Membership survey - have your say

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<table>
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<th>FACT</th>
<th>Ultrasound guided anaesthesia improves patient care</th>
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<tr>
<td><strong>Risk of Failed Nerve Block</strong></td>
<td><strong>Post-Operative Pain Score</strong></td>
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<tr>
<td>1.25%</td>
<td>0.3</td>
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<td>8.75% reduction</td>
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<td><strong>Nerve Block Duration</strong></td>
<td><strong>Time to Reach Discharge Criteria</strong></td>
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<td>11.3 hrs</td>
<td>120 min</td>
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<td>24% improvement</td>
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<td>15 hrs</td>
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**Peripheral Nerve Stimulation** | **Ultrasound-Guided**
There is something special about September. The air is fresher. We return from the beaches, invigorated, tanned, and filled with new enthusiasm for the job. We set about completing all those tasks which seemed impossible or pointless only a few weeks earlier. Everything is possible, nothing is too much trouble. Even the mandatory training. OK, maybe I’m getting carried away. Anyway, this splendid state generally lasts at least until Annual Congress, when those of you who attend can feed this enthusiasm with new ideas and insights. This year, we are in Edinburgh and I really think this will be an outstanding meeting. I won’t be able to be there for the whole meeting, because it is my turn to a do some ‘real’ work so that my colleagues can go instead, but I am sure I will be there for at least one day. I look forward to seeing you there!

This year, we return to unusual challenges in both our professional and our domestic lives. MPs return to Parliament to a financial mess. It may seem in hindsight that expending quite so much time and effort to work out that the practice of obtaining information illegally was widespread amongst the media, whilst the European and global economies and indeed the political structure of Europe is under threat was misguided. Whatever plan B is for the economy, it is unlikely to involve doctors being paid more or the health services in general receiving more funding. The submission of NHS employers to the Doctors and Dentists Review Board (DDRB) in England and Wales [1] makes salutary reading; three of the main points made are that incremental pay progression means that our pay effectively continues to rise, that recruitment and retention is stable and that we are more likely than other NHS staff to report satisfaction with our levels of pay. With respect to clinical excellence awards, the message of NHS employers is plain – ‘Employers believe that the current arrangements for consultant clinical award schemes should end ….. or be significantly reformed.’ [2]. Specialist Societies (including the AAGBI) received a letter in May from the advisory committee on clinical excellence awards (ACCEA) warning us that the DDRB is considering its response to the proposal from NHS employers that new national awards should not be made in 2012 (it may already have announced its decision by the time you receive this). Whilst many of you will not cry over this, and indeed many in the profession might have supported a process of change, it seems likely as I write that this will simply be money lost to the profession. Together with pay freezes, increased pensions contributions and so on, we will all be feeling the pinch in our pay packets. At the same time the cost of everything is rising (though we at the AAGBI are
Editorial continued

For some years now NHS employees have been able to purchase a copy of Microsoft Office for home use for less than £20. This has been due to an agreement between Microsoft and the NHS called the Home User Programme (HUP). In mid-2010 this agreement came to an end and any NHS employee who had taken advantage of the HUP was obliged to uninstall the software or buy a full licence from Microsoft to remain legal.

OFFICE SOFTWARE

OpenOffice.org (its formal name for copyright reasons) is the original free replacement for Microsoft Office. The full package contains word processing, spreadsheet, and presentation software, plus a database, drawing and formula programs. It is completely free to download from the organisation’s web site. Versions are provided for Windows, Mac OS X, Linux and other operating systems. Updates are issued regularly across all platforms. Although OpenOffice has its own open file format, modules can open and save files in the formats of other office software packages, including Microsoft Office (.doc, .xls, and .ppt). The translation between formats is usually perfect but editing can sometimes be required to correct minor errors.

OpenOffice has spawned several derivatives, or ‘forks’. This has been possible because the software code is open source and anyone with the requisite skills may create their own version. Lotus Symphony provides word processing, spreadsheet and presentation software derived directly from OpenOffice, while NeoOffice is a fork designed purely for users of Mac OS X. NeoOffice has the same modules as OpenOffice but claims to be faster and more compliant with OS X’s conventions than OpenOffice itself.

The AAGBI members’ survey will have landed on your doormat with your paper copy of Anaesthesia News this month. We’re keen to find out from you, our members, what you think about us, our work and the service we provide to you. It’s been some years since we carried out a survey and we need to ensure that our activities continue to reflect your needs, views and opinions so that the AAGBI can continue to support you and your career for years to come.

Please help us by either filling in the survey online at www.enventure.co.uk/aagbi/survey.htm, or fill in the paper copy and send it back using the freepost envelope provided. The survey should only take 10-12 minutes to complete, and we really appreciate your taking the time to complete it. If you have any questions about completing the questionnaire, please call the survey helpline on 0845 345 9110 or email Matthew at our market research company aagbi@enventure.co.uk

Val Bythall


FRONT COVER PHOTO COMPETITION

‘Apologies to all entrants for the photo competition in September; as we are distributing our members’ survey, we have decided to defer the competition until next month. We will consider the entries for September for publication in October, and if there is sufficient interest we will extend the competition by an extra month at the end’.

Val Bythall

The most recent fork is LibreOffice. Sun Microsystems had been a major sponsor of OpenOffice.org since its inception. During 2010 Oracle Foundation bought Sun. A number of developers working on OpenOffice.org became unhappy with the direction in which they thought Oracle might take the project so, in September 2010, they left to form the Document Foundation with the aim of producing a truly open suite of office software — although they do, necessarily, have some major commercial supporters. Using the open source code from OpenOffice.org they managed to produce the first production version, LibreOffice 3.3, in January 2011. Version 3.3.1 was released in late February. For all intents and purposes LibreOffice is an upgrade of the last version of OpenOffice.org. There are versions for all the popular operating systems plus a portable version. As with all the other free open source office software suites it can be downloaded for nothing from the internet.

An alternative approach, which is advocated by some, is to move wholly to Cloud-based computing, creating documents on a web server using web-based applications. At the moment this is probably not viable as a full replacement for a suite of office software but those who have a Google/Gmail account might find GoogleDocs worth trying.

**EMAIL, CALENDARS & ADDRESS BOOK**

Those who have been using Microsoft Office in the hospital and at home have probably become accustomed to using Outlook as their email client, and also for their calendar and address book. There are many alternatives. Not all of the alternatives provide a single integrated replacement but they are free and the different elements can work together harmoniously.

Users of Microsoft’s Windows operating systems may decide that the software provided with their version of Windows will do everything they need. Only the most sophisticated users will be disappointed. Windows Vista, for instance, comes with Windows Mail, Windows Calendar, and Windows Contacts. Windows Live Mail is a more recent product and integrates email, calendar and address book in one application. Mac OS X has Mail, Address Book, and iCal already installed. Although they are separate programmes they do work together. To Do Lists can be set up to be visible simultaneously in Mail and iCal, while one click adds meeting invitations received by email to iCal or the email addresses of senders to Address Book.

On both Windows and Mac OS X the mail client can send and receive emails from multiple service providers. These can be configured using POP or IMAP, depending on the preferences of the user and the facilities of their email provider. For instance, Google’s Gmail can use POP or IMAP, although IMAP is recommended. Yahoo mail, on the other hand, can only be configured using POP.

More technically adept users might want to try one of the free packages available on the internet. There are many of them. Evolution was originally an integrated email, address book and calendar for use on Linux systems. A version is now available for Windows but not for Mac OS X. It rivals Windows Live Mail as an integrated solution to replace the functionality of Outlook. The Mozilla Foundation, producers of the popular Firefox web browser, have a cross-platform mail client called Thunderbird which includes an address book. They also produce a stand-alone calendar, Sunbird, but this is being superseded by Lightning, a calendar and schedule manager that integrates with Thunderbird (so there will be Thunderbird and Lightning!). The cross-platform Web browser, Opera, has a built-in email client, while Eudora Open Source Edition is another cross-platform email client from the Mozilla Foundation that shares code with Thunderbird.

There is an alternative strategy to using an email client on your personal computer, and that is to keep everything in “the Cloud” by using webmail. Doctors.net.uk, Yahoo, Hotmail and Gmail/Googlemail, are popular examples. These portals all include calendar/scheduling and contact management functionality and can be linked with the relevant applications on a smartphone. Calendars can also be shared with named individuals. The only downside to this approach is that it requires a reasonably reliable and speedy internet connection. In this scenario it is not possible to read and reply to email “off-line”.

NHSmail can also be accessed from any computer using an approved web browser. It uses Microsoft Outlook Web Access and provides a secure environment for the exchange of sensitive information about patients. NHSmail includes calendar and contact management functions and has undergone many improvements over the years. It is likely to become the preferred email system for all NHS employees as local NHS Trust email systems are phased out. It can also be synchronised with many smartphones, although this may require the purchase of a special app.

**CONCLUSION**

The fact that Microsoft has withdrawn the Home User Programme does not mean that users must go out and buy the full price version of Microsoft Office. There are plenty of alternatives, and many of them can be downloaded for nothing from the internet.

A P Madden, Bristol
president@scata.org.uk
Patience is required!

1. Spinal model is placed in plastic box
2. The essential ingredient, gelatine
3. Gelatine should be slowly sprinkled onto hot water and stirred in
4. Phantom must be placed in fridge for gel to set
5. The end product
6. Real time ultrasound guided spinal
7. Paramedian vertical probe position on lumbar spine
8. Paramedian vertical probe position on sacrum
A Google™ search led to the identification of two papers published in the past twelve months which described the production of gelatine models for this purpose. In 2010 Bellingham et al described the development of an ultrasound phantom of the lumbosacral spine by immersing a lumbosacral spine model in a concentrated gelatine solution[1]. They concluded that it offered a chance for trainees to “familiarise themselves with the sonoanatomy of the lumbosacral spine in addition to practicing probe handling techniques and needle placement”.

Then earlier this year Li et al published a paper describing the development of a similar phantom in which they embedded a lumbosacral spine model in a mixture of gelatine and agar[2]. This technique appeared more complicated due to the differing melting points of gelatine and agar. They also added chlorhexidine for its antibacterial properties.

Our first step was to purchase a plastic lumbosacral spine model from eBay. Then it was placed into a plastic box (shoe box size, from Tesco) and fixed with Milliput® epoxy putty (from Amazon.co.uk). A gelatine mixture was prepared. We tried to keep our recipe simple. The volume chosen was that required to cover the top of the model. This resulted in dissolving 30 sachets (equivalent to 300g gelatine, bought in boxes of 6 sachets from Tesco) of gelatine in 4l of hot water. It is important to sprinkle the gelatine on the surface of the hot water and mix it in slowly. Patience is required! The phantom is then placed in the fridge for up to 12 hours until it has set.

After our first model was observed to develop mould at around 5 days later, we also added one cup of chlorhexidine on making it again. We also kept the second model refrigerated when it was not in use. It had not developed any mould when it was destroyed 10 days after being made. For protection (from damage due to pressure from the probe) of the surface, clear sticky-backed plastic was placed over the top of the second model.

Due to the fact the gelatine eventually breaks down after repeated pressure, and the fact it develops mould over time, it is clear that this model is best used for specific educational opportunities at which it can be used by a number of people repeatedly in a short space of time and then destroyed.

We then put the model to the test by taking it to a regional trainees meeting for use as part of a workshop on the use of ultrasound in neuraxial blockade. The meeting was attended mainly by novices to the technique of ultrasound aided neuraxial blockade. We used the lumbar spine phantom initially to demonstrate probe position and the variety of planes used to identify anatomical structures. The images were very easy to interpret as the echogenicity of the gel and the plastic differed strongly. To be able to compare the ultrasound image with the actual 3-D phantom was felt to be very helpful.

