INSIDE THIS ISSUE:

Quality improvement and anaesthesia: A trainee perspective

WSM London 2014 preview

The Association ‘cycling top’ road test
In this month’s edition there is an interesting article on the skills and knowledge transfer that an anaesthesia trainee has used during a period working on patient safety.

We, as a professional group, are brought up in a safety culture, the first day usually involves an induction process and going through the AAGBI machine check. The discipline, learnt from the safety culture in anaesthesia, should be transferable to other areas of the hospital. I am sure that there are many anaesthetists actively involved in developing safety initiatives throughout the U.K. and Ireland. Please let us know about any projects that have had a positive outcome to a safer patient journey.

Trainees are our future. As the new starters open Anaesthesia News for the first time, those one year further on will be working hard towards the primary FRCA examination. Reading Mark Garcia’s article on representing Gibraltar and coming away with a gold in the team triathlon.

This year has seen the Anaesthesia Sprint Audit of Practice, “ASAP”, for hip fracture patients; deliver, what promises to be the biggest ever study looking at anaesthesia practice. This has been an important collaboration with The National Hip Fracture Database (NHFD). I would personly like to thank all the anaesthetists, of all grades, who have contributed to this project, which proved particularly difficult during the initial stages of the project. I would like to give a special mention to one particular trainee, who has now completed his training, called Amer Majeed. He worked tirelessly to get information out to anaesthesia trainees and offered advice to many over the whole process.

Last month a group of anaesthetists completed an epic cycle ride to the Annual Congress, in Dublin, in aid of Lifebox. We wore the alternative “green jersey” for the ride from London, via Cardiff to Dublin. This edition includes a road test of the original, and I should say, much sought after, red jersey. It was tested on one of the most difficult amateur races, the Etape du Tour. The designer of the jersey, James Kenningham also appears in the photo gallery. I would love to mention to one particular trainee, who has now completed his training, called Amer Majeed. He worked tirelessly to get information out to anaesthetists and offered advice to many over the whole process.

For further information and to register logon to www.sonomiteeducation.co.uk

For the full listing of Baltimore and Edinburgh courses, click here to go to www.sonomiteeducation.co.uk

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Editorial

UCU-RA-UK

These courses are organised by Regional Anaesthesia UK (RA-UK) in conjunction with SonoSite Ltd for training in ultrasound guided regional anaesthetic techniques. Previous experience in regional anaesthesia is essential – Awarded 16 Category 1 CPD credits from the RCoA and Counts towards the EERDA.

Course Dates: 29-30 November 2013

Location: Nottingham

Organiser: Dr Neel Badlani

Day 3:

1. Ultrasound appearance of the nerves
2. Motor characteristics and set up
3. Imaging and influencing techniques
4. Continuous approaches with brachial plexus / upper / lower limb
5. Workshops – using phantoms / models / cadaveric procedures (A)
6. Ablation based courses (with cadaveric phantoms)

Day 2:

1. Consultant teaching and image selection
2. Upper / lower limb techniques
3. Ablation / neuraxial techniques
4. Continuous single / double / block procedures
5. Workshops – using phantoms / models / cadaveric procedures (A)

Day 1:

1. Introduction to the brachial plexus / upper / lower limb
2. Workshops – using phantoms / models / cadaveric procedures (A)
3. Ablation based courses (with cadaveric phantoms)

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Anaesthesia News

Chair: Christopher Grifiths, BMJ Publishing Group
Editors: Kate O’Connor and Caroline Wilson (GAT), Val Bythell, Richard Griffiths, Nancy Wood, Seen Tijtje, Ian Watson and Tom Wootton

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The Ritchie Double Cross System

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The Association ‘cycling top’ road test

When I read that my old mate and cycling nut extraordinary James Kenningham had designed a top in the colours of our professional organisation, it was not a hard decision to purchase, but is it any good? To find out it needed to be road tested. First results on a local charity ride were encouraging, but where will you get the most conclusive results. If not on the biggest amateur cycling event of all, the Etape du Tour.

The 2013 edition was held in the absolutely stunning surroundings of the French Alps on a course around Annecy. Through a happy coincidence James took part, too, and he was able to witness and scientifically validate the testing procedure, by wearing a neutral, if expensive, top himself.

I have ridden the Etape six times to date, different tops each time, the designer ones, slightly comedy ones, my local bike shop’s, but I never had as much appreciation and friendly banter as in this one. “This must be the best top I have seen all day!” (There were 13000 to choose from.) I certainly kept people entertained and had quite a lot of good will from the general public for our specialty and the work we do. I know there were at least 6 British Anaesthetists in the race and I think I made at least one sale.

Unlike James who appeared to be in a hurry (1579th in 5:44 h), I made sure to maximise the exposure by keeping myself on the road for 9 h 15 min and finishing in position 10147 out of over 11000. Despite the heat and the general suffering of most of the riders the medical emergencies appeared to be minor and were dealt with excellently by the French emergency services. Over 800 riders did not finish. What can I say, you will see me in the same colours in the “Etape Cymru” in North Wales this September, and, of course, like I said the last five years, this was my last Etape. I don’t need to keep punishing myself. (A sneaky look at next year’s course won’t do any harm, though?)

P.S. There are rumours about a green colour version of the top which may call for more rigorous testing.

Any commission due to eventual sales will, naturally, as well as the fee for this little commercial, go directly to the Lifebox charity. Keep pedalling guys!

