capacity. Perhaps limited surgery.</td>
<td>Surgery, CT scan, transfusion, larger holding capacity (up to 200 beds). Integral transfer capacity.</td>
<td>Definitive treatment &amp; rehabilitation</td>
</tr>
<tr>
<td>Medical Resources</td>
<td>1 doctor</td>
<td>2-6 doctors. Perhaps 1 surgical team.</td>
<td>3-6 surgical teams</td>
<td>NHS tertiary level care</td>
</tr>
<tr>
<td>Example</td>
<td>Regimental Aid Post</td>
<td>Dressing Station/Medical Regiment</td>
<td>Camp Bastion</td>
<td>University Hospital Birmingham</td>
</tr>
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</table>

The initial management of a typical severely injured casualty (e.g. triple limb amputee) is described in table 2. This can be accomplished during a flight time as short as ten minutes, due largely to the high degree of teamwork and co-ordinated care provided by Medical Emergency Resuscitation Team (MERT). MERT is considered by many to represent the cutting edge of pre-hospital medicine worldwide.
Critically unstable patients may undergo. Local slang refers to this as “right turn resuscitation.” This Damage Control Resuscitation (DCR) name comes from the historical configuration of the operating theatre in Bastion – a right turn from the Emergency Department. In essence, this group of patients undergo immediate resuscitative surgery in the operating theatre, bypassing ED. Embarking on Damage Control Resuscitation requires confined decision making, which can be triggered by the Emergency Department or initial surgical examination. Admission to surgical incision times may be measured in seconds to minutes, rather than minutes to hours as so often in civilian practice.

Many fit young soldiers will tolerate extreme hypovolaemia, even to the potential for rehabilitation. This reduces residual physical deficits and improves the presentation, even if following immediately on from Damage Control Resuscitation. The ability to warm fluids adequately and treat hypothermia prior to returning immediately to theatre for ongoing surgery. This may be regarded as “operating on physiology, not anatomy” interpreted as shorter than one hour to prevent the onset of the bloody pause.

Many of the Afghan patients are poorly nourished prior to wounding, and the catabolic stresses of severe injury often lead to a high mortality rate, or a prolonged recovery for the survivors. This generates a steady flow of ethical dilemmas and practical management issues requiring senior group discussions and mature judgement.

The current staffing of the 10 bed (14 if surge capacity required) ICU is provided by two consultants working a 24 hour, 1:2 rota, and around 40 nursing staff. At busy times, either anaesthetists or medical staff can help but generally, if the intensive care unit is busy, so is everyone else. In my last summer tour, the ICU in Camp Bastion accepted as many patients each month as my 17 bed NHS Intensive Care Unit (which has 18 medical staff and over 100 nurses).
for major trauma (since the mortality rate for ISS>16 and above is 10%). The average ISS for UK military casualties in Afghanistan is 53. The military are currently revising ISS in part to account for a large number of unexpected survivors, both statistically and clinically, over the last decade.

Extreme injuries which many in civilian practice would regard as non-survivable are not only survived by this military population, but the long term functional outcomes, even if significantly physically disabled, have been sufficiently good to justify the large amount of resource devoted to managing them. This lit, young, and highly motivated population may not be reflective of the general population, but are repeatedly defining the limits of survival. This constantly raises ethical questions about the appropriateness of some truly epic treatments such as hemipelvectomy for triple limb amputations. In many ways, this is similar to civilian debate around the practical limits of neonatal resuscitation.

Whatever one may think of the reasons for, and conduct of the wars of the last decade, it is undeniable that the Defence Medical Service has risen to the challenge and performed at a very high level. Lessons have been learned about the management of victims of major trauma which should help save lives in future.

Dr Ian Nesbitt
Consultant in Anaesthetics & Critical Care,
Freeman Hospital, Newcastle upon Tyne

References:

CONCLUSION
Military medicine is a rapidly evolving field, especially in the area of trauma resuscitation. The information in this article is freely available from various sources.

The website for the Journal of the Royal Army Medical Corps http://www.rcmjournal.com/index.htm allows open access to the journal, which contains numerous articles of interest.

The Philosophical Transactions of the Royal Society (B) published in January 2011; issue 366, also provides more details of much of the above.

*AoCt - Acute OaCoPathy of Trauma
**ISAF - International Stabilisation Afghanistan Force
***FAST - focussed Abdominal Sonography in Trauma

Further reading
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ABSTRACTS FOR PRESENTATION AT THE AAGBI ANNUAL CONGRESS, BOURNEMOUTH 2012

You are invited to submit an abstract for oral (free paper) or poster presentation at the Annual Congress.

The deadline for submission is midnight on Monday 28th May 2012 and full instructions, including a template abstract and submission form, can be found on our Annual Congress microsite: www.anual.congress.org and on the AAGBI website www.aagbi.org/research/awards

After the deadline, a preliminary review of the abstracts received will determine which ones are accepted for presentation at the Annual Congress in Bournemouth. Some authors will be invited to present their work orally, under the following three categories: audits and surveys, case reports, and original research. The remaining successful authors will be invited to present a poster.

All accepted abstracts will be published in Anaesthesia in the form of a fully referenceable online supplement. In addition, the best ones, selected by a judging panel at the meeting, will be printed in the hard copy version of the journal. [NB Editor-in-Chief reserves the right to refuse publication, e.g. where there are major concerns over ethics and/or content].

Authors of the best free papers and poster(s) will be awarded ‘Editors’ Prizes’. If you have any queries, please contact the AAGBI Secretariat on 020 7631 8812 or secretariat@aagbi.org

AAGBI & MPS PATIENT SAFETY PRIZE

The AAGBI and MPS would like to offer a new Patient Safety Prize to showcase examples of improved safety in anaesthesia.