In addition we performed real time ultrasound guided spinal needles on the phantom. We used the paramedian vertical plane and an in plane needle approach. A standard 25 G Whitacre needle was easily visualised with ultrasound and could be accurately redirected as needed.

The downside of the model was, that it did not feel like human tissue. There were no pops to feel and the needle could be redirected without pulling it back. Also the needling left tracks in the gel which started to obscure the image after several attempts. Nevertheless, we had approximately 30 people using the model that evening and it survived without major damage.

We believe that for novices and for those trying to perform realtime techniques our spine phantom can aid understanding and the acquisition of technical skills before using ultrasound for neuraxial blockade on a real person. Considering the overall cost of only £ 25 and the fun involved we can recommend our recipe to those who love baking and ultrasound.

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References
Down Under

The road to working in Australia as an anaesthetist is well-trodden.

As a UK graduate, making the transition from one hemisphere to the other is eased by a common language and a familiar medical system. From an anaesthetic perspective, once the initial shock of not having an anaesthetic room passes, many of the practices are comparable. The anaesthetic machines are the same, as are many of the drugs and thankfully there is even the Australian equivalent of the ODA, the trusty technician. A degree of similarity is perhaps unsurprising since both the UK and Australia invest similar amounts in healthcare and are comparable in terms of the level of higher education and demographics. However, there are some interesting differences in the delivery of anaesthesia which we observed whilst working Down Under, that have challenged and perhaps changed our ideas and practices within our speciality.

Whilst this article highlights variations in the speciality between the two countries, it must be stated that they are based on our experience at The Royal Perth Hospital in Western Australia. Whilst some of these differences exist nationally, some may not be reflected elsewhere. The Royal Perth is a tertiary referral and trauma centre, receiving patients from all over Western Australia, a state ten times the size of the UK, with a population of 2.3 million. 65% of the anaesthetic workload is of an emergency nature. Many of the patients come from remote areas with inevitable delays in transfer to hospital and therefore significantly advanced pathology. The majority of cases encountered are similar to those presenting in the UK, but some are fairly unique to Australia including: shark trauma, spider bites, crocodile injuries and a plethora of watersports-related injuries. Every hospital must respond to the needs of the community it serves, so some of the anaesthetic practices we observed have been influenced by those specific demands, but many are readily transferrable to the perioperative environment in the UK. The most obvious areas where variations exists, which we discuss further in this article, are: choice of perioperative drugs, anaesthetic pre-assessment and training.

Choice of Peri-operative Drugs

Compared to the UK, there are significant differences in the treatment of acute pain. Most immediately apparent is the preference for fentanyl rather than morphine as the primary opioid for perioperative pain control; with its rapid onset and lack of active metabolites quoted as reasons for this decision. Fentanyl is the first choice intraoperatively, in recovery and in PCAs. Morphine is available but used much less frequently at any point perioperatively.

Despite a preference for fentanyl, other opioids are often considered, such as hydromorphone and methadone. Switches in PCA opioids are made if one is failing to adequately control pain, with the realisation that different opioids are simply better in different patients and that rotating opioids may be beneficial. Making these changes relies on the attention and dynamism of the acute pain service (APS). The APS is a 24-hour service provided by acute pain nurses, anaesthetic registrars and pain specialists. It has a high profile within the hospital and is consulted on the majority of pain-related issues by other specialties. Greater demand and frequent referral to the APS, has implications for anaesthetic department workload and may deskill other specialties in their ability to treat acute pain, but is arguably offset by improved patient care and outcomes in this area.

Adjuncts to opioids are also more widely available and more frequently used than in the UK. Pregabalin was prescribed pre-operatively and post-operatively by many anaesthetists. It is regarded as one facet of a multimodal and evidence-based approach to pain that is underpinned by the ANZCA publication ‘Acute Pain Management: Scientific Evidence’. Other opioid-sparing approaches include the use of intra-operative clonidine and ketamine. Ketamine is used postoperatively to good effect in conjunction with an opioid PCA. A 1mg/ml intravenous ketamine infusion is often set up post-operatively with a suggested starting rate of 0.125 - 0.2 mg/kg/hour to minimise hallucinogenic side effects. This is particularly useful in the opioid-tolerant patient and, importantly, is well-accepted by both patients and ward nursing staff. Having more avenues for managing acute pain appears to deliver more satisfactory postoperative pain control, in comparison with the relatively restricted options available to us in the UK.

Neuraxial methods of anaesthesia are not common, which may be related to the volume of acute cases with an associated higher frequency of contra-indications. It may also reflect a trend, away from epidurals towards a more multimodal approach - perhaps the result of both medicolegal issues and evidence-based medicine. The majority of patients undergoing acute abdominal surgery have TAP blocks, a fentanyl PCA and...
a ketamine infusion even when an epidural is not contraindicated. A decline in enthusiasm for epidurals appears to have filtered down the ranks, so that registrars about to complete their ANZCA training have limited experience of them. Epidurals have been shown to provide optimal postoperative analgesia, yet in our experience may be increasingly unavailable to patients in Australia. We were also given the privilege of using sugammadex for reversal of neuromuscular blockade. This was introduced to the department relatively recently and has had a rapid uptake into regular clinical practice, replacing neostigmine and glycopyrolate in most instances. Our own experience would suggest that it is an extremely useful drug, most instances. Our own experience would add that it is an extremely useful drug, and as with many systems it is open to abuse. Inappropriate referral of uncomplicated ASA 1 patients is common, and responsibility for pre-operative work-up is often abrogated by surgical teams once a referral is made.

### Pre-operative assessment

Seeing patients on the ward pre-operatively is uncommon. A recent departmental audit found that 46% of patients are seen in pre-anesthetic clinics, 33% in the holding area before theatre, and 21% on the ward. 84% of elective patients are seen in pre-anesthetic clinic some days before the operation and then briefly again on the day in a holding area adjacent to theatres. The clinics are consultant-led, providing a useful training opportunity for registrars and allowing organisation of necessary investigations well in advance. Importantly it is an appropriate time for a frank discussion of the risks and benefits of the anaesthetic and allows the patient to sign the dedicated anesthetic consent form. Having patients thoroughly pre-assessed means that very few patients are cancelled on the day and operating lists are able to start at 08:15. The flip-side is the extra resources required to run the clinics and an increase in the number of hospital visits for patients.

There is an ongoing trial in the department addressing clinical decision making in the pre-operative setting. This is mainly assessing the role of a nurse led telephone pre-anesthetic assessment modelled on Professor G Ludbrooks’ work in Adelaide. It is aimed at ASA 1 and 2 patients coming in for routine surgery and hopefully will ease pressure on clinics. Also, due to the size of western Australia, some people are travelling huge distances for their anaesthetic assessment and anything to reduce this would be beneficial. The scheme will hopefully be formalised here by September.

Patients who are already admitted to hospital and need an anaesthetic review are catered for by the ‘e-consult’ system. The surgical specialties request an anaesthetic consultation via the intranet and a registrar is allocated each day to specifically review these patients. Following review an anaesthetic chart is completed and an electronic reply generated, highlighting areas of concern and requesting specific pre-operative investigations. Formalising the acute anaesthetic assessment helps to ensure smooth running of the emergency lists, preventing last-minute cancellations and assisting in the pre-operative optimisation of patients. However, as with many systems it is open to abuse. Inappropriate referral of uncomplicated ASA 1 patients is common, and responsibility for pre-operative work-up is often abrogated by surgical teams once a referral is made.

### Anaesthetic training in Australia takes 5 years.

The structure of training is very similar: two years of basic training during which a primary exam is taken, followed by 3 years of advanced training and required success in the final exam. Currently training is divided into 12 modules that are in the main specialty- specific, but plans are in place to change the curriculum. It will be divided into ‘clinical fundamentals’ such as airway management and peri-operative medicine. Part of the reshaping process involved an in depth survey to both ANZCA trainees and ANZCA fellows, in which greater than 85% of them agreed with the current length of the training programme. This is somewhat at odds with the weight of opinion in the UK that our training programmes are not long enough. Intensive Care Medicine is a completely separate specialty to Anaesthetics here so the ANZCA trainees do at least 6 months less ICM than RCoA trainees. The ANZCA trainees are also not affected by the hours restrictions of the EWTD, so actual case numbers may be comparable.

At a more local level a wealth of clinical and non-clinical training opportunities are available and in contrast to the UK, usually free. The most noteworthy is training in ‘can’t intubate can’t ventilate’ or as they are referred to here ‘can’t intubate can’t oxygenate’ scenarios. These take place on mannequins in a ‘dry lab’ and on anaesthetised sheep in a ‘wet lab’. The latter has been described in the literature and provides a unique opportunity and experience in an area that thankfully most of us have never encountered in reality. Simulation also appears to have become ingrained into staff training programmes in Australian hospitals, with regular sessions for all members of the Medical Emergency Team (MET). Every week an anaesthetic registrar, medical registrar, two residents and four ward nurses undertake MET training, focusing on crisis resource management and development of their non-technical skills. Simulation courses are available in the UK, but are yet to become part of the regular framework of multidisciplinary training within most of our hospitals.

There are other interesting differences we have observed working in Australia, which unfortunately we are only able to touch on within the limits of this article. The indigenous population presents unique challenges to delivery of healthcare in Western Australia. Staff are encouraged to attend an Aboriginal cultural awareness course to bring down some of the barriers that exist, in an effort to provide a more effective service for all citizens. It has also been revealing to witness the impact of the large private sector in Australia. It inevitably has implications for the public sector (some positive and some negative), which we could learn from if healthcare was to move more in this direction in the UK. Australia seems to have looked to the UK for health strategy, with the recent introduction of the ‘4-hour wait rule’ in the Emergency Department (ED). Whilst generally a positive move, the effects on the rest of the hospital are not dissimilar to those we experienced at home when this policy was initiated. The ED in Australia is a very self-sufficient department, with little help needed from anaesthesia. This means no transfers to CT - wonderful! But when a patient needs emergency surgery, the anaesthetists might only meet the patient on arrival in theatre - not so good.

Overall, the experience of working ‘Down Under’ has been hugely beneficial both personally and professionally. Our anaesthetics have improved and our knowledge has increased. It has been refreshing to see that there are many different ways the specialty can be practised, yet still provide an exemplary service to patients. As a trainee in Australia it is clear that the balance is in favour of learning opportunities and teaching rather than service provision, a situation we are also now thankfully approaching in the UK.

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Sam Hillyard, Specialist Registrar, South East School of Anaesthesia, Simulation Fellow and Specialist Registrar Royal Perth Hospital, WA

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MAGILL SYMPOSIUM
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Chair: Professor Masao Takata and Dr Neil Soni
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Session II:
Clinical Science Section: What are the problems now?
Speakers: Drs Simon Finney, Suveer Singh, Duncan Young, Steve Brett

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The new Intensive Care Medicine training programme and how this will affect anaesthetic trainees

Intensive care medicine (ICM) training is changing this year with the ICM curriculum being implemented in August 2012. This short bulletin outlines the changes as they stand at the end of July, and acts as a prelude to a guide to the application process that we aim to publish in a forthcoming edition of Anaesthesia News prior to the first round of ICM single CCT recruitment.

What the changes mean for anaesthetists interested in a career in intensive care:

The new ICM training program will start in August 2012; it will now be possible to train solely in ICM. Entrance to single CCT training will be at ST3 level and will last 5 years. Dual training will take longer and in anaesthesia it will extend training by 1.5 years. Applicants wishing to pursue dual training will most likely be required to compete separately in each specialty (and be successful in both) in a national process run by a lead deanery.