Dr Klaus Mahler
Consultant Anaesthetist, Walsall Manor hospital, West Midlands

It has been a fascinating year so far from the patient safety point of view. Robert Francis’s final report into the terrible events at the Mid Staffordshire NHS Foundation Trust was published in February. With 1,794 pages in its three volumes, and another 125 pages in the Executive Summary, it would not surprise me if some fewer readers were still working their way through it. The report made 290 recommendations, the details of all of which are, I am sure, indelibly imprinted on your memory. Who can forget the incisive Recommendation Number 220: “A (leadership) training facility could provide the route through which an accreditation scheme could be organised”, or the near poetic and potentially epoch-moulding Recommendation Number 284: “The Lord Chancellor should issue guidelines as to the criteria to be adopted in the appointment of assistant deputy Coroners”. Francis’s report was exactly what you would expect from a distinguished lawyer: forensic, detailed, analytical, precise and mind-crushingly long. The Royal Colleges leapt in with mostly platitudinous responses that explained how their approaches to patient safety would stop this sort of thing ever happening again, forgetting all the while that some of them were arguably in part the authors of the disasters that befall the people of Staffordshire, although admittedly more as a result of inaction than action. The Royal College of Physicians (RCP) boldly stated that it was “committed to continuing (its) leadership role in ensuring doctors take responsibility for holistic care”, adding that it was “looking forward to working…to develop more and better quality standards”*. The Royal College of Anaesthetists seemed to support the focus on more standards and guidance, arguing that “by setting clear evidenced guidelines for best practice…doctors can be reassured that they have specially specific expert guidance as a point of reference”. While most official responses from professional organisations took an overarching view, painted with very broad brushes, garlanded with the promise of more standards, I am proud to say that the AAGBI’s response was an example of sanity, simplicity and practicality that did not try to arch over anything. It challenged everyone who works in hospitals to ask themselves one simple question: “Would I want this sort of care for my family?”

Robert Francis’s report was followed in August by the publication of Don Berwick’s report entitled: “A promise to learn – a commitment to act”. The report is a reporty of positive mood in the NHS England. The two reports could not be more different: almost 2,000 pages and 290 recommendations in the final Francis Report; 46 pages of terse text and only 10 recommendations in the Berwick report. The forensic, legal dissection of complex regulatory structures in one report is completely overshadowed by the simplicity, honesty and good sense in the other. Berwick’s messages are clear and concise: abandon the blame culture; learn from your mistakes; listen to patients more; adequate staff numbers; simplify supervisory and regulatory systems; challenge every healthcare worker to be a quality assessor and to speak up when they see patients being put at risk; Berwick does not ask for more regulation or another layer of professional guidance, or for additional inspection to ensure that the latest batch of practice standards is being obeyed. His message links safety and simplicity – and this is a message that the AAGBI endorses.

This year has also seen “safety” developments in the field of anaesthetic equipment. I have placed the word “safety” in inverted commas for good reason, as I am becoming increasingly convinced that any device that has the adjectives “safe” or “safer” appended to it is likely to be highly likely that there is no published evidence whatsoever that the device is indeed safe, let alone safer, and (B) many of these devices seem to justify the adjective “safe” simply because they are largely ineffective at performing the task for which they were primarily designed. Let me explain using, as an example, the new safety cannulas that are being introduced following a recent European Council Directive (2010/32/EU - for those who are interested). I am sure that all readers of Anaesthesia News will be familiar with them – they strongly resemble ordinary cannulas but are cunningly designed such that after the device is inserted into a vein, any attempt to withdraw the needle from the cannula has two consequences: firstly, the automatic covering of the point of the needle such that it cannot then be inadvertently inserted into your anesthetic assistant or any other passing healthcare professional (this a safety feature), and secondly, the automatic removal of the cannula itself from the vein (this appears to be another safety feature). This is achieved by the simple creation of significant friction between the cannula and needle caused by whatever patented and devious process leaves the needle covered once it has been removed. Thus, as the needle is withdrawn from the patient, so is the cannula - et voila - a perfectly safe needle and cannula! Now that both the needle and cannula reside in the cardboard kidney dish used as a rubbish receptacle, we can see the breathtaking simplicity of the new “Much Safer Device” - a cannula that cannot be in any way implicated in a Never Event for, even if the wrong drug were to be injected through the cannula, its careful positioning in the cardboard kidney dish means that no patient harm could ever result. No overdoses will be given, no air can be injected intravenously and, even if a connection were to result, no Dasté incident forms would ever need to be completed.

Cynicism about new cannulas aside, I really do believe that simplicity and safety are closely related. I hope that we are now leaving an era in which patient safety issues were addressed by more regulatory bodies, more standards and more inspection. I want the Berwick report to be seen as a “low point in safety” and the Francis report to usher in a more positive mood in the NHS in which we focus on the relationship between healthcare professional and patient, in which both are listened to rather than lectured to, and in which errors are learned from, not punished.

William Harrop-Griffiths
President, AAGBI

References
Anaesthesia

Cases

Following the successful launch of Anaesthesia Cases earlier this year, the new website will become the sole route for submission of case reports with Anaesthesia or Anaesthesia Cases from 1st October 2013.

From 1st October 2013 case reports can no longer be submitted directly to Anaesthesia. The Anaesthesia Cases website is hosted by the AAGBI and may be reached here www.anaesthesiacases.org. Case reports will be considered for publication online at the Anaesthesia Cases website, and a proportion will be passed to Anaesthesia for possible publication in the Journal. Those not published by Anaesthesia will be passed back to Anaesthesia Cases for publication there. Once published online (or in the Journal for those accepted there), reports cannot be submitted for publication elsewhere.