The prize is open to members of the AAGBI. The project could involve an individual, department, medical students or allied health care professionals, provided the project lead is a member of the AAGBI.

You will need to demonstrate:
- Clear aims and objectives
- An innovative idea(s)
- How the project was introduced and implemented
- How performance was measured and benchmarked
- How information about the project was disseminated
- The sustainability of the project
- Transferability of the project to other departments

Amount: Up to €1,000 (at the discretion of the awarding Committee).

There may be more than one prize.

Awarded: At the AAGBI Annual Congress

Format of submissions: Poster presentation

In addition, the shortlisted entries will be expected to:
- Make a brief oral presentation to the judges at Annual Congress

The winner will be expected to:
- Make a five minute oral presentation at Annual Congress
- Submit an article for Anaesthesia News

Please visit www.aagbi.org/research/awards for further details.

If you have any queries, please contact the AAGBI Secretariat on 020 7631 8812 or secretariat@aagbi.org
Regular and Reserve Defence Anaesthetists from the Royal Navy, the Royal Army Medical Corps and the Royal Air Force have been serving in Afghanistan since the beginning of the conflict there in October 2001.

Many Defence Anaesthetists have seen more severe trauma in a single day than many civilian anaesthetists will see in a year, and have seen many as 3 major incidents in a 24 hour period being experienced on occasions. The level of trauma and the ensuing resuscitation continuing long into surgery, subsequent intensive care and even into tactical and strategic evacuation has been demanding in the extreme. It has often required two or even three specialties working together, and it has often been managed by those volunteers who repeatedly return for these extremely taxing duties on operational deployments. The stress of working daily with critically injured young UK and Coalition Service personnel and local civilians, including many children, has affected the level of dedication and critical care experienced during this evacuation since early 2002. They have been serving as a direct result of the 11th of September 2001 attacks on the United States. Initially a small number of Defence Anaesthetists worked to support Special Forces during the commencement of Operation Enduring Freedom with the establishment of the joint Operational Anaesthesia Team (OAT). Consultants and later in the mission, trainees, have been deployed to provide medical support to combat and security personnel.

Defence Anaesthetists have been outstanding members of the medical team, leading advances in care, which have seen a great many unexpected survivors from trauma. This has heralded the lowest mortality amongst casualties in any conflict to date, to the extent that there has been the involvement of the anaesthetist at every stage of the evacuation chain from pre-hospital care, resuscitation, anaesthesia, intensive care, pain management and aeromedical evacuation, through to command as Medical Directors.

Conditions at the commencement of the conflict during entry operations were extremely harsh and fraught with personal danger and through the threat to personal safety has been considerable, in particular the threat to the UK’s presence in the region, it will be ever-present. Personal risk has been a constant accompanied over many tours of duty for some and they deserve particular mention. Defence Anaesthetists, who are more specific groups are identified are it important to recognise the dedication they deserve particular mention. Before specific groups it will be ever-present. Personal risk has been a constant.

Pask Certificate of Honour

Pask Certificate of Honour Recipients 2012

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<td>Maj</td>
<td>Royal Navy Defence Anaesthetist</td>
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<td>Surg Lt Col Alcock</td>
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Pask Certificate of Honour to Defence Anaesthetists that have served in Afghanistan

Group Captain Neil McGuire

The Pask Award was instituted in 1977 after the Moorgate Underground disaster of 1975 and the desire of Council to honour the gallantry and professionalism of the medical team. The Pask Award was presented to the first person to treat their patients and support the overall medical effort during the rescue and evacuation. The Pask Award is presented to those who have distinguished themselves during a period of extraordinary and exceptional conduct. The recipient is chosen by the President of the British Association of Military Surgeons and the Commander-in-Chief, Defence Medical Services, in consultation with the Association and his command. The award is made by the Council of the BAMS to those who have rendered distinguished service, either within the United Kingdom or overseas, in a single act of extreme, heroic or meritorious act or consistently and faithfully over a long period. The award was named after Professor E A Pask, who had a distinguished career as an anesthetist and an experimental physiologist in the Second World War. This included dangerous self experiment requiring considerable personal courage.

Pask Certificate of Honour

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Pask Certificate of Honour to the Royal Family

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Pask Certificate of Honour to Defence Anaesthetists that have served in Afghanistan

Group Captain Neil McGuire

The Pask Award was instituted in 1977 after the Moorgate Underground disaster of 1975 and the desire of Council to honour the gallantry and professionalism of the medical team. The Pask Award was presented to the first person to treat their patients and support the overall medical effort during the rescue and evacuation. The Pask Award was presented to those who have distinguished themselves during a period of extraordinary and exceptional conduct. The recipient is chosen by the President of the British Association of Military Surgeons and the Commander-in-Chief, Defence Medical Services, in consultation with the Association and his command. The award is made by the Council of the BAMS to those who have rendered distinguished service, either within the United Kingdom or overseas, in a single act of extreme, heroic or meritorious act or consistently and faithfully over a long period. The award was named after Professor E A Pask, who had a distinguished career as an anesthetist and an experimental physiologist in the Second World War. This included dangerous self experiment requiring considerable personal courage.
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The Queen’s Honorary Surgeon

Congratulations are in order for Group Captain Neil McGuire, who has represented anaesthesia, critical care and pain doctors in the defence medical services at the AAGBI since 2007 on his appointment as Queen’s Honorary Surgeon.