Applicants in ST3+ posts will be eligible to apply for the new program provided they meet the requirements laid out in the person specification (TBC). These individuals, if appointed, may be able to use competencies previously achieved during ST3+ training towards their ICM CCT.

It will still be possible to follow the current joint CCT pathway for a short period. Trainees who are appointed via the current regional process before July 2013 will be able to undertake the program regardless of when their advanced year will take place. After this date there will be no more appointments to this program.

Examination in ICM will resemble the RCoA structure, with a primary (which will be taken in CT1/CT2) and a final (taken in ST5/6). The final will be a compulsory part of the new CCT. Exemption from the primary will be offered to those who already hold the Primary FRCA, MRCP (complete) or MCEM (A).

The Final FFICM examination will also be available to advanced trainees as part of their current joint CCT program, however this will not be compulsory for award of a CCT.

What the changes mean for anaesthetists without an interest in intensive care:

The RCoA continues to view ICM modules as a core element of anaesthetic training. A fully trained anaesthetist should be able to provide critical care in the peri-operative period and many of the skills required are learned during ICM modules.

The introduction of the single CCT and new curriculum should not impact on anaesthetic trainees doing their ICM modules. The extra ICM posts being created by the single CCT route will initially be small in number, and will likely be created from existing trust posts (e.g. clinical fellows).

Trainees will not be able to accredit non-ICM module ‘on-calls’ for the ICM section of the new RCoA curriculum. This is not new, but if you are undertaking anaesthesia during the day, then your ‘on-call’ counts towards service provision in anaesthesia regardless of where you conduct it.

So will the single CCT ICM program result in less service demand from ICM on anaesthesia? It will be a significant period of time before deaneries can provide sufficient ICM trainees to cover ICM rotas in all teaching and district general hospitals. In the near future, intensive care units will continue to be staffed by anaesthetic trainees.

With the first round of ICM single CCT recruitment occurring in December, we will be publishing more information, including advice for applicants, in our October issue. Until then, for further information please see the ICS training update letter at www.ics.ac.uk.

Richard Paul, Registrar in Anaesthesia and Intensive Care Medicine, GAT Honorary Secretary and representative on the ICS trainee committee

Chris Booth, Registrar in Anaesthesia and Intensive Care Medicine, Chair of the ICS trainee committee

Correspondence: gat@aagbi.org
I have recently returned from a cleft lip and palate camp, held in Nagpur, central India and organised by the Northern Cleft Foundation (NCF). The NCF is a UK based charity, which runs an annual 2-week trip to India, offering free cleft correction surgery to those who can least afford it. It was founded in 2001 by anaesthetist George Teturswamy. This was their 10th such visit, arranged in conjunction with the Rotary Club of Nagpur West and the Directorate of Health Services, Government of Maharashtra; together they helped with logistics, locating patients and the general infrastructure of the camp. This year the project was based at the Mure Memorial Hospital, a small mission hospital in Nagpur. It was the culmination of a year of extensive campaigning, which received media coverage in both India and the UK.

Mure Memorial Hospital

I am currently an ST5 trainee and after hearing about the NCF’s annual camp, was keen to get involved. After contacting the charity’s organisers the year before, I was finally ‘enlisted’!

The camp ran for 10 days and offered free surgery, hospital stay, meals, medication and postoperative care with travel reimbursement. People often travelled for days, by various (and occasionally inventive) means, in the hope of obtaining treatment for their or their child’s cleft lip or palate. Lip repair patients from the previous year also attended for their follow up palate surgery and I was amazed that, in only one year, the scars had become barely detectable. During the camp we carried out 87 operations. These procedures not only provide people with a chance for better health and nutrition, but also for social acceptance, economic survival and the life opportunities that may otherwise escape them.

The team...

Each year the project is led by 3 cleft surgeons and 3 consultant anaesthetists. Alongside this core were a further 3 consultant anaesthetists, trainee anaesthetists and maxillofacial surgeons, theatre staff, a (very busy!) recovery nurse and a specialist cleft nurse. We descended on the hospital’s 3 theatres and took over a large ward, with a huge preoperative holding area. Nurses from the hospital staffed the ward and proved themselves to be very adaptable to our ‘invasion’.

Despite our short stay of only 10 days, inevitable teething problems were rapidly resolved, with the UK team and local staff working efficiently together, overcoming equipment and logistical issues. The hospital staff worked hard at adjusting to the project’s demands and schedule. We were made to feel very welcome and on occasion, bizarrely, made to feel like celebrities.

The 10 day run...

Arriving in Nagpur on a Tuesday evening, we were greeted by the Rotarians. This marked the first of many gestures of hospitality, endless supplies of food and inevitable weight gain! That same evening, a core few visited the hospital to gain reassurance of the state of the anaesthetic machines and theatres, as well as completing preoperative assessments for the following day.

The first day of the camp involved setting up theatres, recovery and starting surgery. On subsequent days our schedule followed a similar pattern. I would routinely wander down to breakfast and then somehow find myself on the bus for the 20- minute ride to the hospital. On our arrival we would go to our allocated theatres to set up, ready for an 8am start. This involved the usual machine checks and preparation of stock drugs for the day, which would later be used for bartering purposes and social visits between theatres!

The hospital was able to offer us use of all 3 of their theatres, intermittently becoming 2 as required to fit in with their own emergencies. With the inevitability of such cases, and in order to avoid any cancellations, at one point we opted to run 2 lists in 1 theatre.

The anaesthetic machines were basic Boyle’s machines which, normally fitted with a Goldman vaporizer, had been modified to fit a Tec vaporizer. We were surprised to find that sevoflurane vaporizers had been attached which, due to the use of high flows for the T-pieces, were rapidly replaced with the significantly cheaper halothane ones! Monitors had been brought out by the team, (very narrowly avoiding confiscation at the airport!), in addition to all theatre expendables and medication, bar opiates, which were purchased from the hospital.

Patients were preoperatively assessed the
day before surgery to ascertain operative and anaesthetic suitability, determine acceptable weights (no less than 3.5kg), obtain haemoglobin results and decide upon an optimal theatre schedule. Those cases that could not be undertaken due to reversible medical problems were referred on for follow up under the hospital, frequently with prescriptions for FeSO4 and antihelminths accompanied by feeding advice, optimising for next year’s camp. By the second day we were tackling the smaller weights (3.5kg) and more complicated corrections. There were only a few teenagers and adults, with the majority of cases being children, starting from 3 months of age. It became strange to see weights greater than 20kg!

For the children, we typically carried out gas inductions with halothane, followed by cannulation. Adults and teenagers received thipentone. We then used vecuronium for intubation. Tube placement relied on tube fogging, watching chest movements and listening to the chest—there was no CO2 monitoring. A precordial stethoscope was secured prior to draping. Analgesia included fentanyl, with the addition of intraorbital nerve blocks for the lip repairs. Intravenous paracetamol was also routine, with some receiving diclofenac pre-operatively. There were no nerve stimulators and reversal use was standard. Morphine was occasionally administered on an as needed basis in recovery. Reflective warmer blankets were used for all cases. These were apparently successful as, even in the smallest babies, normothermia was maintained. Despite limited resources, it was clear that throughout the camp the emphasis remained on safety and providing good quality care.

The lists ran efficiently, with no delays in sending for patients since recovery was never deemed to be too full! Two small children to a bed was a frequent occurrence, which, with their accompanying parents, really meant four per bed. With only one allocated nurse in recovery (who was doing a remarkable job of running things) the anaesthetic trainees would rotate through to help out. The working day varied in length, and whilst we generally finished at around 8pm, we were sometimes at the hospital past 10pm. We would then all pile into the bus for the return journey. Back at the hotel we would sit and chat over dinner before retiring to bed. The Rotarians were keen to get us out to a couple of social events, which meant some late night (or rather early morning) finishes. Whilst such late nights generally made early starts somewhat of a struggle, a collective few (to which respect is due!) still continued with the established 6am morning run/ truck dodging exercise—something I managed only the once!

### My experiences...

Taking part in this trip has been a fantastic and hugely rewarding experience. It was a privilege working with this group of patients, seeing the immediate physical results of the corrective surgery, but also knowing the impact it would undoubtedly make on their future. Despite the long hours and unavoidable halothane T-piece side effects, it was exhilarating to work as part of this team. The humour and banter maintained whilst working in theatre played a pivotal role, with the only major disagreements arising from some questionable iPod playlist choices (gangster rap, really??!).

As an anaesthetic trainee, it was a great opportunity to gain skills and confidence in working with infants, difficult airways and carrying out gas inductions with halothane. We were also given space to manage challenging situations. The ever-patient paediatric anaesthetist, Mike, had a great knack of appearing just when needed, for advice and guidance. Difficult intubations, use of infant bougies and tricky tube exchanges in the under 10kg were made possible under his encouragement. Time in recovery provided good experience in assessment of pain and post-operative complications in the infants. This included managing a couple of cases with post-operative stridor. I also soon had to discern between (or really rule out!) infant cries due to hunger, pain and parent separation.

One patient proved to be a particular highlight on the trip. He was a lively 3-year old, who had come for a bilateral cleft lip repair and became somewhat of a celebrity amongst the group. Known to us as ‘Mr Busy’, he was fascinated by everything going on around him, soon took to using my stethoscope and, rather too quickly for my liking, mastered buttons on my camera (fortunately it still works)! His ability to effortlessly captivate the entire theatre team was very impressive. He’ll return next year for his palate repair.

Working in a different culture clearly has its challenges, but I was impressed by how our limited resources were managed, the ability of staff to adapt to changing situations, as well as the warmth and generosity with which we were received.

### Fundraising and Thanks!

The Northern Cleft Foundation relies on donations to fund its camps without which all this would simply not be possible. The charity, via its team members, raises money during the year to help fund the trip. My sincere thanks and gratitude go to the AAGBI for their donation towards the camp. I remain extremely appreciative of the generosity and kindness shown by friends, family and, amazingly, people I’ve never met, for their support of this trip. I must also mention the great fundraising party organised at the ‘Love2Eat’ Bistro in West Didsbury! Thanks!

Dr Rachel Stoeter  
Specialist Trainee, North Western Deanery

[www.northerncleftfoundation.co.uk](http://www.northerncleftfoundation.co.uk)
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- Mr Giles G Peek  CESAR trial and beyond
- Professor Luciano Gattinoni  ECMO without ventilation
- Dr Jon Smith  Principles of respiratory and cardiac support with ECMO
- Dr Alain Vuylsteke  Medical management of the patient on ECMO
- Jo-Anne Fowles  Nursing management specific to ECMO
- Dr Nicholas Barrett  ECMO and pandemic influenza (H1N1) infection

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Intensive Care Society of Ireland

19th - 23rd October 2011, Dingle, Co. Kerry, Ireland

Day 1: Wednesday 19th October 2011
Session 1: Controversies
Trauma Resuscitation (Mike James)
Hypoxia is good for you (Dan Martin)
Sedation by non-anaesthetists is safe (Richard Sturgess)

Session 2: Perioperative Monitoring
Coagulation (Mike James)
Cardiac output (Phil Newman)
Neurological: BIS monitoring and awareness
(Paul Myles)
Welcome Reception

Day 2: Thursday 20th October 2011
Session 3: Advances in diagnostics and treatment
Manipulating coagulation: pro and anti (Marie Scully)
Cardiopulmonary exercise testing: where are we now? (Mike Grocott)
Personalised diagnostics: the fairytale’s in town
(Vanya Gant)

Session 4: Who should pay for healthcare?
NHS and UK perspective (Colin Berry)
Irish perspective (Brendan McElroy)
Global perspective: Who should pay for outcome studies?
(Paul Myles)

Session 5: Anaesthesia and Pain Presentations
Session 6: Rod Armstrong Plenary Lecture
ICSI & UCL Joint Conference Dinner

Day 3: Friday 21st October 2011
Sessions 7, 8 & 9: General Medical Update for Anaesthetists and Intensivists
Respiratory (Des Murphy)
Haematology (Marie Scully)
Nephrology (Liam Plant)

Session 8
Gastroenterology (Richard Sturgess)
Cardiology (Phil Avery)
Infection control: where’s the evidence? (Vanya Gant)

Session 9:
Critical Care Abstract Presentations

Session 10:
Right to Treatment/Right to Die
The Legal Perspective (Penney Lewis)
Round Table Discussion

Day 4: Saturday 22nd October 2011
Session 11: Kate Flynn Critical Care Case History Abstract Presentations
Session 12: ECMO, Oscillation and H1N1
HFOV and H1N1 (Rob Plant)
Irish ECMO service (Ed Carlton)
ECMO (Palle Palmer)

Book by phone: +44 (0)161 603 4719 or full details and on-line booking at

www.DingleConference.com
The ins and outs of applying to work in the Antipodes

So, you think you might be keen to do the same, or are considering an OOPE? Congratulations! You’ve taken a huge leap already just getting to this stage. Yes, Oz and NZ are really far away. Yes, they are the same-but-different to the UK. Of course, living there changes the nature and substance of your significant relationships. But, this doesn’t necessarily equate to being a bad thing. Living so far away just means that you really come to appreciate every minute you spend alive, especially with those you love.