As a trainee, I think most of us are looking for ways to stand out from the crowd. In order to make our CV look a bit different to the norm, so when I saw an advert for a Quality Improvement Fellow, I got my attention.

The Deanery in which I am working recognised the usefulness of quality improvement methodology and the immediate and long term benefits it can bring to areas of learning about quality improvement.

I found the multidisciplinary nature of the post, as well as the collaboration with other industries, notably engineering, particularly interesting. Working in anaesthesia, I feel we may be ahead of many of our colleagues with regard to human factors training, but there are many areas I feel we can learn from other high pressure industries.

I decided to apply for the job without discussing it with anyone, just a brief mention to my college tutor once I had submitted the form, who said ‘we should see what happens’, fairly pragmatically.

At the interview, it was explained that the project I would be assigned to would be relating to falls. Having had a short while to ponder things over prior to the interview, I would have been interested in looking at throughput of theatres or something a little more anaesthetic-focused, but I was keen and interested nonetheless.

Now the fun began. I still needed to pass my FRCA primary and this was very much a priority for me, whilst the programme was due to start after I received my job offer! This was clearly unacceptable to my department, and a fair amount of negotiation was required before it was agreed that I could undertake the project after taking my primary, and I had to pass it. So no pressure then!

With the necessary Deanery approval and FRCA in my pocket (thankfully), I began in early January. I had a non-medical colleague with a background in patient safety, who has been invaluable to work with. I have found the work, for the most part, fascinating. I have learned a great deal about how the NHs works and that the most important factor in driving a project forward is effective networking with the right people.

We have been very fortunate to have had a taught element to the course, ‘masterclass’ sessions have been delivered in association with the King’s Fund on a variety of topics by inspirational speakers. These were attended by Quality Improvement Fellows(QIFs) from around the Deanery. All of us who attended felt re-energised in our work having attended these sessions.

Alongside the taught element, Action Learning Sets took place periodically. These involved a facilitator and a ‘client’ with the remaining members of the group acting as a sounding board. Although initially, many of us felt that these were slow & frustrating, in retrospect these sessions allowed us to overcome many of the barriers we thought were slowing us down or stopping our project from moving forward. Most of the Quality Improvement Fellows came from relatively junior management positions if non-medical, or were trainees. However, the barriers we met were often similar; relating to lack of confidence in approaching senior management.

I have met some wonderful people whom I hope to have the honour of working with again, as well as gaining a far greater understanding of the NHs, how it works and how to get it to work for you. One of the most beneficial things for me has been meeting a QIF in the ambulance service. I am constantly impressed at how it manages to function to such strict targets, especially in a rural region. I have also been able to use his knowledge and contacts to facilitate my own project which has been very useful.

Finally, has the falls project been a success? Yes and no. We have tried lots of ideas; some have worked and some haven’t. The project still has a way to go and I am hopeful that more can still be done. At the moment, fewer serious falls have occurred in this year as compared with last, so fingers crossed, this will continue.

I know that personally I have gained an invaluable skill set, contacts and feel that it is time well spent. However, I intend to spend the forseeable future back in anaesthesia.

David Green,
CT2 in Anaesthesia,
Peterborough & Stamford Hospitals
The Ritchie Double Cross System

A technique for older anaesthetists to avoid leaving things in changing rooms

The need to develop a reliable technique became evident when I began to lose things in the changing rooms of Operating Theatres. I was aware that perhaps I was not alone and that the frequency of such events was directly related to the chronological age of myself and to that of other subjects under study.

Inspiration for this advanced, life-enhancing manoeuver came in one of those rare moments when frustration necessitated a solution. I remembered a joke.

The Joke

A priest was driving along a country lane. He came upon the scene of a motor vehicle accident - a car was in a ditch and beside it was a Jewish Rabbi, obviously the driver. The bemused priest noticed that the man was obviously crossing himself whilst looking at his severely damaged car. "My Son," said the priest - "what an awful accident. You are lucky to be alive and I can only assume it must have been so frightening that you have seen the light and converted to Christianity." "Don't flatter yourself, Priest" replied the Rabbi "After that accident I crossed myself in order to check my spectacles, my testicles, my wallet and my watch!"

Ch. = (I'm not that funny but read on!)

Inspiration Drawn From Necessity

Any man, greater than 45 years of age, and working in modern operating theatres is likely to have the following problems:

1. A need to use reading glasses.
2. Forgetting to do up their trouser zip.
3. A high incidence of having their wallet stolen.
4. An inability to wear a watch because of bare below the elbows policy.

All these items are likely to be left behind, or forgotten, particularly if working on multiple sites and in a rush. The first four items are easily remembered by the act of crossing oneself in the manner of the Jewish Rabi. But two other items kept being left behind. That’s when the “Double Cross” system came into its own because by repeating the horizontal part of the cross they could be checked as well.

5. One’s Pen
6. One’s Mobile Phone

After full Ethical committee approval, rigorous safety testing and informed consent The Ritchie Double Cross System for the elimination of tagging things in the changing rooms was implemented. It was validated in a double blind crossover trial involving one person. It was an absolute imperative of the trial that no animals be harmed – except the subject.

Results were astounding. The incidence of forgetting things fell dramatically. Financial costs have been zero, even beneficial, to the subject. There was a serious cost to the personal credibility of the subject when observed repeating the mantra in a crowded changing room but as he had long been thought going a bit ‘strange’ it didn’t seem to matter.