The appointment takes effect on the 1st April 2012 and was approved by Her Majesty the Queen in late 2011. It is for a period “at Her Majesties pleasure”, but it is normally continued while serving in HM Forces. This is one of a small number of Honorary Medical appointments made from the Armed Forces, which includes Queen’s Honorary Dental Surgeons, Queen’s Honorary Physicians and Queen’s Honorary Nursing Sisters.

The role includes duties at Royal occasions such as Investitures, Garden Parties and State Banquets where the incumbent is a “registrar”, part of the extensive medical cover which is accorded such events. The QHS etc are always accompanied by a “registrar”, who is either a consultant or senior trainee anaesthetist.

The holders of this appointment are distinguishable by the fact that the uniform has Royal Cyphers (EIIR) accompanying the fact that the uniform has Royal Cyphers (EIIR) accompanying their shoulder rank insignias and the wearing of aiguillettes with some uniforms (ornamental braided gold wire cord with metal tips).

Buckingham Palace, London

Anaesthetists’ risk assessment of placebo nerve block studies using the SHAM (Serious Harm and Morbidity) scale

J. Jarman, N. Marks, C.J. Fathy, D. Conti and A. M. Cyna

The role that placebo play in clinical research involving local anaesthetic blocks has created some controversy. This study follows a previous publication by this group in which they described a SHAM (Serious Harm and Morbidity) scale to assess the risk that patients are subjected by the performance of a placebo block. The authors reviewed a number of studies using their scale and concluded that some studies were in contravention of the Declaration of Helsinki, which states that “the patient who receive placebo or no treatment will not be subject to any risk of serious or irreversible harm”. Some criticism and useful debate followed the publication of this article in our correspondence section.

In this article, the authors examined the validity of their scale. They compared the SHAM scale scores awarded by 43 anaesthetists who were given ten randomised, controlled trials involving local anaesthetic blocks. They demonstrated that the patients who receive placebo or no treatment will not be subject to any risk of serious or irreversible harm’. Some criticism and useful debate followed the publication of this article in our correspondence section.

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The Royal College of Anaesthetists’ book Raising the Standard: Information for patients describes how best to enable information transfer from medical professional to patient. We used this information, along with standards suggested in the RCoA Raising the Standard: A compendium of audit recipes, to design and undertake an audit investigating what information patients undergoing anaesthesia for elective procedures at the Royal Devon and Exeter hospital (RDEH) were receiving. This initial audit, of 88 patients across a range of specialties, took place during May and June 2009. As well as looking at the types of media used to transfer information (information sheet, procedure booklet, anaesthesia booklet, verbal advice), it also investigated whether the patients received any written information that they were satisfied with the information that they had received. It demonstrated that although all but one received fasting information, only 11% of patients had been given the RCoA’s anaesthesia booklet, 66% had received a procedure specific information leaflet – most of which contained some information about anaesthetic. 32% of 66 (79%) of patients seen in a pre-assessment clinic felt that they had received adequate verbal information at this time. At this time, 13 of the 88 patients (15%) surveyed were unhappy with the quality or quantity of information that they had received. All patients who had been seen in an anaesthetic pre-assessment clinic or had received the anaesthetic information leaflet were satisfied. The only dissatisfied patients were those who had not received either of these interventions. In response to this audit, the importance of making patients aware of the information that is given in an interactive format, including a study by Gautschi et al in Switzerland, was confirmed. Although not all octogenarians are as internet savvy as they could be, they are generally more internet savvy as they could be, they are generally more internet savvy as they could be, 52 of 72 patients (72%) had one computer programme, providing only written and verbal information are able to obtain this, and hence are satisfied with the information service we provide.

However, she was not given any information about her anaesthetic choices at those appointments and this was something that what this could entail. She therefore looked to me for this information. I explained that practices vary between hospitals and anaesthetists, but she found the information I was able to give reassuring. This led me to think about the information that my patients were receiving prior to their preoperative visit on the day of surgery. Were they too being placed under unnecessary stress because of our communication, or lack thereof?

In 1992, the Patient’s Charter informed British patients that they have the right “to be given a clear explanation of any treatment proposed, including any alternatives, and to be given relevant statistical information as part of the treatment”. A systematic review of the literature on patients’ priorities conducted in 1998 by the European Task Force on Patient Evaluations of Practice (EUROPEAN) raised patient involvement in decision-making and “time for care” were values patients sought in their consultations with doctors.1, 2 As patients become more medically fit for surgery, the audits demonstrated that 83% had received some written information or verbal advice, it also investigated whether the patients received any written information that they were satisfied with the information that they had received. It demonstrated that although all but one received fasting information, only 11% of patients had been given the RCoA’s anaesthesia booklet, 66% had received a procedure specific information leaflet – most of which contained some information about anaesthetic. 32% of 66 (79%) of patients seen in a pre-assessment clinic felt that they had received adequate verbal information at this time. At this time, 13 of the 88 patients (15%) surveyed were unhappy with the quality or quantity of information that they had received. All patients who had been seen in an anaesthetic pre-assessment clinic or had received the anaesthetic information leaflet were satisfied. The only dissatisfied patients were those who had not received either of these interventions. In response to this audit, the importance of making patients aware of the information that is given in an interactive format, including a study by Gautschi et al in Switzerland, was confirmed. Although not all octogenarians are as internet savvy as they could be, they are generally more internet savvy as they could be, 52 of 72 patients (72%) had one computer programme, providing only written and verbal information are able to obtain this, and hence are satisfied with the information service we provide.