In terms of anaesthetics, it is safe to assume that the standard of work, training and teaching you will get, and care you will give, are comparable to any first world country. However, living and working conditions for you as a doctor are better than in the UK, so what you really need to decide before making your decision to move is what kind of person you want to be. Making the decision to move to the Antipodes is mostly about making the decision to look after the person you are outside of work. It’s time to be a little selfish, ponder your own future and work out what really is in your best interest.

**Rotas and the working week**

Here’s where it really starts to get good. Basically, all the information from here on in is based on my experience of Western Australia so you will need to check that local policy is the same for the state you are planning to go to. However, the following is fairly universal.

The basic working week is 40 hours and that is set in stone. For those of you with shaky maths, yes, that really does equate to a four-day working week. If you work over these hours you get paid for them, and paid well. Yes, that’s right, paid for the hours you work AND rewarded incrementally for giving up YOUR free time to do so.

Weeks of nights are also a thing of the past. The AMA (Australian Medical Association), who, unlike the BMA, actually do the job of representing their junior doctors, campaigned against the full week saying it was dangerous. It is now illegal to do more than 4 nights in a row.

**Everywhere in-between**

It’s really important to remember that there is heaps more to both countries than the cities we’ve all heard of and, in my opinion, you’ll get so much more out of your Antipodean experience if you at least explore the possibility of far flung places. Again, it really depends on who you are and to a certain extent your seniority, courage and breadth of experience, but if you really want to, you can thrust yourself out of the flying pan and into the fire with a hugely demanding but rewarding rural position. You could run a base hospital, work in a clinic 1000km from the nearest tertiary referral centre, cruise with the flying doctors, act up a grade, make real life and death decisions, gain infinite clinical skills and life experience and really become that which the UK government seems hell-bent on destroying: a true doctor, well rounded, a server of a community in every sense of the word.

**Australia or New Zealand?**

This choice really depends a lot on who you are and what floats your boat. There is no substitute for thorough research. Australia is more than twice the size of Europe and NZ twice as big as Britain, so there is precious little I can really say save my own stance on the few places I’ve been and/or heard about. Be warned … the two countries are NOT the same!

**NZ**

Much like Australia, the North and South islands are incomparable and should be thought of as individual destinations. Warm(er), wet, windy and volcanic, the north is a playground for the water babies and outdoor types amongst you. Glacial, rugged and breathtakingly beautiful, the south is for the climbers and skiers. Make no mistake, it is cold!

It is worth noting that NZ is that much smaller and that much further away so it tends to attract fewer immigrant medics. Consequently, jobs and visas (including permanent residency) are often significantly easier to come by.

**Everywhere in-between**

The Australian and New Zealand College of Anaesthetists are the overseeing body responsible for run through training, professional accreditation and development. The College is based in Melbourne, and local schemes are run by state boards. It is possible to move interstate during your training, and indeed between Australia and NZ, though this can be extremely complicated. It is worth being sure you want to stay where you are before you apply.
Previous anæsthetic experience

ANZCA’s policy on accreditation of previous experience is something you MUST be aware of before you go, as it can be a total deal breaker. Essentially, unless you arrive as a fully-fledged consultant of several years standing (not just 6 months post CCT) you will almost invariably have to sit the ANZCA final exam, and quite possibly the primary also. In addition, if you find yourself in the above category it is extremely unusual for anything more than 24 months of your prior anæsthetic experience to count no matter how many years you may have done. Do NOT arrive in Australia expecting a smooth sail through what you consider to be your final years of training; they can and will start you at the very beginning if they want to. My husband has 5 years of anæsthetic experience behind him, 18 months of which was solo in NZ, and they have made him begin again at year 2 of training. And yes, he has to sit the primaries again too. As they say over here, if you want to live this blessed life you just have to “suck it up”.

Exams

Much debate rages about whether the UK or Antipodean primaries are harder. Being diplomatic, they are just very different. The ANZCA primary is much less clinical, being split into pure Physiology and Pharmacology sections. There is a lot of rote learning, and the exams are painful. Furthermore the style of exam is different; there are eight essay questions per subject in addition to 75 “most correct answer” MCOs. The second part exams seem to correlate more closely to what can be expected of UK exams.

Which grade should I apply for?

This is where one of the major differences between the UK and the Antipodes comes to light. During UK house jobs we seem to be given much more responsibility than Australians do at their equivalent grade of intern. When we become SHOs they become RMOs and in my mind the difference is quite marked. Brits get a lot more leeway to make their own decisions and seem to have more expected of them. In Oz, an RMO is basically a buffed house officer. I went to Perth to be an RMO, having done my house year and a two month SHO locum expecting seniority, but found myself frustrated that I was basically a houseman all over again. In short, an RMO is equivalent ONLY to a first year SHO at best and if you are any more experienced than this in the discipline you plan to apply for I would suggest you go for a junior registrar post. Sound like madness? Allow me to explain …

You do not need exams or a number to become a registrar. Bizarrly, it is medical staffing who decide who becomes a registrar! You usually become one as quickly as your third year out of med school and, though this seems odd, it works and people do it. If you are a second year SHO or above, have some or all of your UK exams and are confident in your clinical and diagnostic skills, aim high and go for a junior registrar job. It might be a baptism of fire for a week or two but you won’t regret it. They DO NOT have a structured SHO rotation equivalent so it is not expected that you will need to have done a minimum 2 years in your chosen discipline before applying to be a reg.

Anaesthetics is competitive, more so in the capital cities, but there are usually a number of “service” posts which are best found out about by applying the anæsthetic department of a hospital directly. Training schemes are almost impossible to land from overseas, and you should be aware that it is becoming almost obligatory to have permanent residency or citizenship before applying. There is no substitute for getting your face known prior to the applications coming out, so a service post is never wasted and can potentially be accredited retrospectively.

Locum agency or hospital direct?

Again, another major difference between the UK and NZ is that locum agencies handle a large number of a hospital’s semi-permanent posts. It’s tricky to get your head around at first, but because of the geographical diversity of the Antipodean doctor pool it would be too complicated for hospitals to do it themselves. This basically leaves you 2 choices:

Applying to a hospital direct

This has many advantages, and I would specifically advise you take this route if you know at which hospital you want to work, you are applying to a city or you have a contact there that can recommend you. Hospitals also tend to prefer you applying by this route, as it means they don’t have to pay agency fees.

Applying via a locum agency

This is a very attractive option for a number of reasons. They do all the hard work for you sourcing the jobs, and tend to know the area and hospitals (especially those in med staffing) intimately. They tend to have a good range of positions at various levels, and a good agency should help advise you personally giving your unique career to date, and level of experience.

Furthermore locum agencies offer a wide variety of incentives, which typically, at worst, amount to the cost of your return flight. But be warned, this will only be reimbursed once you have completed your contract and if you bail early, you won’t get a cent. Some agencies may also stretch to relocation expenses, initial accommodation and similar benefits for your partner and/or family.

It should be noted that, unless you are applying for a rural position, you are unlikely to find anæsthetic jobs advertised by locum agencies as they are too popular.

Visa issues

On this, Australia and NZ vary enormously and if you are at a loss to decide which country to go to, you might let this sway you.

Oz

Essentially, Australia has an immigration policy that is exclusionary for everyone of any nationality. Never have I encountered such a pointless and unnecessarily complex bureaucratic minefield. Applying for a work visa is expensive, long winded and until recently needed to be repeated every year of your stay. Everyone has to have a medical, costing a small fortune. These can only be done by a small number of medical people around the country, so there is no getting out of it by persuading occupational health and the radiographer in your hospital to quickly bang them off for you. Then there are police checks, references, interviews, the list goes on. The whole process takes about 3 months. The only visa you used to be able to apply for was a temporary resident, subclass 422, which was valid for 12 months. Nowadays, the recommendation is you apply for a long stay business visa, subclass 457. These are amazing as they allow you to stay for up to 5 years, though are more stringent in terms of positions and employer sponsorship. Check out your options at www.immi.gov.au

NZ

Infinitely easier and more sensible. I took a year long post there and for this applied for a temporary work visa 1015. This takes about two to four weeks to process, no medical is required, and it only costs about £70. Longer stay options are possible, as is permanent residency that can even be granted from the UK, particularly if your partner is a nurse (they are in desperately short supply and seen more favourably than doctors. The same goes for Australia.) Check out www.immigration.govt.nz for more information.

Rates of pay

This is another area of fundamental difference between Oz and NZ and will go some way to
making you understand why people are more inclined to struggle through the OZ red tape. In a nutshell, doctors in OZ are somewhat better paid than in NZ. There is a good table of comparison found in www.imrmedical.com for both countries, as well as some good extra info on both countries.

**Salary packaging**

This is quite possibly the most amazing thing ever invented! It is only available in Australia, and even then only to Doctors, Nurses, Teachers, Civil servants and the emergency services. It is a system whereby you can package your salary pre-taxation so that anything up to $18,500 is discounted from your gross wage each year. This potentially knocks you from the highest tax bracket to the lowest. Clearly, this means you keep more of your hard earned cash than you would normally.

Even better, to “salary package” you have to specify how you want the $18,500 to be removed in instalments from your salary each month. You can literally spend it on anything: flights, rent, credit card bills, meals and entertainment(!). The company you appoint to organise this then tells you how much you have to spend each month doing all these great things. All you need to do is save your receipts and then send them to the company at any interval you choose, and you get the money back. I still don’t understand how it works but all I can tell you is, it does and it’s amazing!

There are several companies in each state who offer this, and in the bigger teaching hospitals there is often a financial adviser who can help you tinker with your package free of charge. Start investigating it the minute you get off the plane.

**Essentials before you go**

There are several things you really can’t do without in the Antipodes. One is full driver’s licence. Public transport can be rudimentary, and it’s expensive and time consuming to learn here. If you can’t drive yet, learn before you go.

The other thing that is really useful to take is a mobile phone handset. It sounds ridiculous but you will be staggered at how expensive even the most rubbish phone is in OZ. The same goes for monthly plans and international texts. We got pay as you go Vodafone ‘Red’ SIMs that are excellently priced and, if you persuade all your friends to get them too, you can call free between them.

The third is a credit card that allows you to collect air miles. It’s amazing how much a few trips across the earth can rack up the points and the goodies to go with it. Perks include upgrades and use of the posh lounge.