Technique in Detail

(Apologies to Leonardo da Vinci – Vitruvian Man)

The Ritchie Double Cross System has been proven to stop ‘mature’ male anaesthetists leaving thing behind in changing rooms (or emerging from such rooms unzipped).

Movements in Order

1. Lift hand to head & shout “Spectacles”
2. Lower hand to groin & shout “Testicles” (but actually check zip!)
3. Cross hand to right side & shout “Wallet”
4. Cross hand to left side & shout “Watch”
5. Repeat cross to right side & shout “Pen”
6. Repeat cross to left side & shout “Phone”

Conclusion

The Ritchie Double Cross System has been proven to stop ‘mature’ male anaesthetists leaving thing behind in changing rooms (or emerging from such rooms unzipped).

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Dr Peter Ritchie
Consultant, Chesterham & Gloucester Hospitals

UP TO £750

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Quality improvement and anaesthesia

A trainee perspective

On the 5th of July 1948 Aneurin Bevan imbued the National Health Service (NHS) with its founding principles of universality, equity and quality (Figure 1)1. Some 65 years later and in light of the recent Francis inquiry it would appear that his vision is far from reality2.

During this time, societal transition from post-war to consumerism culminated in the recent global financial crises dictating change in all industries and organisations. If the NHS and its founding principles are to prevail then a fundamental change in direction and more importantly culture is required. Paramount in this is patient safety and overall quality improvement.

What do we mean by quality in health care?

The Institute of Medicine defines ‘quality’ using six internationally recognised dimensions of care (Figure 2)3:

- Safe;
- Patient-centred;
- Effective;
- Timely;
- Efficient; and
- Equitable.

Robert Francis QC (2010)

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- Equitable.

Robert Francis QC (2010)
Although anaesthetists have strong historical links to patient safety and clinical audit the transition to improve science is relatively new. As external factors continue to drive system change within the NHS, it is clear that the focus in performance and its assessment will become essential development skills for all. This has, in part, inspired the Royal College of Anaesthetists publication ‘Raising the Standard: a compendium of audit recipes’ where an entire chapter is assigned to basic improvement techniques developed by the Associates in Process Improvement and taught through the Institute for Healthcare Improvement (IHI). A personal experience Two years ago during another general anaesthetic rotation at a district general hospital I decided to try to undertake a management project. Having no idea where to start I arranged a meeting with my line manager where several topics were discussed. The Royal Alexandra Hospital, Paisley serves a population of over 200,000 and runs the busiest trauma service in Scotland. Recent imbalances in the system had resulted in elective theatre cancellations despite the theatre running 7 days per week. Resultant clinical pressures runs the busiest trauma service. Recent imbalances in the system had resulted in elective theatre cancellations despite the theatre running 7 days per week. Resultant clinical pressures had led to many other similar endeavours. As the largest single hospital in the study period to 09:11 as depicted in the run chart and representing a non-random change in trauma service. Interestingly and in keeping with many improvement projects this process change was not maintained over time with some regression back to baseline at one year highlighting the need for ongoing clinical commitment. (Figure 5).

Taking everything into consideration by far the most challenging aspect of this project was changing the pre-existing mind set and culture of the health professionals involved. In this regard it became readily apparent at a very early stage that clear, two-way communication from top to bottom at all levels was essential. Realised, a successful implementation of change management, this pilot project triggered a positive transformation within our institution that led to many other similar endeavours. As the largest single hospital specialty. Anaesthesia plays a pivotal role in the peri-operative care of a wide variety of patients, making us ideal candidates to champion the quality improvement process. If however, improvement science is to be taken seriously across the board other specialists urgently need us to get on the same line.

Dr Antony Vassalos Consultant in Anaesthesia Golden Jubilee National Hospital, Clydebank

Professor Kevin D Rooney

Dr Justin Phillips

Consultant in Anaesthesia

Laurence Ayrton and Somerset NHS Trust

References

1. Delamothe T. Founding Principles.
Once again the time has come to book your place for the AAGBI WSM. We have uploaded the programme onto the AAGBI website earlier than ever this year, so that you have plenty of time to book your study leave and get some good deals on travel and accommodation.

SESSIONS

This year we are delighted to welcome the APAGBI and the OAA who are hosting sessions for us:

APAGBI: Codeine in children - problems and alternatives (Dr Mike Trumett, UK); Surgery and anaesthesia in the DGH – an endangered species (Dr Kathy Wilkinson, UK); Red flags in paediatric anaesthesia (Dr Simon Courtman, UK)

OAA: The good, the bad and the ugly (Dr Thierry Girard, UK); Measuring sedation (Prof Pedro Gambus, Spain); Barcelona, National Journal session: BP control during GA for the elderly, the problem of systolic hypertension (Dr Rob Sanders, UK)

We also have sessions on:

- APAGBI Guidelines
- Innovation
- Independent Practice
- AAGBI Panel discussion with AAGBI Council Members and Dr Mark Porter, Chair BMA Council

Our ever popular Core topics opens WSM London with 16 x 25 minute lectures on a variety of topics such as: How to write a Reflection, Microbiology on ITU, Generation Y, How to read an ECG, Latest thoughts on fluid therapy, Cardiac output measurement (Dr Andrew Klein, UK), Nitrous oxide (Dr Rob Sanders, UK).