To improve their satisfaction. The aim is to improve information transfer and thus create a group of well informed patients, who are able to make autonomous decisions about their care. As well as Gauch’s, studies others have demonstrated that the use of interactive multimedia devices to intervene in diabetes self-care was effective in raising the subjects’ knowledge about the disease. As well as being a point of access for more information for all patients undergoing elective surgery, this type of medium could also be beneficial for the minority of patients who do not wish to receive information at that time, but whose wishes change prior to their admission to hospital.

Although interactive multimedia transfer undoubtedly confers benefits, it disadvantages must also be recognised, as demonstrated in a recent US based study by Zigmund-Fischer et al. Through assessing the effect of the introduction of interactive graphs to a computer-based information programme about the risks of different thyroid cancer interventions, they demonstrated that the interactivity, however visually appealing, distracted people from understanding relevant statistical information. The intervention group were also less likely to complete the survey.3 In order to encourage patient autonomy, one of the main purposes of providing pre-operative information for our patients is to inform consent. This requires patients to understand and retain information relating to risks. Developments in this medium would therefore need to be aware that interactive risk presentations may create worse more disquiet than presentations of static risk graphic formats.

In summary, we have a wide variety of patients, with a wide variety of requirements, undergoing a wide variety of procedures, which can be presented in a wide variety of ways. Although it would be very difficult to encompass all of the information required in a single medium, it is falling short at the moment. Patients, who are the most medically fit for surgery, the audits demonstrated that 83% had received some written information or verbal advice, it also investigated whether the patients received any written information that they were satisfied with the information that they had received. It demonstrated that although all but one received fasting information, only 11% of patients had been given the RCoA’s anaesthesia booklet, 66% had received a procedure specific information leaflet – most of which contained some information about anaesthetic. 32% of 66 (79%) of patients seen in a pre-assessment clinic felt that they had received adequate verbal information at this time. At this time, 13 of the 88 patients (15%) surveyed were unhappy with the quality or quantity of information that they had received. All patients who had been seen in an anaesthetic pre-assessment clinic or had received the anaesthetic information leaflet were satisfied. The only dissatisfied patients were those who had not received either of these interventions. In response to this audit, the importance of making patients aware of the information that is given in an interactive format, including a study by Gautschi et al in Switzerland, was confirmed. Although not all octogenarians are as internet savvy as they could be, they are generally more internet savvy as they could be, 52 of 72 patients (72%) had one computer programme, providing only written and verbal information are able to obtain this, and hence are satisfied with the information service we provide.

Dr Clare Atwood
CT2, Royal Devon and Exeter hospital
Clare Atwood is a second year trainee at Juta Teaching Hospital in South Sudan. The AAGBI generously awarded her a travel grant to work there.

References:

Too little, too late?
A study of the pre-operative information we impart to our patients
In early 2009, my grandmother underwent an elective total knee replacement at her local district general hospital. At her pre-assessment visit she was given lots of written information about the procedure to take home and read. A surgeon discussed the procedure with her and she was given the details of an interactive American website, which allowed her to learn about the different stages of the procedure should she wish.... and she did.

The re-audit correlates with previous studies, demonstrating that whatever format the information transfer takes, informed patients are more likely to proceed. It also showed that although our department had improved its communication of information to patients, this was still failing short of the RCoA guidelines and DoH guidelines. Although the vast majority of patients were happy with the service that we offer, some were still dissatisfied. Most of these patients were those who felt they had access to too little information, but a few also wanted to receive less information. In the reference guide to consent, first published by the DoH in 2001, no mention is made of the patient may wish to be given information prior to a procedure. Both audits demonstrated a small proportion of patients who thought that providing anaesthetic information prior to their admission, or even prior to their procedure was unnecessary. The guidelines recognise that it is possible that individuals’ wishes may change over time and that respecting a person’s wish not to know, at the same time as providing opportunities for access to further information is even more important in this subset of patients.

Our hospital is working towards streamlining its pre-assessment processes, which will ultimately result in fewer of the ASA I and II patients attending a pre-admission clinic. Although these patients are the most medically fit for surgery, the audits demonstrated that it is this patient group that are most likely to receive inadequate access to information about their anaesthetic prior to their admission to hospital. This led us to ask, how do we empower them? Do we encourage patient autonomy, one of the main purposes of providing pre-operative information for our patients is to inform consent. This requires patients to understand and retain information relating to risks. Developments in this medium would therefore need to be aware that interactive risk presentations may create worse more disquiet than presentations of static risk graphic formats.
Anaesthesia Conference
Benin, West Africa

My journey to Benin began shortly after I commenced working at the North Hampshire Hospital in Basingstoke. I had been approached by a colleague to teach on a conference in Benin, West Africa, as faculty for the Anaesthesia conference he was organising. What I remember most clearly about the day I received the call was that I was extremely happy to learn that I would be able to attend, as I had never visited a country outside of Europe before.

As a medical anaesthetist with 20 years experience, I have visited several countries in Africa, but Benin was a new experience for me. I was excited about the opportunity to share my knowledge and skills with my colleagues and to learn more about the culture and healthcare system in Benin.

The conference had been planned in partnership with Professor Martin Chebil, who runs the School of Anaesthesia in Benin, the only school for medically trained anaesthetists in West Africa. I have to confess I'm not sure I heard of Benin before, it is a small country by African standards; covering 110 000km², with a population of 8.5 million and a national religion of Voodoo. I had never been to Sub-Saharan Africa and the little I knew of the travel within West Africa involved guarded enclaves and armoured vehicles. But Keith said it would be fine, and so it was.