I hope this has in some way been useful and that you are a little more clued up and raring to go! Honestly, once bitten you’ll never look back. Happy job hunting!

**Useful contacts**

www.kiwisstat.com For fantastic, professional and friendly service, and great NZ jobs

www.medrecruit.com To tantalize you as to what’s out there in NZ. Also a fantastically doctor focused site to help you choose the best for you.

www.wave.com.au For a huge variety of jobs in Australia, at both senior and junior grades

I don’t want to put in a list of many locum agencies as I think its best for you to do your own research and find out who look like they will suit our needs best. The above are just a good place to start. Best of luck!

**Dr Clare Fellingham**

Anaesthetic Registrar

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**Association of Paediatric Anaesthetists of Great Britain & Ireland**

**6th National Linkman Meeting**

Teacher Building, Glasgow

Friday 25 November 2011

The 6th APAGBI Linkman meeting is hosted by the Scottish Paediatric Anaesthetic Network in 2011. All APAGBI Linkmen are eligible to attend, but we also welcome the participation of any anaesthetist with an interest in paediatric anaesthesia.

As usual we focus on new and developing issues in paediatric anaesthesia, and this year’s topics will cover:

- Patient Safety – how does it impact on paediatric anaesthetic practice?
- Anaesthesia and the developing brain
- Quality improvement
- Clinical conundrums – an opportunity to discuss the management of an anaesthetic problem and the issues it raises in your practice

**Registration fee is £150**

Further details and application forms will be available from August 2011 to download via the APAGBI website: www.apagbi.org.uk

For further information, please contact: meetings@apagbi.org / 0207 631 8604

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**BRITISH SOCIETY OF ORTHOPAEDIC ANAESTHETISTS’ 16th ANNUAL SCIENTIFIC MEETING**

**jointly with the Section of Anaesthesia**

THE ROYAL SOCIETY OF MEDICINE

**Friday 11th November 2011**

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Annual dinner £40

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Further info at www.BSOA.org.uk Register at www.rsm.ac.uk/anaesthesia
The fourth annual meeting of the National Hip Fracture Anaesthesia Network (HipFAN) was held in Bournemouth on 5th May 2011, following the tradition of holding a separate session during the Annual Scientific Meeting of its parent organisation, Age Anaesthesia Association. It was attended by about half of the HipFAN membership, approximately 100 delegates.

Richard Griffiths, the network lead, presented an overview of the progress made so far and the exciting new developments concerning the network. The news that hip fracture has secured a position on the top table agenda of several important organisations was received with great pleasure. These included:

- Health Services Research Centre (HSRC), which is a part of the National Institute of Academic Anaesthesia (NIAA), recognised HipFAN as an important national audit relevant to perioperative medicine.
- National Hip Fracture Database (NHFD) has given representation to HipFAN on its executive, and our request for inclusion of anaesthesia related data in its data-set has been granted. This is relevant as the DoH has agreed to resource the NHFD for assessing compliance with the standards required to achieve the Best Practice Tariff (BPT).
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report has sent a strong message across the profession regarding the dire need to uplift the quality of care received by the elderly surgical patient, the majority of whom are admitted due to hip fracture and face unnecessary delays in getting their operations. This has helped to push the problem higher on the DoH agenda.
- National Institute of Clinical Excellence (NICE) is finalizing its guidelines for the management of hip fractures and has declared it a “research priority”
- Association of Anaesthetists of Great Britain & Ireland (AAGB&I) is in the process of launching its guidelines on the management of hip fractures.

A recent review of the HipFAN membership revealed that not all of the members were anaesthetists. In order to make the network fully representative and more inclusive, it was proposed that the name should be changed to Hip Fracture Perioperative Network (HipPeN). The members present voted in favour of the proposal, hence it was adopted. Proposals were presented, and agreed by the members, for launch of regular weekend trauma lists and establishing a national voluntary reporting system for complications of cemented hip repairs. The need for expanding the administration of the network was elaborated and volunteers were sought to take on the lead role as well as a literature tsar. Stuart White, the research lead for the network, presented an overview of the achievements of the network in this domain. He summarized the successfully completed HipFAN projects, as below, and sought proposal for future projects:

1. Basic Audit of one month hip fractures in 22 hospitals
2. Projected incidence of proximal femoral fracture in England
3. Survey of transfusion practice for hip fracture patients

The meeting ended with excitement for the forthcoming launch of the NICE and AAGBI guidelines.

References:
http://www.niaa-hsrc.org.uk/article.php?newsid=120
http://www.ncepod.org.uk/2010eese.htm
http://www.nice.org.uk/guidance/index.jsp?action=folder&o=53900
THE PRIMARY CHALLENGE

Having been subject to countless academic, musical and sporting assessments for the best part of 25 years, I do not recall one that I have struggled with so much before finally crossing the line. This was my third attempt at the OSCE/SOE ... after my third attempt at the MCQ. This is a truly humbling statistic whichever way you choose to look at it, and one that I certainly do not revel in for a moment. The vast majority of trainees do not ever need to draw inspiration from a reflective piece such as this.

Equally a sense of real perspective must be maintained – I have not overcome a debilitating illness, the loss of a child or suffered at the mercy of an earthquake or war-torn nation. However, what I have been asked to deliver here is a personal account and perhaps a little advice in retrospect, aimed at those who are yet to scratch the surface of the Primary FRCA.

Before you read on, may I mention that this is certainly not intended to be a formalised ‘Guide to passing the Primary’. For that, I would instantly re-direct you to Dr James Shorthouse’s invaluable resource on the Anaesthesia UK website¹. James and I were colleagues at medical school in the all-too-distant past, and I am sure that he would not mind me advertising the product of his wisdom and experience. There you will discover, in very practical terms, the level of preparation, resource and commitment that is required before you embark upon the journey. Browse further for details of popular textbooks, national revision courses and a comprehensive bank of past exam questions.

So what is my story? Chronologically, though I am not a postgraduate trainee, I pre-date the Foundation Programme. I spent significant years in Emergency and Internal Medicine before falling head over heels for Anaesthetics during a placement in the ACCS programme. My level of commitment was considerable - enough to surrender guaranteed higher training in Emergency Medicine. The prolonged exposure to other acute specialties and Membership examination was sure to aid my cause to establish a solid foundation in this new career. Indeed virtually all aspects of clinical training appeared to be smooth sailing with commendations... until I ran aground in desperate fashion – on Island Primary.

Of course there are any number of metaphoric images that can be used to describe this particular obstacle, and to some these are more daunting and troublesome to overcome than others. Perhaps there are unpredictable circumstances which conspire to throw you off course, no matter how meticulously you prepare for a mission, or even a fight, if you will. But this should not ever imply that you underestimate the importance of getting ready. Do not be ignorant of the expectation upon you. Familiarise yourself with the course. Equip yourself with the tools that are required. Choose your weapons. Know your enemy. Approach with initial caution, and then with conviction.

Candidates, take note – the FRCA Primary is the first part of a fellowship examination. With the greatest respect, please do not ever try and compare this to the membership examinations that your contemporaries in virtually all other specialties are conquering at the same stage of career. According to MMC criteria, this traditionally revered postgraduate qualification is now considered a ‘competence’ in the grand scheme, another tick-box alongside your workplace-based assessments that you require to progress. However I believe that you engineer any ounce of disdain at your peril.

I knowingly accept that there are those for whom facts and concepts are assimilated more naturally, and there are certainly several ways to skin this animal, in terms of how you attain your knowledge and build confidence. But for the majority, certain facets should follow a common theme: a period of considered planning in amongst an already hectic personal and professional schedule, a structured approach to study over time that will allow you to cover all of the required material, and an unswerving implementation of that approach in order to attain your prized objective. I
have heard the opinions of a few College Examiners that the Primary is more of a challenge to pass now than in years gone by, on account of the split of MCQ and OSCE/SOE components. Whilst I am not in a position to compare and contrast this historical format, one may appreciate that the candidate’s mentality would be somewhat dissimilar if preparing for all three components and not one. In addition the exam would not traditionally be contemplated without at least 12 months’ clinical experience, if not 18. Some modern Core Trainees, advisably or not, are attempting the MCQ only 6 months after completing their Foundation Training. The pressure to achieve this ‘competence’ within a restricted time period is compounded by the boundaries set by the MMC Training Programme. The caveat now, of course, is that only the failed component needs to be repeated and not all three. But the point is this – whatever the rules of engagement, it is not merely about putting the hours in; your preparation must be specific and tailored to the individual task in hand.

The concept of MCQ, I would imagine, is Marmite-flavoured for many. The negative marking system no longer exists and so every candidate must now attempt every question on the paper – an apparent level playing field for all, not just for the expert guessers in the crowd. As Dr Shorthouse suggests, there is no outright method to prepare for this section, particularly when this is the candidate’s first exposure to anything academic related to the practical aspects of the specialty. Textbook revision alone is certainly inadequate and yet, as I felt personally, solely attempting MCQs left me with a gross dissatisfaction as somebody who prefers to conceptualise and understand topics. It is plain enough to suggest that a balance between the two is required. However, in retrospect, I am inclined to swing towards a single-minded dedication of MCQ repetition and very little else. Scour the earth for as many questions as possible, whether they are published or in online banks. They should preferably be accompanied by explanations of answers. Do not become frustrated by poor performance levels to begin with. Instead take encouragement from the patterns of questioning that will inevitably emerge once you reach a certain level of practice. Indeed you should have attempted at least two or even three thousand questions by the time of the sitting. A friend advising me at the time simply said this: “Do MCQs until your eyes bleed - and then do some more”.

As I compose this piece, I am aware that the College are making changes to the format of this paper. As from September 2011, the number of MCQs will be reduced from 90 to 60, and Single Best Answers will be introduced. Clearly you must be guided by any new resources that the College may produce in relation to this. Collect as many sample questions as possible and of course, over time, banks will begin to accumulate. I am sure that my principles of advice would be much the same as for the MCQs. Onwards then to, what is for some, a psyche-altering if not life-changing experience that is the OSCE/ SOE. Though we whisper them in the same breath, these two components are separate adversaries. It is quite remarkable how an overwhelming majority of candidates become focused, if not obsessed with preparation for the SOE. This is not intended to be an accusatory statement, but simply reflects the tremendous apprehension towards the prospect of an inquisition that they feel will expose their very soul. Consequently the OSCE plays a poor second-fiddle, often neglected until late in the day. After all, history-taking, resuscitation, communication and technical skills are areas that are practiced almost on a daily basis, so why bother too much? Surely it is more productive to spend those waking hours absorbing complex physiological equations and graphical representations or memorising pharmacokinetick data ad nauseam? Be warned, this is a dangerous path to tread. For the Star Wars fans amongst you, one must make efforts to bring balance to the Force.

That said, I certainly accept that logistics will play a part in your preparation. Of course it is far less complex to arrange opportunistic SOE practice with your consultant colleagues in your daily theatre schedule, than it is to construct an array of OSCE stations in the workplace. OSCEs admissible require a painstaking level of military-level organisation and resource, and this is a principle reason, if any, to invest your finances into attending one or more local or national revision courses. You must subject yourself to a real-time experience of completing a 16-18 station OSCE set. Regardless of your level of performance in each individual station, you must recognise the intense physical and mental stamina that is required. Without wishing to psychoanalyse the task, there must be a supreme skill in being able to constantly reset one’s mind to a completely unrelated topic every few minutes for the better part of two hours. The fundamental adage of the OSCE is simply not to dwell on the previous station - or face allowing the next one to suffer, and the next one, and the next one... There is no doubt that the vast majority of stations are not only predictable, but allow you to demonstrate aspects of your daily clinical practice. Whilst this is a reassuring comment, this is no excuse to allow complacency to confer a detrimental effect on your OSCE performance. This is an opportunity to impress and to maximise your mark-scoring. The rationale for not neglecting this component in favour of the SOE should be more apparent.