Safety supported by SALG: Five things you can do to improve patient safety (Prof Alan Merry, Auckland). Output from incident reporting (Dr John Woodcock, UK) and Mortality and outcome reporting (The Establishment of an integrated reporting system (Dr Mano Kamar, UK).

Wellbeing: The importance of a good working environment, (Speaker TBC). The effect of the ageing workforce on the NHS (Dr Mike Blayney, UK), Hume, airway, and ARDS - an overview of current practice and knowledge.

DEBATE

As a finale to close WSM, we have a fun and controversial debate seeing the clash of 3 Titans. Dr Craig Morris will challenge Prof Mervyn Singer to debate: Goal-directed fluid therapy: in the net or over the bar? Mervyn will propose that the motion that GOT is part of a good anaesthetic, have perspective micopapillary growth in the lung. Who will win your vote, or more importantly, who will change your mind?

KEY SPEAKERS

This year we have some very exciting and unusual topics lined up for you. Mr Piers Mitchell, Consultant Paediatric Orthopaedic Surgeon from Peterborough will be talking about ‘The Scientific Bridge. He will undoubtedly give us some top tips on team building in designing the Velodrome, Lansdown road and fixing the Millennium Bridge. We will be returning to the Savoy for our Annual Dinner. This year we have negotiated hard and have reduced the price of the dinner ticket. Last year, the food and wine were superb and the ambience glorious. If you only know one person going, you can always request to sit next to them, and after milling round with a glass of champagne, you will be surprised at how many other people you know at the dinner.

For those of you who want to burn calories in order to eat calories, Dr Richard Griffiths is once again leading the 5k run.

Social Events:

We are now making the parents and baby room a regular feature of WSM, GAT and Annual Congress. Meet other parents, look at all the resources that we have available for you, and, get the lectures from the main auditorium streamed directly to you. We are providing this facility for you, so use it! The more we can do to help parents, juggling families and partaking in CME and CV enhancing activities, the better.

WSM LONDON

QEII Conference Centre, Westminster

15-17 JANUARY

2014

WORKSHOPS

This year, we have some old favourites and some new ones to wet your appetite. The GMC, in their guidance on CPD, have identified that “You should however seek a variety of activities that allow you to learn in different ways.” Our workshops provide a great alternative to didactic lectures:

- How to Publish a paper Prof Jaijeep Pandit and the team from Anaesthesia
- Regional Ultrasound Workshop (RA-UK) led by Dr Mome Wolmarans on upper limb above the clavicle; upper limb below the clavicle, spinal sonography and lower limb
- Paediatric workshop led by Dr Dave DeBeer and the team from GOSH
- TOE led by Dr Sue Wright
- Human Factors - Non technical skills led by Dr Manisha Kulkarni and the team from Chelsea and Westminster
- GE Healthcare Workshop on CPX
- Mentoring sessions led by Dr Nancy Redfern and her excellent team of trained mentors. These are free drop in sessions and can be booked in advance or at the registration desk. Book early, these slots get snapped up quickly.

We will be running mock Consultant Interview sessions with a panel of Consultants throughout the WSM. These sessions are part of the Seminar they run at the Portland Place. The Seminars are always oversubscribed, and as over 100 trainees attend the WSM we thought it would be nice to bring the opportunity to WSM.

- Dr Nancy Redfern and Kathleen Ferguson will be running an interactive round table workshop on ‘Revalidation’

Trainees

Apart from all of the lectures and workshops, and as mentioned before, we have mentoring sessions, consultant interview practice sessions and the trainees lunch, which is an opportunity for Trainees to mingle with Council Members and the GAT committee. We also hope that many of you will ask questions at the AAGBI interactive question time where members of the Exec of Council and Dr Mark Porter, the Chair of the BMA, will be able to give you honest and frank answers to your questions.

Parent and Baby Room

We are now making the parents and baby room a regular feature of WSM, GAT and Annual Congress. Meet other parents, look at all the resources that we have available for you, and, get the lectures from the main auditorium streamed directly to you. We are providing this facility for you, so use it! The more we can do to help parents, juggling families and partaking in CME and CV enhancing activities, the better.

Book online at www.wsmlondon.org
The importance of meeting Ernest.

“An elderly patient who changed my views on anaesthesia.”

“My date of birth? Certainly. It’s the twenty-fourth of September, nineteen twenty-one.”

“Nineteen twenty-one?” I can hardly conceal my surprise.

“In retrospect, he’s probably had the same line delivered countless times through his implausibly long life.

“Yes.” A hint of a smile creeps into the corner of his mouth. He knows what is coming, he says with a tentative smile, “I can hardly conceal my surprise.”

“I’m not surprised. I take a moment to look at Mr Ernest Kenway again. He’s a tall, slim gentleman with a rigidly relaxed posture; his feet, encased in weathered but sturdy brown boots, are firmly planted on the ground; his knees, hidden behind well-pressed light beige chinos, are bent to near ninety degrees; and his arms, tucked in the long sleeves of his blue and white checked shirt, are hanging along the faux wood armrests of his pastel green NHS issue armchair. His nose is pointy but not excessively sharp; his cheeckbones are well demarcated but not obtrusively so; and his mouth is topped by a thin, closely-cropped patch of sandy-white hair. The only features that belie his true age are the spoke-like pattern of numerous minute wrinkles radiating out from his brilliant blue eyes and the plan J-shaped wooden walking stick hanging from the headboard of his pre-admission unit bed. In short, this isn’t what I expected from a ninety-one-year-old on an orthopaedic list. As for impressions go, Kellgren & Lawrence grade IV osteoarthritis of the hip looks quite pleasant.