Aside from Dr Thomson there were three consultant and three trainee faculty members. In addition, we had two interpreters, a Canadian computer engineer and a French national anaesthetic trainee faculty members. In addition, we had two interpreters: a highly polite and informative, however, the lack of equipment resulted in their being left rudderless with limited parameters to guide therapy.

On the evening before the conference began we visited the venue to survey the facilities and found thankfully an air-conditioned lecture hall. Our last minute changes proved over burdensome for our interpreters; as the most junior members, Stuart and I e-mailed our final drafts to students at the school of anaesthesia, crossed our fingers and hoped nothing got lost in translation.

Heading out for the first day of the conference we loaded up the Mercy Ship’s Land Rover with Resusci-Annie and her pals. On arrival at the venue it was a daunting prospect to watch the lecture theatre fill up with more than 200 people; 50 medical anaesthetists and 150 nurse anaesthetists, mostly from Benin, though some from further afield; Nigeria, Mali and The Republic of South Africa. The conference opened with a lecture from Dr Thomson, detailing his work in Africa and with Mercy ships over the years. I was surprised, though Keith took the comment with good grace, that the first question he had was a doctor questioning the longevity of Western intervention in Africa. This is a commonly debated issue and in some ways not a surprise at all, but made me consider anew in light of this man’s question.

There is no doubt some truth in the idea that ‘you can’t solve a problem by creating another one’ and as such postgraduate teaching and as such professional development for these individuals can be hard to come by. The feedback obtained told us that our teaching had been well received and that appropriate subjects for the delegates attending.

In summary we would wholly recommend the experience of teaching at a conference in Sub-Saharan Africa.

Dr Emma Taylor
ST6, Wexford Deanery
The Misuse of Anaesthetic Agents through time

All anaesthetic agents have the potential for abuse as well as use. The abuse can be both criminal and recreational and this seminar, timed to link-in with the current, temporary exhibition in the Portland Place museum, explored all these aspects over the years.

The first speaker was Alistair McKenzie who took us back to the beginning...and into the future. He traced the use and abuse of drugs – from alcohol and opium in antiquity to nitrous oxide and ether in the 19th century. Then he covered accidental addiction in scientists and doctors, deaths of patients under anaesthesia before the introduction of measures to improve safety, equipment hazards and human error. Three aspects of the ‘dark side’ of anaesthetic drugs were considered:

- legal (execution by lethal injection)
- ethical (euthanasia)
- criminal (murder, rape, auto-eroticism)

Roger Maltby investigated some tangents along the way.

Ann Ferguson described “Some Curare Murders”. Of note, the Wheeldon case led to identification of pancuronium in the urine of patients who unexpectedly arrested in ICU. However, it was never established who deliberately injected the pancuronium.

Mark Harper then looked at the abuse of chloroform over the years. In fact its potential for use as an anaesthetic was first recognised by a medical student, Michael Cudmore Furnell, who tried it recreationally, having been banned from using and abusing ether. He explored the origins and then dispelled the myth, so popular in drama, that it could be used to instantaneously render victims unconscious. He then went on to describe its role in murder, rape, auto-eroticism and even Tintin taking in some interesting tangents along the way.

The afternoon started with another talk attempted murder of the British prime minister by curare in 1917. The Jascalevich case involved multiple deaths of patients at Oradell, New Jersey in 1965-66, curare being found in exhumed bodies.

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The Misuse of Anaesthetic Agents through time

from Professor Maltby entitled ‘Things are not always what they seem’ which had the subtitle of how to take a fall from a horse. This described a case from the US where a husband murdered his wife when they were out riding by injecting her with Sucrinocoline. When she was dead, he reflected on his head injury on her and initially managed to convince the authorities that this was the cause of death. However, this injury was not consistent with a total outcome and a drug scan revealed a chromotographic peak overlapped by the peak of sucinocoline. Then a second autopsy revealed an injection site.

Professor Alan Dronfield, a retired chemist (and president of the historical section of the Royal Society of Chemistry) then gave us an enquiring account of a proposed murder. Michelle Wooddon was, by all accounts, an extremely friendly and personable sports scientist. Unfortunately she attracted the interest of a male ITU nurse who, when she didn’t reciprocate his affections, administered a fatal dose of propofol for her under the guise of helping her migrate. This never had been discovered were it not for the persistence of the pathologist, Martha Burt. She noticed a tiny puncture wound on the victim which led her to investigate more closely. The murder then occurred on the basis of DNA from his saliva on the needle sheath (from when he brought out the needle) and the records from the electronic drug dispensing system from the hospital where she worked. Next, Professor Allsop discussed the legal history of anaesthetic misuse. This led us from the first inquest into death under anaesthesia (1847) through the use of ether and chloroform for nefarious purposes in the 19th century. Moving into the 20th and then 21st century he described recent cases of murder, manslaughter, suxamethonium, sexual assault and murder involving various anaesthetic agents.

Ann Ferguson is both a retired anaesthetist and one of the judges of this year’s ‘Anonymous Anaesthesia’ competition. She gave us a talk that encompassed the worlds of books and medicine. She described the classes of murder seen in literature and the problems really good story-telling has for medicine. She discussed the legal history of anaesthetic misuse. This led us from the first inquest into death under anaesthesia (1847) through the use of ether and chloroform for nefarious purposes in the 19th century. Moving into the 20th and then 21st century she described recent cases of murder, manslaughter, sexual assault and murder involving various anaesthetic agents.