Let us now embrace the SOE. Firstly this is exactly what it says on the tin - Structured Oral Examination. In this sense the more traditional and popular term ‘viva’ is misleading. In modern times, I would advise that this is not simply a performance stage in which you are asked to convey as much information as you possibly can about a chosen subject in the allotted time. In the past, the possibility of becoming wickedly embroiled in an examiner’s more peculiar pet topic was all too common. Equally, as odd as this may be, the more studious candidates may possess more knowledge than their assessing counterparts, which provides another type of negative imbalance. The compromise, therefore, is a more strictly scripted question-and-answer sheet, around which a surprisingly rigid discussion will take place. The marking scheme has been significantly simplified to assess both a basic knowledge and
understanding of each chosen topic, and it is astonishing as to how rapidly that time passes. If there was an adage for the OSCE, then the one that underpins SOE survival is a complete demonstration of composure and poise, and an absolute refusal to be intimidated by circumstance. Any defeat is all too commonly self-inflicted, and it is frequently not for lack of knowledge.

Whilst you are strongly encouraged to pester your senior colleagues in the workplace for ‘practice’, you must be wary of allowing these sessions to develop into nothing more than an amicable discussion with a familiar face, especially as it bears little consequence. Remember that on the day, you are outnumbered by two unfamiliar faces to one, whose attentions are focussed on you, and you alone, across a small table. Candidates are often counselled, however improbable it seems, that the examiners are striving to assist you across the line – but this cannot and will not come to pass if the candidate struggles to handle the situation from the outset. You must become alarmingly comfortable with the reality of a set-up that resembles an interrogatory process. This is indeed another prime justification for attending revision courses out of local region, and inevitably the more that you are subjected to, the better. On this subject, I would add that there is no greater pressure than being examined, not by the professorial-looking consultant who sneers at you over his pince-nez, but by your very own peers. Perhaps this is to be experienced before it is believed, but what more effective way to learn about the psychology of a candidate, than to be an examiner yourself. By establishing a partner or group dynamic, I would suggest that the benefits are considerable.

My own story

My own story, then, is only a reflection of everything that I have discussed so far. There is little to comment on the MCQ section, but instead my description of the OSCE/SOE is more detailed:

I would accept that I was grossly underprepared the first time due to plain ignorance as to what was expected. Having dedicated myself to the second attempt at significant financial and emotional cost, I felt almost bulletproof but without being over-confident. I was scoring more than respectable marks in revision course SOEs under exam conditions and passing OSCE sets comfortably. I could not have dreamt of a more favourable set of SOE questions to be asked on the day, and I finished several OSCE stations with minutes to spare (in fact one of the examiners asked me whether I was finding the rest of the circuit as easy). The smile on my face was a mile wide when I walked out of the College that day because I was convinced that I had done enough, and that all of the effort over the past months was going to be rewarded. I was absolutely devastated, therefore, to discover that I had failed not one, but both components. I was also made to suffer the double ignominy of surrendering a training number that I had been offered to commence a fortnight after the exam, had I been successful.

We are privileged to have two College Examiners at our hospital and so they kindly arranged for the mark sheets to be delivered for a formal feedback meeting. Their impression was that for the Physiology/Pharmacology SOE I had required a significant level of prompting, which I completely rejected and this only served to aggravate my anger and bitterness. I felt that they had interrupted me at every opportunity and were not interested a shred in any information that I had to offer. Of course in retrospect, they were only following their scripts and I did not follow their lead. Conversely the examiners for the Physics/ Clinical SOE were an entirely different set of personalities, they allowed me to express my answers and I scored highly, but not enough to compensate. For the OSCE, I scored higher than the mean for that set, but it was still below what was required. My misery was compounded by the fact that my two lowest-scoring stations were Resuscitation, when I value my role as an ALS instructor.

Though I am not normally so introspective, I descended into a pit of self-loathing with morale at absolute rock bottom. Whilst I never contemplated the thought of quitting, my mind was dominated by the concept of failure and I was convinced that if it was anything, it would be my absurdly negative attitude that would prove to be my downfall. Over the weeks that followed I am convinced that I licked several of the listed physical and psychological symptoms of clinical depression before I summoned the will to open any FRCA notes again.

I was, in my own mind, nowhere near as ‘prepared’ for the next sitting, mostly due to a non-existent confidence level and still carrying the baggage of my previous experiences at the College. In brief, I dragged my physically and mentally shattered person into exam week, genuinely felt that both SOE and OSCE were complete disasters from start to finish, and travelled home absolutely inconsolable. I reflected that I had performed several times better in the previous sitting, when I thought that I had passed and actually failed. I had been discussing the implications of a botched anaesthetics career with my father the next morning, and was emotionally preparing for a fourth and final sitting when I reluctantly opened the results page. Without wishing to over-dramatise, I honestly thought that there had been a misprint next to my candidate number with the words “PASS PASS” next to it. I checked it and rechecked on numerous occasions before collapsing in tears.

I express my sincere gratitude to all members of staff at Peterborough for their patience and provision, and to the organisers and faculties of courses that I have attended around the country. I would like to pay particular tribute to Dr David Gray and his team at the Mersey School of Anaesthesia. I am honoured to have directly experienced a product of Dr Gray’s principles, perception and purpose. From the outset, he redefines the candidate’s perspective as to what a stressful situation actually is and for me, it was also about experiencing a level of joy and motivation for the correct reasons that had been lacking for so long. I believe that the knowledge, personal skills and attributes that this syllabus demands of a candidate are exclusive, and it must be given the complete respect that it deserves. Yes, the FRCA Primary is ‘just an exam’, but it should open doors to progress with training in this wonderful specialty in which it is a truly a privilege to practice.

I would also like to thank Dr Richard Griffiths (Consultant Anaesthetist, Peterborough) for this unique opportunity to reflect upon my experience as I endeavour to encourage colleagues of present and future. I am indebted to him for the invaluable support that he has shown during this period.

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Since the app market became available in 2008, there are currently over 3 billion different apps on offer for the iPhone with numerous apps that anaesthetists can obtain either free or at a cost for reference and to facilitate the dissemination of information. These can be downloaded from the iTunes website. Updates and amendments to current guidelines and practice can now be disseminated widely making evidence based practice more current than ever before. Pubsearch provides an interface for medical literature searches that is quick and easy to use, providing access to thousands of journals indexed in PubMed.

Paeds ED and Paeds ED Lite initially sold in 2009, updated in November 2010 are useful to trainees trying to memorise paediatric drug doses or for anaesthetists not regularly involved in paediatric cases. After inputting the child’s age and weight, this app calculates drug dosages for various situations such as rapid sequence induction or resuscitation. Similarly PICU calculator, released January 2011 allows the user to calculate doses for neonates whilst iRemi, July 2010 calculates the dose of remifentanil. Epocrates is a continually updated detailed drug database with information on dosages, interactions, contraindications and images of drugs. It can also provide information of alternatives and can help identify a drug by its appearance or imprint code.

Intensive care can be daunting for anaesthetists with limited medical experience, but again there are several applications available that can be of assistance. ICU pearls (critical care tips for doctors and nurses), released by Kavapoint 2009 and updated in April 2010 was developed from feedback by intensive care personnel who asked for a way to learn “pearls of wisdom” collected by their peers and professors. It offers small tips designed to be learned on a daily basis to accumulate knowledge.

ICU steps – A guide to intensive care, has been produced by the UK’s only intensive care patient support charity and is written by ex-patients from the patient perspective. The guide gives an introduction to critical care in plain English and explains to patients and relatives some of the physical and psychological issues that patients may face in their recovery and who they can turn to for help. It is endorsed by the Department of Health and is used by over 40% of intensive care units in the UK.

For those with an interest in regional anaesthesia, RA-log, November 2010, is the logbook for regional anaesthetists allowing the user to record exact details of the block so that technique can be improved. The Developer, Dr Kirk-Bayley has an improved PRO version in progress that will permit photos and videos to be included. Spinal Vademecum, December 2010, presents 3D and interactive information including anatomical relationships, sites of puncture and dermatomes supplied by spinal nerves. The manufacturers, Sinetica SA propose that this can facilitate explanation to patients on the proposed techniques. The SonoAccess application from Sonosite provides access to videos demonstrating techniques for specific scanning procedures, clinical images and nerve blocks.

Resuscitation providers have released several apps that are not only useful as a prompt during psychologically stressful clinical scenarios, but can also be utilised by other medical staff and the public to facilitate effective early resuscitation. iResus, released in January 2010, is provided free of charge by the Resuscitation Council (UK) to provide its most up to date guidance for hospital practitioners or those with an interest in first aid. It includes current adult and paediatric algorithms in an interactive and intuitive format whilst remaining entirely faithful to the original content. A randomised control trial was conducted to determine where the application improved the performance of doctors trained in advanced life support in a simulated emergency. 31 doctors were assigned to either control group (no smart phone) or test group with iResus on smart phone. They were assessed using a cardiac arrest simulation test scoring system and it was found that scores were significantly higher in the smart phone group compared with the control group. Junior doctors felt it would provide them with an increased level of confidence in a stressful scenario and in contrast to a previous study did not consider using iResus to be unprofessional or reflect a poor level of training. Since 2010, there has been an explosion in the number of apps available related to this topic on iTunes. Some examples include ACLS simulator, ECG rhythms, Cell phone CPR and lipid ALS.

The Difficult Airway Society released its contribution in November 2010, IDAS. This app presents the airway management algorithms authorised by the Difficult Airway Society and provides a method of keeping up to date with developments through its alert functions. The latest newcomer is iNAP 3, only released in February 2011. This presents the findings of the Royal College of Anaesthetist’s National Audit Project 3, which...
investigates the likelihood of complications following regional anaesthesia.

Every application on the iPhone’s “App Store” must be approved by Apple first and they can exercise a veto option without giving reasons. This may be beneficial to us as clinicians as a quality control/safety net to ensure that only reliable developers can produce anaesthetic related applications. Inaccurate or outdated information has the potential to have disastrous and potential fatal outcomes. However, this may alienate some credible or innovative developers. Google has a very different and open business approach, with applications for the Android continuing to grow. Google is sponsoring millions of dollars in prize money for developers who built the best applications for the Android and as such there is the potential for development of medical applications, for example a portable 3D image viewer. This could be utilised to access CT scans, Xrays or ECHO’s from remote locations or to facilitate ultrasound scanning of structures not yet within the hospital. Stores such as this could be available to every anaesthetist and clinicians as a learning resource for trainees or as a quality control/safety net for paediatric theatres. A range of cartoons, television programmes and interactive games have been downloaded for children aged 1 to 16 and these are introduced at the preoperative visit. With the use of headphone, an immersive experience is provided to the child, which, in conjunction with topical anaesthesia allows a stress free intravenous cannulation and intravenous induction. Here, the anaesthetists have found the technique more successful for intravenous induction, as the leads and headphones can be obstructive to inhalational anaesthesia.

Many other unexpected iPhone features enhance overall functionality as a medical information device. The YouTube application allows easy access to a growing number of medical education videos that are available to download. These can be used as a learning resource for trainees or as a reference guide for patients so they can visualise the procedure they will be undergoing.