For a man in his tenth decade of life, Mr Kenway’s medical history is remarkably unremarkable. Aside from a childhood appendicectomy and an episode of pneumonia over thirty years ago he seems to have kept a clean bill of health for most of his life. It’s possible that his career in the navy is the major contributing factor; one can only imagine the long term health benefits of forty years of intensive physical activity with regular military medicals. Or perhaps it’s more a reflection of his determined personality; even as a retiree he ran marathons for fun, and then when his knees no longer held him up he started long distance cycling. Or maybe it’s just a result of his constitution; he’s a lucky winner of the genetic lottery.

Whatever the cause for delay, it seems inevitable that age catches up with us all eventually. Aged eighty-seven, and troubled by right hip pain, he reluctantly went to see his GP. It was as he feared: osteoarthritis. With the diagnosis came a prescription for paracetamol (one gram four times a day) and the acknowledgement of age. In the time since, his hip has held up remarkably well. Even with old creaking joints Mr Kenway was still a keen walker. Then in the last twelve months things started to deteriorate. The choice was clear: take his chances in the operating theatre, or live on with the pain and the prospect of progressive immobility.

References
Far and wide

The cycling jerseys have been sent far and wide, there are some in Australia and a couple in New Zealand.

It is worth reflecting, that each one sold does buy a small part of an oximeter for operating theatres that do not have them. I am old enough to have worked pre oximetry, I cannot imagine delivering anaesthesia without one.

If anybody has photos of cycling trips from around the World can you please email them to anaenews@aagbi.org, the jerseys prove a big talking point on sportives, even when you are feeling particularly hypoxic on a long climb.

The runners won't be left out for long, as the running tops are now available. Please continue to support Lifebox and buy your gear using the order form on the opposite page.

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Registered Charity in England & Wales (1143018)
Dear Editor,

We are writing to remind other readers of the Anaesthetist’s role in ensuring sterile operating fields are not compromised.

We were recently involved in providing anaesthesia for a patient undergoing an emergency laparotomy. The patient had skin prep-applied, and was draped by the surgeon to produce a sterile field. Having elevated the drapes to provide a “blood-brain barrier” we noted that there appeared to be a mark on the surgical drapes (Universal Set, Standard; 365 Healthcare Ltd).

On closer inspection it became apparent that a fly had become embedded within the “underside” of the drape during the manufacturing process (see Fig 1). We informed the operating surgeon, who was unable to see this contamination from their position (see Fig 2).

As the sterility of the surgical field had potentially been compromised, the team elected to repeat preparation and draping.

Sadly the area of contaminated drape containing the fly was required by the scrub team to return to the manufacturer as part of the clinical incident reporting process, and we were unable to exhume and formally identify the insect!

Matthew Creed, CT 1 Anaesthesia, Department of Anaesthesia, Worcester Royal Hospital

Satinder Dalay, CT 2 Anaesthesia, Department of Anaesthesia, Worcester Royal Hospital

Jo Marriott, Consultant Anaesthetist, Department of Anaesthesia, Worcester Royal Hospital

Dr Matthew Creed, CT 1 Anaesthesia, Department of Anaesthesia, Worcester Royal Hospital

Dr Satinder Dalay, CT 2 Anaesthesia, Department of Anaesthesia, Worcester Royal Hospital

Dr Jo Marriott, Consultant Anaesthetist, Department of Anaesthesia, Worcester Royal Hospital

Dear Editor,

Further to the cycling theme of the March 2013 editorial, in our department this number of bicycles you need is defined as “d – 1” where d = number of bicycles that will result in divorce.

Michael Charlesworth, Core Trainee 1, Pinderfields General Hospital, Wakefield

Dear Editor,

Your readers may be interested to learn that, on the Aspire View anaesthetic machine, which is commonly used in theatres up and down the country, the FiO₂ alarm will only sound when it drops below 0.18. (see diagram)

Rose McRobert, Consultant Anaesthetist, Ayr Hospital

Regional Anaesthesia Course 2013

course organised by the John Hammond Department of Anaesthesia, East Surrey Hospital, Redhill

Great transport links – only 10 mins. from Gatwick Airport

Course Director:
Dr Frederic Sage, Consultant Anaesthetist, East Surrey Hospital

Keynote speakers:
Dr Ki Jinn Chin, Associate Professor of Anaesthesia Toronto Western Hospital
Dr Lukas Kirchmair, Consultant Anaesthetist, AUVA Trauma Centre, Salzburg

Wed 20 Nov 2013, East Surrey Hospital, Redhill

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Fri 22 Nov 2013, St George’s Hospital, London

CADAVERIC ANATOMY WORKSHOPS AND LECTURES
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The Editor, Anaesthesia News at anaenews.editor@aagbi.org
Please see instructions for authors on the AAGBI website

Fig 1

Fig 2

As the sterility of the surgical field had potentially been compromised, the team elected to repeat preparation and draping.

Sadly the area of contaminated drape containing the fly was requested by the scrub team to return to the manufacturer as part of the clinical incident reporting process, and we were unable to exhume and formally identify the insect!
On the 12th July I was lucky enough to join over 2000 athletes to take part in the 2013 International Island Games.