Professor Mark Harper, a consultant anaesthetist, shared with us some of his previously published writings and his defence of Murray. In all, as the book draws to a close, we learn of the real emotional turmoil resulting from this author’s career in anaesthesia – this I would call the crying part of the book. Dr. Zeitlin is quite open about the various medical problems that have plagued him for the last several decades, including heart issues (a bypass, multiple stents, pacemakers, but still going strong), and major depression (including the medical and electrical treatment thereof) that eventually resulted in his leaving clinical practice. Was the depression caused by his anaesthetic career and the trauma he witnessed? Or was it an ‘incurable’ finding? The reader is challenged to ponder some questions: Are anaesthetists particularly prone to psychiatric problems? Or are physicians with a tendency toward psychiatric issues drawn to a career in anaesthesia? Perhaps a little of all is true, but this book will make the reader think – think about your practice, think about your choices in life, think about patient safety, even think about what you think about during a boring patient safety, even think about what you think about during a boring surgery start times) will be jealous of Dr. Zeitlin’s fond recollections of surgery start times) will be jealous of Dr. Zeitlin’s fond recollections of 9:00am surgery start times) will be jealous of Dr. Zeitlin’s fond recollections of a leisurely 9:00am start in the UK.

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My interest in undertaking a fellowship abroad started early on in my anaesthetic training. As a senior house officer in the West Midlands, I would listen with considerable interest to senior registrars discussing their various plans to travel and work abroad. One such registrar had organised a fellowship in the US. Although she turned her work and family life upside down, I thought that doing this would be an interesting experience!

There were numerous reasons for choosing a fellowship in Melbourne, Australia. Namely, I have a strong interest in anaesthesia for trauma, head and neck surgery and major general surgery. The Alfred Hospital is a tertiary referral centre, and all surgical specialties are performed with the exception of paediatrics and obstetrics. The hospital is also the state burns and trauma unit, as well as the state cardio-thoracic transplantation centre. The above reasons, along with our interest to travel to an uninvaded country, cemented our decision.

The General Anaesthetic Fellowship at the Alfred Hospital commenced in February. I started work within a couple of days of flying out to Melbourne. The first striking observation was how incredibly friendly and down-to-earth everyone seemed to be. From the Professor of the department to the anaesthetic secretaries, we were all warm and inviting. I was instantly made to feel at home – which is so important when you are thousands of miles away from your true home.

The Australian training system is not too dissimilar from ours in the UK. They may also not be exposed to as wide variety of cases in each sub-speciality as the UK. They may also not get a ‘good handle’ on each sub-speciality until later in their training. One advantage with the structured modular training programme in the UK is having a sense of completeness with a particular anaesthetic sub-specialty. The requirement of maintaining a logbook is also useful, both in the short and long term. The disadvantage of such a rigid system means that a trainee can get particularly experienced with a sub-specialty, and then may have no exposure to that field for another three years.

The main difference in Australia is that whilst it lacks such structure, trainees are expected to anaesthetise for a variety of different anaesthetic sub-specialties on a day to day basis. For instance vascular day one, and plastic surgery the day after. This keeps trainees on their toes, and channels them to giving a more academic anaesthetic whilst also allowing them to tailor their anaesthetics. I feel that they may be at a disadvantage with such a constant change as younger more inexperienced trainees may not get a ‘good handle’ on each sub-specialty until later in their training. They may also not be exposed to as wide variety of cases in each sub-specialty as the UK.

Supervision of all trainees ranging from the first year registrar to the most senior trainees was commendable. All trainees and fellows were doubled up with a consultant colleague for the vast majority of the week. This was especially apparent in the first few weeks of the year. As familiarly with the hospital environment grew, trainees were placed on independent lists. At all times, a consultant-in-charge ‘CIC’ was available, to discuss any challenging cases, administrative issues or any other problems. One could argue that senior trainees were ‘over supervised’, however in most instances we were still given the autonomy to manage our own anaesthetics.

If a trainee or fellow were placed on their own theatre lists, provision was always made to have tea breaks and lunch. There were only a handful of occasions where trainees and fellows were made to stay late if they were not on-call.

Obviously having flexibility in the system does positively affect work-life balance. If trainees knew that they will be relieved of duties when not on-call, they are more likely to have a better work ethic. As do UK trainees, Australian trainees work very hard. There is a work-hard play-hard atmosphere. Whilst it is expected they put in long hours, they do, 24 hour on-calls for fellows with the next day off, they are also expected to relax and pursue extra-curricular activities during their time off. I haven’t met such a large group of anaesthetists who regularly participate in tri-athlons, marathons and cycling events since! Trainees at the Alfred are also strongly encouraged to pre-operatively assess their patients the day before. This reduces the incidence of any surprises on the day of surgery, whilst also encouraging the trainee to read and learn about their patient. trainees in the UK can often be seen on the morning of an elective case thereby limiting trainees somewhat. Hospital bleed division could be made here in raising awareness of theatre lists and cases in advance.

The case-mix at the Alfred Hospital was varied, ranging from highly complex patients with multiple co-morbidities to the straightforward patient needing an appendicectomy. As a general fellow, I gained experience in most fields of anaesthesia including trauma anaesthesia, anaesthesia for major general surgery (including vascular), neuroanaesthesia, obstetrics, obstetric anaesthesia and anaesthesia for ENT surgery. I also had the opportunity of assisting to the Royal Victorian Eye and Ear Hospital for a week, where I became extremely proficient with various eye blocks. During this time, there were also many opportunities to visit local cafes and enjoying the numerous public gardens that Melbourne has to offer.