Smartphones have a built in camera, the quality of which varies depending on the make and model. These can easily be viewed on the phone itself or be emailed to others. This has the potential to be used to gain expert advice from colleagues not located immediately within the hospital or specialist advice from tertiary referral centres. Prehospital crews such as HEMS regularly utilise this capability on the handover of trauma cases to trauma centres so the receiving team can gain a clearer impression of the mechanism of injury in order to guide further investigation and treatment. However, there are security and confidentiality issues with sending photos by phone. At present only those that are registered with the information commissioner as a data controller are allowed to take and send photos. If medical images are used in the decision making process for the patient, it is compulsory to document this in the patients notes along with who took the photograph and when. Several major PACS applications are now written on the JAVA platform, and can be modified to run on Android with minimum reformatting to display medical imaging. A recent case report from 2011 describes the use of the Open Source OsiriX software to display 3D images and reformatted planes on the iPad during lung segmentectomy. The images were generated preoperatively using standard high resolution CT and transferred to the iPad for intraoperative use. During the operation, the iPad was inserted into a sterile plastic bag so that the images could be manipulated and used in the operative field to identify anatomical landmarks, in particular the arterial and venous supply to that segment. This software provides the tools for interactive reconstruction of 3D images and reformating from any imaging modality. It has an intuitive user interface and high performance processing power enabling the generation of real time images and the anatomy to be indentified in different planes and from other angles. Static and dynamic images can be transferred along with the original imaging. This could have potential indications for anaesthetists and intensivists in performing invasive procedures safely, and as an aid to teaching and learning complex anatomy.

In the UK, the versatility of smartphones is becoming widely recognised by the anaesthetist and clinicians as a whole although we are not at the stage yet for them to be fully integrated into patient care. However, Mount Sinai Hospital in Toronto is a step ahead. Here the iPhone is fully integrated into the hospital’s daily operations with an in house application enabling doctors to gain secure access to patient information. Their revolutionary app amalgamates reference material, patient information and clinical data so that patient charts and results can be accessed to review a patient’s progress both within the hospital and outside it, thus facilitating rapid and informed decisions into the patient’s care.

M-Health, the use of mobile computing and communication technologies in health care and public health, is a rapidly expanding area.

The explosion in smartphone technology has been harnessed as a potential educational and diagnostic tool by many individuals in the anaesthetic speciality.
“Smart” Anaesthetists: The iGeneration

of research and practice. Current documented M-health interventions and programmes include: mobile phone text messaging to support management of diabetes, hypertension, asthma, eating disorders and HIV treatment; mobile phone text messaging and PDAs as aids to smoking cessation, body weight loss and reducing alcohol consumption; PDAs for data collection in healthcare and health research and to support medical education and clinical practice. It is feasible that these could become more widely used in anaesthetic practice, for example in optimising a patient prior to elective surgery after the preoperative clinic visit. In 2010, a systematic review protocol was submitted in order to summarise the evidence for the effectiveness of mobile technology interventions for improving health and health service outcomes around the world. This systematic review will provide recommendations on the use of mobile computing and communication technology in health care and will guide future work on intervention development and primary research in this field.

The Future

The smartphone market is still in its infancy and continues to grow at a phenomenal pace. Despite the success of the iPhone it only represents a small fraction (1%) of the entire mobile cell phone market. There is sufficient room for growth in the smartphone industry. We should be looking not at what the best device is currently, but which will be the most dominant in 10 years time when smartphones will have undoubtedly replaced traditional cell phones entirely. Google and Apple have radically different business models and philosophies. Google promotes freedom and flexibility with the Android, whereas Apple controls virtually everything regarding the iPhone. If Apple continues along this path, how will they insure that the best applications are available to users and will they be able to compete with a vast, global development community?

This new technology has already changed the way anaesthetists practice in numerous ways: how we access and store information, communicate with our colleagues and patients alike, as a teaching resource and in the display of digital multimedia imaging. As newer, more powerful faster devices are continually being developed, it is essential that all anaesthetists are willing to accept and embrace the smartphone in order to utilise it to its full potential. Smartphones are revolutionising anaesthesia and we are the “iGeneration”.

Dr Claire Gaunt
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The country

The Republic of Georgia is in the Caucuses bordering Turkey, Armenia, Azerbaijan and Russia. It became independent of Russia in 1991 after 70 years of occupation. It has a population of 4.6 million and a birth rate of 12.87 births per 1000 population. The maternal mortality rate is 48 per 100,000 live births.\(^1\)

Background

In 2007 Dr Mörch-Siddall visited the Republic of Georgia as part of the Kybele programme. This American programme delivers physician education focussed on the introduction of regional anaesthesia for Cesarean section. Over a six year period the programme has successfully achieved its aim converting a general anaesthesia rate of almost 100% to a regional anaesthesia rate of over 70% and rising.\(^2,3\) Some Georgian obstetricians and anaesthetists expressed an interest in UK practice and Managing Obstetric Emergencies and Trauma type teaching.

Planning and organising the event

Two Georgian doctors, Dr Nino Ninidze a consultant anaesthetist and Dr Tiniko Gagua (right) a senior obstetric trainee, commissioned the resuscitation training day identifying a need for a formalized way to teach resuscitation of the mother and the neonate in Georgia. The Georgian Medical Society agreed to host the conference. The Georgians expressed an interest in learning about the UK confidential enquiry into maternal mortality, (currently Centre for Maternal and Child Enquiries, CMACE) wanting to set an enquiry up in Georgia.

After discussion, the Georgian Medical Society set the theme for the conference focussing on the top causes of maternal mortality worldwide: preeclampsia and eclampsia; haemorrhage; sepsis and trauma completed with a lecture on neonatal resuscitation. Dr Mörch-Siddall joined forces with Dr Felicity Plaat and they assembled a faculty for the trip which consisted of: Dr Valerie Bythell (anaesthesia), Mr Charles Cox (obstetrics), Miss Suzi Jackson (obstetrics), Dr Sam Richmond (neonatology), Professor Steve Robson (fetomaternal medicine, obstetrics), Mrs Gillian Treanor (senior resuscitation officer) and Dr Sarah Wheatly (anaesthesia).

Resuscitation training day

5th May 2011

The event was hosted by the clinic of Professor David Gagua. There were 28 attendees who were senior anaesthetists, obstetricians and neonatologist and midwives.

It began with lectures on ‘Teaching the teachers’, ‘Neonatal resuscitation’ and ‘Maternal trauma’. This was followed by
a demonstration trauma moulage. The attendees broke up into four groups and rotated through: haemorrhage, eclampsia, shoulder dystocia and neonatal resuscitation stations. The method of teaching using attendee participation, performance in front of the group and the use of the mannikins was novel and well received. In the third part of the day the groups split into specialties and there followed three very animated question and answer sessions.

The conference ‘Common Problems, shared solutions’ 6th May 2011
The conference was attended by 150 doctors from throughout Georgia with over 50% coming from outside of Tbilisi. It was opened by Professor Gagua and Mr Mikheil Dolidze vice head of the Ministry of Health. The lecture slides were projected on two screens one in English and the other in Georgian. Simultaneous translation was provided by Miss Nutsa Aldashvili an exceptionally impressive final year medical student. It was followed by a traditional Georgian banquet a ‘Supra’.

Impact
The feedback from the resuscitation day was overwhelmingly positive, many attenders ranked it as ‘excellent’ and several commented ‘it has been the most informative teaching I had ever attended’. With regard to the conference all lectures were rated as ‘excellent’ or ‘good’ and there were many positive comments on Confidential Inquiry lecture ‘It is something we want to start and the information provided was very much needed’. The conference was less relevant to the neonatologists in the audience but they found it interesting anyway. We made the TV, evening news on the two major channels IMEDI and Rustavi 2 and featured in a programme for prospective parents ‘Enki Benki’. We had an article about the visit in a magazine called Saloni. The following day several members of the public stopped us in the street and thanked us for our visit.

Acknowledgements
I would like to thanks everyone involved in the programme. In particular:
• The faculty for volunteering their time and expertise
• Kybele for the initial opportunity to visit Georgia
• The Georgian Medical Association for inviting us
• Drs Gagua and Ninidze for their invitation and their exceptional organisational skills
• The Clinic of Professor Gagua for canceling elective work on the resuscitation day enabling the day to go ahead plus his generous hospitality
• Miss Aldashvili for her excellent translation skills which were crucial to the success of the programme
• The Association of Anaesthetist of Great Britain and Ireland for their travel grant
• The Obstetric Anaesthetic Association for their travel grant
• Cook Medical for their generous support of the project and donation of intrauterine balloon catheters in particular Mr Keith Goulden who sadly unexpectedly died.
• Ferring for their generous support

Dr Julia Mörch-Siddall, FRCA

References:
Visual attention of anaesthetists during simulated critical incidents


Situational awareness has long been associated with competent anaesthetic practice and its importance in patient safety is well recognised. In this paper the authors have attempted to monitor anaesthetists’ visual awareness in various situations.

Crucially the experience of the anaesthetist has been noted to determine whether seniority has any impact of the distribution of a practitioner’s visual attention in differing scenarios.

In pilots, differences have been demonstrated, with experienced flyers having improved automated information extraction with more frequent fixations and shorter dwell time. Is the same trend true in anaesthetic practice?

Methodology

Fifteen anaesthetists of varying seniority induced anaesthesia with and without a critical incident (anaphylaxis) in an advanced simulator, whilst being monitored by head mounted eye tracking systems. This technology monitored an individuals’ gaze on various regions of interest (ROI) such as the respiratory mask, thorax, monitors or others. Data obtained included times spent observing various ROIs during each scenario and event.

Results

It is perhaps not unexpected that more experienced anaesthetists were able to increase the time they spent doing manual tasks and decrease the time spent monitoring during a critical incident. This was in contrast to novice anaesthetists who spent more visual time looking at monitors and less on manual tasks. What was unexpected was that the ROI sequence of mask – thorax – mask – thorax was only observed in the more senior group and not throughout all grades as might be expected in a critical incident.

Conclusions

More studies are required but these results and exercises such as these may have an impact on the future design of monitoring devices and in education of anaesthetic trainees. Perhaps visual and situational awareness will be given equal weight in the anaesthetic curriculum as conventional laryngoscopy.

Dr Philip Docherty
ST4 Anaesthetics, South East Scotland Deanery

Reference:

Effect of high flow oxygen on mortality in chronic obstructive pulmonary disease in patients in pre-hospital setting: randomised controlled trial

BMJ 2010; 341; c5462

Current guidelines, including from the British Thoracic Society1, recommend the treatment of patients with COPD with controlled oxygen therapy titrated to oxygen saturations rather than administering high flow oxygen. However high flow oxygen is still widely used in the acute setting especially during pre-hospital care. We are all taught hypoxia kills; it feels correct to give high flow oxygen to the acutely breathless patient. The authors of this controlled trial set out to provide evidence to quantify the dangers of high flow oxygen and to support the recommendations for titrated oxygen therapy in patients with an acute exacerbation of COPD.

The study was carried out in the pre-hospital setting in Tasmania, Australia and the intervention was provided by paramedics of the Tasmanian Ambulance Service during transport of patients to the Royal Hobart Hospital. The study population was identified by the paramedics and comprised of patients over 35 years with a presumed diagnosis of acute exacerbation of COPD.

This was a randomised, controlled, parallel group trial with two arms: the active arm provided titrated oxygen therapy (oxygen titrated to achieve saturations of 88-92% and nebulisers driven by compressed air) and the control arm provided conventional high flow oxygen (8-10L/min via mask plus oxygen driven nebulisers). The paramedics were cluster randomised. Other treatment provided by both groups during transport included standard nebulised bronchodilator and steroid therapy. The intention was that on arrival to hospital all patients would have an arterial blood gas performed. The primary outcome to be measured was mortality. Secondary outcomes were length of hospital stay and arterial blood gas (ABG) measurements.