Essentially a “mini-olympics” held every 2 years, the Island games sees athletes from 24 islands around the world compete in 16 sports over 6 days. With most events having professional athletes that regularly take part in the Olympics, Commonwealth games and World championships, the level of competition is high. This coupled with fantastic facilities, incredible weather and thousands of crazy Islanders, provided a spectacular exhibition of sport at its best.

Obviously my decision to compete was based entirely on a desire to represent my beloved Gibraltar* in the Triathlon, and had nothing to do with the fact that this year the Games were held in Bermuda.

Taking place on the first day of the games, the Triathletes had the least amount of time to acclimatise to the 38 degree heat and near 100% humidity. The tough Olympic-distance course didn’t make life easier either, and together these factors took their toll on the athletes, with many competitors dropping out and/or needing IV fluids and ice baths afterwards. The northernmost islands were understandably the worst affected. Of note, the entire Greenland team seemed to go missing during the race, presumably evaporating soon after exiting the water.

In the end, however, the suffering seemed worth it as Team Gibraltar’s averaged time earnt us the coveted Triathlon team gold medal, something that we had been training towards for the last 18 months.

The next 6 days were spent cycling around the island (with regular beach stops), supporting the other events and ‘revising’ for the primary exam. Yes, mostly revising for the primary exam.

We also decided to film the team doing a specialised training session; something that we feel gives us the edge on competition day (just youtube “Gibraltar triathlon harlem shake” and you’ll understand).

Next stop is the World championships in London this September and then after a couple of Ironman distance races next summer the team will start planning for a slightly less tropical but equally anticipated games in Jersey 2015.

*And for the eagle-eyed amongst you wondering how on earth Gibraltar, a peninsula, managed to get into the Island games; the games began while the border with Spain was still closed. This provided the argument that the isolated Gibraltar was, for all intents and purposes, an island and as such should be allowed to take part.

Mark Garcia, C12 in Anaesthesia, Peterborough & Stamford Hospitals

On the 12th July I was lucky enough to join over 2000 athletes to take part in the 2013 International Island Games.
The ability of bispectral index to detect intraoperative wakefulness during isoflurane/air anaesthesia, compared with isolated forearm technique

Russell IF.

Isolated forearm – or isolated brain? Interpreting responses during anaesthesia (or ‘dysanaesthesia’)

Pandit JJ.

Certainty and uncertainty: NICE guidance on ‘depth of anaesthesia’ monitoring

Smith D, Andrzejowski J, Smith A.

Perhaps we should abandon unconsciousness as the prime objective of general anaesthesia, replacing it with the aim of avoiding suffering, both intraoperatively and postoperatively. This would allow for various intraoperative brain states whilst avoiding unintended consequences of attempts to obliterate any coordinated neural activity.

Three papers in this issue of Anaesthesia address different aspects of this theme. Dr Russell provides further evidence that between one and two thirds of ‘anaesthetised’ and otherwise paralysed patients will squeeze their isolated hands in response to command. One might expect that both the action and recall of movement would be accompanied by movement in response to pain and the memory of pain, which was not the case.

I’ve questioned the word ‘anaesthesia’, because if we don’t know what consciousness is we can’t define its absence. This forms one thread of Professor Pandit’s editorial: a motor response doused in anaesthetic drugs is not the same as a similar response without drugs. The Titan supercomputer and the simplest calculator can sum 1+1, but only the former at over 10 petaFLOPS.

Professor Smith and colleagues point out that only a dipstick would measure anaesthetic effects as a depth. Above the neck, spinal motorways rapidly entangle into swirling spaghetti junctions and traffic lights. NICE have shone a green light on BIS and the like, but if anaesthetics turn some neural traffic lights red, all one can see in green light is the dark.

J. B. Carlisle,
Editor, Anaesthesia

N.B. the articles referred to can be found in either the latest issue or on Early View (ePub ahead of print).
The Wyile Medal will be awarded to the most meritorious essay on this year’s topic related to anaesthesia. Something old, something new, something borrowed, something blue written by an undergraduate medical student at a university in Great Britain or Ireland.

**THE WYLIE MEDAL UNDERGRADUATE PRIZE 2014**

Prizes of £500, £250 and £150 will be awarded to the best three submissions.

The overall winner will receive the Wyile Medal in memory of the late Dr W Derek Wyile, President of the Association 1980-82.

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

Closing date: 06 January 2014

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**PRIMARY FRCA OSCE/VIVA COURSE**

**DATE:** THURSDAY 16th & FRIDAY 17th JANUARY 2014

**VENUE:** Clinical Education Centre, Leicester Royal Infirmary

**FEE:**
- Thursday OSCE £140.00
- Friday OSCE/VIVA £140.00
- Thursday & Friday: £260.00

Lunch/refreshments and car parking (if required) included
Please Note: Accommodation is NOT included

This is a 1 or 2 day course devoted to intensive VIVA & OSCE preparation, individual appraisal, and small group tutorials directed by experienced teachers and examiners. Candidates can register for 1 day or both days depending on requirements.

TO REGISTER PLEASE EMAIL YOUR DETAILS TO st155@le.ac.uk OR CONTACT FRCA COURSE ADMINISTRATOR SAN THORPE ON 0116 258 5735.
Leaders’ and followers’ individual experiences during the early phase of simulation-based team training: an exploratory study.

Lisbet Meurling, Leif Hedman, Li Felländer-Tsai, Carl-Johan Wallin

Introduction:
Effective teamwork is essential for better patient outcomes. Doing repetitive simulation allows teamwork to be practiced. Current simulation based training fails to concentrate on the whole team, including followers. This exploratory study aimed to assess individual experiences and behaviours of novice leaders and followers to simulation based team training (SBTT).