Friday afternoon sessions end with a visit to the local ‘Belgian beer garden’ where you can sit back, relax and wait for the weekend to start! Despite only having five weeks of annual leave, we had the opportunity of visiting local attractions in Melbourne as well as day trips around Victoria, including sampling the wineries in the Yarra Valley. We travelled to Sydney, the Blue Mountains, Cairns, and Port Douglas. We drove through the Great Ocean Road and visited the Twelve Apostles. We had the chance to dive in the Great Barrier Reef too – all with a small baby in tow! We had the opportunity of making many new life-long friends who we will keep in touch with.

Overall, it was a tremendously enjoyable experience – one which I would recommend any trainee to apply for in the future.

Dr Anjalee Brahmbhatt, 517 Anaesthetics, Norfolk and Norwich Hospital
Evidence-based management of postoperative pain in adults undergoing open inguinal hernia surgery


Pain peroperatively for elective inguinal hernia surgery is treated symptomatically by a combination of analgesics and the use of local anaesthetic (LA) techniques. Standard postoperative pain management protocols include oral or subcutaneous analgesics, with local wound LA and parenteral LA if required. The use of epidural analgesia following surgery is a relatively infrequent procedure in this setting.

The use of epidural analgesia following surgery is a relatively infrequent procedure in this setting.

Postoperative adverse events are common following open inguinal hernia surgery. Postoperative pain, delayed wound healing and wound-related complications, particularly the development of infective complications, are major concerns.

The optimal method of pain management following inguinal hernia surgery remains controversial. For this reason, the authors conducted a systematic review to evaluate the evidence for the use of epidural analgesia in this setting.

Methods

A systematic literature search was conducted using MEDLINE, EMBASE and the Cochrane Library and included all randomized controlled trials and non-randomized comparative studies that compared epidural analgesia with another pain management technique in the postoperative period following open inguinal hernia surgery. Trials were excluded if they were less than 10 days and did not have a minimum follow-up of 6 weeks.

The primary outcomes were the development of wound infection and time to return to work.

Results

The review included 12 randomized controlled trials and 3 non-randomized comparative studies that compared epidural analgesia with another pain management technique in the postoperative period following open inguinal hernia surgery.

The overall incidence of wound infection was lower in the epidural group compared to the control group, but this difference was not statistically significant.

The median time to return to work was significantly shorter in the epidural group compared to the control group.

Conclusions

Epidural analgesia following open inguinal hernia surgery is safe and reduces the time to return to work.

References


Guidelines for Performing Ultrasound Guided Vascular Cannulation: Recommendations of the American Society of Echocardiography

Anaesthesia & Analgesia 110(1), January 2010, p64-72

Over the past ten years, the use of ultrasonic guided techniques for vascular access has become widespread. This review article uses PubMed and Medline to review the literature on the use of ultrasound and whether it reduced complications. In the United Kingdom evidence that the use of ultrasound imaging before or during vascular cannulation greatly improves the first-pass success and reduces complications was incorporated into recommendations from the National Institute for Health and Clinical Excellence.

Ultrasound is available in different modalities and the addition of Doppler colour to ultrasound images can help confirm presence of central blood flow. Higher frequency probes are preferred for viewing vascular structures even though they will have poorer penetration for deeper structures.

Appreciating how probe orientation relates to image display is fundamental – for example when cannulating the internal jugular vein it is useful to stand facing the patient then switch to the left lateral view. A Trendelenburg position should be used and a Valsalva manoeuvre will augment the venous diameter, which is especially useful in hypotensive patients or for central venous cannulation. The use of peripheral cannulation and therefore ultrasound use is no replacement for anatomical knowledge of the relative positions of the vein and artery to each other at such an anatomical site.

This review suggests a clear advantage of ultrasound guidance over landmark technique for internal jugular central venous cannulation. Tsou et al describes the first attempt success rate being improved from 54% to 73% with the use of ultrasound. However review of the current literature does not necessarily support the use of ultrasound in uncomplicated subclavian venous cannulation, but more high risk patients (especially those with BMI >30 or coagulopathy) may benefit from screening of the vessel to identify the optimal site. Similarly the use of real-time ultrasound for femoral venous cannulation is not as strong for the internal jugular vein.

The use of ultrasound to identify the relative anatomy of the femoral vessel and vein is useful.

The use of ultrasound for arterial cannulation is also reviewed and although first-attempt success rates are improved compared to using palpation technique this is not as useful as for central venous cannulation. A similar advantage is given for peripheral cannulation although the use of ultrasound may help identify venous versus arterial access, location and patency of peripheral veins for cannulation or PICC lines.

From the evidence available it is generally accepted that to gain sufficient knowledge and the required dexterity a trainee needs to perform ten ultrasound-guided insertions, and where possible under supervision to demonstrate competence to practice independently.

Jennifer Price
SpA Anaesthetist, North Central London Rotation

References


The Anaesthesia History Prize

The Association of Anaesthetists and the History of Anaesthesia Society will award a cash prize for an original essay on a topic related to the history of anaesthesia, intensive care or pain management written by a trainee member of the Association.

Three prizes will be awarded: a first prize of £500 and a second prize of £250. An essay of up to 4000 words should be submitted to the Educational Events Manager, Nicola Heard, via email secretariat@aagbi.org before Monday 16 April 2012.

The Association of Anaesthetists of Great Britain and Ireland

TRAVEL GRANTS/IRC FUNDING

The International Relations Committee (IRC) offers travel grants to members who are seeking funding to work, or to deliver educational training courses or conferences, in low and middle-income countries.

Please note that grants will not normally be considered for attendance at congresses or meetings of learned societies, educational training courses or conferences.