Methods:
Medical students on elective courses in emergency medicine, trauma, anaesthesia and intensive care were offered to participate in the study. All courses included standardised lectures in physical examination and teamwork training. Participants were consented and study approval was obtained from the review body.

Volunteers were students in groups of 3-5 attending training, which concentrated on patient care. A video scenario was played and the video was shown on a projector in front of the entire group. The group was divided into three teams: leaders, followers and nonspecialists. The nonspecialists were asked to observe and not participate. The video was shown twice, with a brief interval between the two showings. The first time the video was shown, the groups were allowed to watch and take notes. The second time the video was shown, the participants were asked to comment on what they had just seen. The discussions were video recorded for further analysis.

Results:
Eighty-five students participated and 36 video scenarios were analysed. Being novices, none of the students could medically stabilise the patients before help arrived. Their attempts to save the patient could not be achieved. Following training there was a significant increase in the ability to stabilise the clinical scenario (p<0.04) and participants scored better as leaders. The self-efficacy improved for the whole group post training with a significant effect size of d=0.85. Students experienced more strain as a team leader than as a follower.

Discussion:
The multi-modal exploratory study assessed individual experiences and behaviours (as a team leader and follower). After training, the participants’ self-efficacy improved and the team’s clinical performance improved modestly; although the medical goal was not achieved. Performance as a team leader efficacy improved and the team’s clinical performance improved modestly, although the medical goal was not achieved. Measurement should be focused on responder analysis, a more patient friendly measure rather than average effect. Finally clinical trials are addressed in which clinical effectiveness is advocated as a more useful measure rather than average effect.

Dr Christopher Browell
CT2 Northern Deanery

Speed of spinal vs general anaesthesia for category-1 caesarean section: a simulation and clinical observation-based study

Lisbeth Granli, Leif Hedman, Li Fellander-Tsai, Carl-Johan Wallin

The National Institute for Health and clinical Excellence recommends delivery as quickly as possible where there is immediate threat to maternal or fetal life. Clinical observation was undertaken in 100 category-4 caesarean sections. Each procedure was timed from entry into theatre until the end of the intrathecal injection. Measurement should be focused on responder analysis, a more patient friendly measure rather than average effect. Finally clinical trials are addressed in which clinical effectiveness is advocated as a more useful measure rather than average effect.

Dr Christopher Browell
CT2 Northern Deanery

References:

Spinal:

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<th>Simulation</th>
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<th>Total time</th>
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Table 1: Times (median) for simulated and clinical spinal anaesthesia, and simulated general anaesthesia. Values are median [IQR] (range) or median (range).

Discussion:
Regional anaesthesia is recommended for delivery of the fetus as it reduces maternal and neonatal morbidity. Complications of general anaesthesia are associated with physiological changes of pregnancy. Increased frequency of regional anaesthesia makes general anaesthesia in pregnancy less familiar. The procedural aspect of spinal with general anaesthetic med was around 6-8 min and intubation respectively. Surgical block development time was remarkably varied. 3-7, 4-9 min. Level of block was dependent upon the individual anaesthetist and this may explain the variation. This has shown spinal anaesthesia is slower than general anaesthesia for a category-1 caesarean section. Spinal anaesthesia is limited by the varied onset time to achieve adequate surgical blockade.

Dr Christopher Browell
CT2 Northern Deanery

References:

Background:
Regional anaesthesia is recommended for delivery of the fetus as it reduces maternal and neonatal morbidity. Complications of general anaesthesia are associated with physiological changes of pregnancy.

Pain management in many patients does not work and research around this continues. Pain management is essential to achieve surgical blockade. Clinical observation was undertaken in 100 category-4 caesarean sections. Each procedure was timed from entry into theatre until the end of the intrathecal injection. Measurement should be focused on responder analysis, a more patient friendly measure rather than average effect. Finally clinical trials are addressed in which clinical effectiveness is advocated as a more useful measure rather than average effect.

Dr Christopher Browell
CT2 Northern Deanery

References:

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CT2 Northern Deanery

References:

Dr Christopher Browell
CT2 Northern Deanery

References:
New AAGBI guide: Who is the Anaesthetist?

This guide is designed for medical students and foundation doctors who are considering a career in anaesthesia. Historically, junior doctors were able to spend several years sampling different specialties before making their career choices but this is now increasingly difficult. Foundation doctors have to make tough decisions about their future careers, sometimes with limited knowledge and experience of the possibilities.

We hope to explain what a career in anaesthesia entails and explore some of the aptitudes and skills required. We hope that this will allow you to make a more informed choice and so start on a successful, enjoyable and rewarding career.

View the latest guideline online at:
http://www.aagbi.org/publications/publications-guidelines/32

Undergraduate Elective Funding Up to £750

Medical students in the UK and Ireland are eligible to apply to the Association of Anaesthetists of Great Britain and Ireland for funding towards a medical student elective period.

Preference will be given to those applicants who can show the relevance of their intended elective to anaesthesia, intensive care or pain relief.

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

Closing date: 06 January 2014

Going Greener!

The AAGBI is turning greener, and in order to reduce our carbon footprint, we will be publishing the Events flyer every two months. We will still be giving you timely information and would also encourage you to connect with us on Twitter and Facebook or simply access the Events page on our website for information on all of our events on www.aagbi.org

Latest safety updates

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www.aagbi.org/safety/incidents-and-alerts

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