The maximum amount available per grant will be £300. The shortlisted applicants will be invited to present a poster. Entries will be allocated into one of the following three categories depending on the grade of the applicant: Foundation Year Doctors, ACS/CT2 Doctors, ST3 – Doctors. A cash prize and a certificate will be awarded to the winner in each category. All auditors, whether shortlisted for oral or poster presentation, will also be eligible for the Drager Audit Prize. Auditors should demonstrate good understanding of the principle of clinical governance and evidence of evidence-based audit.

The £1,000 cash prize and an engraved medal will be awarded for the best entry.

CLOSING DATE FOR ALL PRIZES: MONDAY 23 APRIL 2012

Full details can be found on the AAGBI website: http://www.aagbi.org/ or telephone 020 7631 8807

Closing date: Wednesday 13 June 2012

Dear Editor

The Association, Anaesthesia: Training. It’s a piece of cake

Frenvery Anaesthetic Department in Bristol is a particular attachment for Trainer within the South West region, with consistently high performance in national training surveys1,2. The Severn Deanery expects high standards of trainees and their CAs at completion of training often reflect this. It is therefore difficult for trainees to stand out amongst such peers. We have hit upon a novel way of improving this and preparing trainees for live as consultants. As part of the national drive towards a consultant based service we introduced a departmental ‘Bake-Off’ designed to meet Domestic Daily Cake Targets and to introduce an Enhanced Recovery Scheme for trainees on anaesthetics on their allocated cohort breaks. We have applied for recognition of this activity for Cake Proficiency Development (CPD) and it will form a significant part of Succulent Pastry Acquisition (SPA) time in the consultant job plan.

Following the success of the consultant programme trainees are encouraged to join a separate competition designed to be compliant with Royal College Guidelines on Workplace Based Assessments. Initial competence is assessed using the standardised DOPS Direct Observation of Pastry Skills form. Progression is confirmed with completion of mini-CARES and final assessment is through a Cake Based Discussion (CBD).

Following a recent sitting of the European Diploma in Intensive Care the Frenchay Anaesthetic Department Bake-Off received international acclaim and accolades for its rigorous quality control. The scheme is in line with current government policy to increase competition within the NHS, and we have been able to achieve this without resorting to commissioning (spouse-baked) or outsourcing (shop-bought) cakes. We would strongly advise any department wishing to adopt a similar system to also actively encourage a ‘Cycle to Work’ scheme to offset the increased calories consumed.

Dr Abigail Lind
Specialist Trainee in ICU and Anaesthesia, Severn Deanery

Dr Julian Brown
Consultant in ICU and Anaesthesia, Frenchay Hospital, Bristol

Dr Ben Walton
Consultant in ICU and Anaesthesia, Frenchay Hospital, Bristol


Dear Editor

Warning! Concerns of a first year core trainee

I would like to express a few concerns of my own regarding the article “Warning! Concerns of a first year core trainee” in February’s edition of Anaesthesia News. The aim of the article appears to be to highlight when to consult with a senior colleague if a clinical scenario exceeds one’s skills or knowledge. While I agree that the article may indeed illustrate this point, I have concerns with the subsequent handling of the scenario, particularly that the manner in which it is portrayed might suggest that this is standard anaesthetic technique or even that it is within the remit of CT1 trainee. To summarise the case as presented, a young elective patient with a raised BMI, significant history of reflux and severely restricted mouth opening appears to have been assessed by an exceptionally junior trainee.

An anaesthetic was then conducted using two opioids concurrently, an induction agent which is known to increase mortality and muscle relaxant of variable efficacy. Without any mention of how the airway was maintained, a nasal intubation was achieved despite “significant” epistaxis. I do not believe that this in any way reflects an appropriate description of the anaesthetic options (including awake fibreoptic intubation) which should have been discussed by the consultant in charge of the case with the patient preoperatively. It does not examine the possible hazards of the chosen technique, particularly the risk of encountering a “Can’t intubate. Can’t ventilate” scenario and the plan for managing it. I also am surprised at the need to add further agents to an already complicated induction regimen in order to achieve “neuroprotection”. Whilst there are many ways to provide an anaesthetic, I do not feel that this article, which aimed at junior trainees, is worth by which they should base their practice and may actually encourage them to undertake what (in their hands) likely be a hazardous non-standard technique1.

Yours sincerely

Alastair Rose
Consultant in Anaesthesia & Intensive Care, Pinderfields Hospital, Wakefield

Editor’s note: We did not intend to endorse the technique described nor suggest that this would be a suitable case for a junior trainee except under direct supervision of a consultant. We would encourage trainees to ask their seniors to explain the rationale behind the techniques used especially if they are non-standard.

Dear Editor

Vit D deficiency

It started off a year ago, when even simple procedures like intubation or inserting central lines would cause severe back ache, and regular intensive care ward staff would require specialist physical therapy to aid with this. But when things went from bad to worse, I consulted my GP who discovered my low vitamin D levels were very low. Initial levels 50-60nmol/L. Vitamin D deficiency may be a particular hazard and a growing problem, albeit not discussed much. As trainees we spend time most of the time in theatres, and with our shift patterns, we are especially prone to this deficiency. It is also more common among dark skinned people, vegetarians, and pregnant women. For HD patients, HD D deficiency has been associated with osteopenia, depression, heart disease, stroke, cancer, diabetes and depressed immune function. With the incidence increasing this is a potential hazard we should be very much aware of.

Dr R Kulkarni
ST6 Anaesthetics and ICN, BCH

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ST1 Paediatrics, East Midlands Deanery


2. Pinderfields Hospital, Wakefield

Letters
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