During the 13 month study period in 2006-07, 405 patients were recruited with 179 in the titrated oxygen group and 226 in the control group. Pulmonary functions tests confirmed the diagnosis of COPD in 214 patients (97 titrated, 117 control).

The intention-to-treat analysis found a significant difference in mortality between groups (relative risk 0.42, 95% confidence interval 0.20-0.89; p=0.02). There were 21 deaths (9%) in the control group compared to 7 deaths (4%) in the titrated group. Analysis of those with confirmed COPD there was again a significant difference in mortality: there were 11 deaths (9%) in the control group compared with two deaths (2%) in the titrated group (relative risk 0.22, 95% confidence interval 0.05-0.91; p=0.04). The deaths occurred in hospital and primary cause of death was respiratory failure. In analysis of ABG measurements in those with confirmed COPD, the titrated oxygen group were significantly less likely to have respiratory acidosis (p=0.01) and hypercapnia (p=0.02). There was no difference in length of hospital stay.

This study supports the recommendation of titrating oxygen therapy to oxygen saturation of 88-92% in adults with acute exacerbations of COPD.

Dr Julia Critchley,
CT2 South East Scotland

Reference:
Lean Body Weight Scalar for the Anaesthetic Induction Dose of Propofol in Morbidly Obese Subjects.

Anaesthesia & Analgesia, July 2011. Volume 113. Number 1; pages 57-62

This was a randomised controlled study comparing different weight-based scalars for dosing propofol for anaesthetic induction in morbidly obese (MO) subjects.

Background

It is well recognised that MO patients present a significant challenge to the anaesthetist; the effects of obesity on a patient's physiology are well documented. However the effect of excess fat on the clinical pharmacology of anaesthetic drugs is relatively unknown.

The volume of distribution of drugs in obese subjects will vary compared with the non obese, resulting in a decrease in lean body weight (LBW) per kilogram body weight. In addition, MO patients have an increased cardiac output, total blood volume and changes in regional blood flow, which affect peak plasma concentration, clearance and elimination half-life of many anaesthetics.

The authors of this study proposed to determine which is the most appropriate dosing scalar - total body weight (TBW), LBW or ideal body weight (IBW) - for the induction dose of propofol in MO subjects. They hypothesised that LBW would be a more appropriate dosing scalar than TBW for MO subjects.

Methods

Sixty MO subjects (BMI >40 kg/m2) were randomised to receive a propofol infusion (100mg/kg/hr) for induction of anaesthesia based on TBW or LBW. Thirty control subjects (BMI<25kg/m2) received a propofol infusion (100mg/kg/hr) based on TBW. Syringe drop was used as the marker for loss of consciousness (LOC), at which point the propofol infusion was stopped. The propofol dose required for syringe drop and time to LOC were recorded.

Results

All patients enrolled completed the study. The propofol dose at the time of LOC was larger in the MO group receiving propofol based on TBW versus LBW (244.7 Vs 183.3 mg, P=0.0002). Dose per kg LBW in the MO group given propofol based on LBW was similar to the dose per kg TBW in the control group (2.76 Vs 2.57mg/kg). Time to LOC was shorter in the MO group who received propofol based on TBW compared with control subjects and MO patients receiving propofol based on LBW (65, 86 and 94 seconds respectively; P = 0.0001)

Discussion

The results from this study suggest that using a TBW dosing scalar in MO patients may result in an overdosing of propofol. An overdose would result in a larger plasma concentration, faster time to LOC, and possibly a greater degree of hypotension and prolonged time to awakening compared to MO patients who receive propofol based on LBW. A limitation of this study when applied to our everyday practice would be the ability to measure patients LBW. There are many formulae for doing so which can be found by performing a quick internet search on Google, or by using a formula described by Janmahasatian et al1: Alternatively, direct measurements can be obtained using a body impedance scale. The scale used for this study, the Tanita TBF-310 costs £1,324.36 (weight limit 270 kg) and requires shipment from the USA. There are cheaper scales available; however these tend to have a low upper weight limit, rendering them useless for this purpose.

Dr Louise Roberts,
ST5, Northern Schools of Anaesthesia

Reference:

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Hung M, Besser M, Sharples LD, Nair SK, Klein AA.

The prevalence and association with transfusion, intensive care unit stay and mortality of preoperative anaemia in a cohort of cardiac surgery patients.

When physicians discuss anaemia they can get very animated and often have widely differing, strongly held, views. Some worry about the complications of transfusion such as reactions and transmission of infection and hence not allow their patients to tolerate very low levels of haemoglobin whilst others will transfuse their patient if the haemoglobin is less than 10 g/dl irrespective of the cause. The authors of the present study examined the blood results of more than 2500 consecutive patients who were admitted for elective cardiac surgery. Surprise findings were that more than half the patients were anaemic preoperatively and that the anaemia was independently associated with increased length of Intensive care unit (ICU) stay, increased transfusion requirements and increased mortality. The study certainly demonstrates that preoperative anaemia is not a benign condition but we still do not know whether the anaemia is a surrogate marker for systemic illness or whether transfusion of blood on its own leads to a prolonged ICU stay. The take home message is that we should be wary of preoperative anaemia in elective patients and perhaps actively treat this before surgery is performed.

Kanlapillai D, Story D, Hart GK, Bailey M, Pilcher D, Cooper DJ, Bellomo R.

Postoperative hypothenmia and patient outcomes after elective cardiac surgery.

In this study from Australasia the authors looked retrospectively at patient data from more than 43,000 admissions to sixty Intensive Care Units following elective cardiac surgery. Defining hypothermia as a core body temperature of less than 36°C they found that fully two thirds of patients had hypothermia at some point during the first twenty-four hours following admission. Persistent hypothermia, that is hypothermia not corrected within 24 hours of admission, was present in 0.3% and this sub-group of patients were much more likely to die than patients who only had transient hypothermia. Although persistent hypothermia may be a marker of generalised illness we know that it leads to problems such as coagulopathy and impaired wound healing so it would appear sensible to actively attain and then maintain normothermia in these patients.

Cowie B, Kluger R.

Evaluation of systolic murmurs using transthoracic echocardiography by anaesthetic trainees.

The authors took five “ naïve” trainee anaesthetists into a classroom for an hour to teach them the basics of transthoracic echocardiography (TTE) after which they spent an hour performing practical TTEs. They were then asked to assess real patients to determine the presence and severity of aortic stenosis. The newly trained anaesthetists were remarkably accurate at measuring peak velocities across the aortic valve because their values correlated well with those of an experienced cardiac anaesthetist. It is clearly important that significant aortic valve disease is excluded when patients present with previously undiagnosed systolic murmurs during preoperative assessment and the training of anaesthetists in basic TTE is helpful. My only concern is the medicolegal implications and consequences if a diagnosis of severe aortic stenosis is missed by the “trained” clinician. These potential problems may be circumvented with the introduction of officially sanctioned short courses for trainee anaesthetists which would, I feel certain, prove popular in my Hospital.
Dear Editor

I would like to inform your readers about a very interesting new book - "While You Sleep", a personal journey in anaesthesia written by Roy M. Humble, a long time member of our association. If they have ever wondered about ways to raise the public profile of our speciality, this book may provide a possible answer. Writing for both a lay and professional readership, the author uses a mixture of anecdote, humour, travelogue and history to present his very personal medical journey through a collection of often hilarious stories from work and play across three continents. He also looks back at some outstanding pioneers from the sixteenth century onwards, opening hidden pages from the past to highlight the emergence of modern anaesthesia and its importance in the history of social progress.

Roy Humble qualified in Medicine at the University of Glasgow in 1953 and spent his early years as a family physician in East and central Africa. After completing his training in anaesthesia in England, he worked as a Consultant Anaesthetist in Dumfries before emigrating to Canada in 1969.

While You Sleep may be obtained directly from the publishers-sales@melrosebooks.com or from most bookshops by quoting the ISBN number-978-907040-78-8 or from amazon.co.uk or amazon.com. At a modest cost of £11.99

I believe your readers will find this a most enjoyable book.

Dr Carmel F. Martin,
Consultant Anaesthetist, Wigan and Leigh NHS Trust

Dear Editor

Piggy in the Middle

Do you remember the playground game where one child, usually the smallest or youngest, had to try and intercept a ball thrown between two bigger kids?

Well, we SAS doctors often feel like that. We are often referred to as ‘middle grades’ when in fact we should be regarded as senior, permanent members of the medical staff. What does the term ‘middle grade’ mean anyway? Is it a trainee half way through training? Is it a specialty doctor on the middle tier of the career progression ladder? Is it a ‘half-trained’ doctor who can only provide a limited service?

It is true to say that we often take part in a ‘middle tier’ of the rota, with trainees below and consultants above, but more and more these days consultants are also on those same resident on call rotas or that middle tier has been removed. In our everyday work, SAS doctors act at many levels, from the provision of basic acute and elective care and working on the out of hours rota, to leading at a very senior level in many specialist areas.

Whatever you want to call us, we appeal to all of our colleagues to stop using the term ‘middle grade’, and for SAS colleagues to stop thinking of themselves that way too.

Dr Ramana Alladi,
AAGBI SAS Committee Chairman

The new AAGBI Innovation in Anaesthesia and Critical Care Section

The AAGBI, whose Heritage Centre houses the largest and the most comprehensive museum of anaesthesia innovations through the centuries in this country, is ideally placed to support future developments in our specialty. Anaesthetists on the whole are very inventive individuals, always at the forefront of innovations and practical solutions, but do not always know how to progress further with their ideas.

The aim of this newly created section is to:

- encourage and promote innovation in our speciality
- facilitate legal and expert help for individuals or groups of innovators
- create a fund for young inventors
- facilitate contacts with, and introduction to, anaesthetic equipment manufacturers
- facilitate testing and marketing of the new equipment
- hold an annual innovation seminar and drop-in ‘surgeries/clinics’
- establish an annual AAGBI prize for the best innovation in anaesthesia and critical care, presented during the AAGBI Winter Scientific Meeting, in London

The Inaugural AAGBI Prize for Innovation in Anaesthesia and Critical Care

The Association of Anaesthetists of Great Britain and Ireland invites applications for the Inaugural AAGBI Prize for Innovation in Anaesthesia and Critical Care. This prize (up to £2000) is open to all anaesthetists and intensivists. The emphasis is on new ideas contributing to patient safety, high quality clinical care and improvements in the working environment. The entries will be judged by a panel of experts in respective fields.

Applicants should complete the on-line application form which can be found at the AAGBI website www.aagbi.org/research/innovation. The closing date for applications is Friday, 25th November 2011.

The winner of the Prize will be announced at the Winter Scientific Meeting in January 2012 and the prize will be presented by Dr Archie Brain.
Dear Editor

We wish to report an unusual cause of endotracheal tube cuff failure during bimaxillary osteotomy. A laceration to the endotracheal tube was accidentally made with an osteotome.

Although this was not full thickness, the pilot balloon tubing within the tube wall was severed, thereby causing cuff failure. This necessitated a change of endotracheal tube and a significant disruption to the smooth progress of surgery. The accompanying photo shows blood tracking away from the site of laceration within the pilot tubing.

Dr Rebecca Campbell,
SpR Anaesthetics, Kings College Hospital

Dr Nicholas Parry,
Consultant Anaesthetist, Kings College Hospital, London

Dear Editor

We would like to bring to your attention an event which occurred recently which we believe contains many lessons for healthcare professionals.

One of the authors attended a cardiac arrest on a medical ward where basic life support was already in progress by nursing staff. Advanced airway management was subsequently handled by the author, who is an anaesthetist. As the patient was being intubated there was a very loud noise from the mask, which had burst. It was subsequently noticed that the syringe port at the bottom of the mask had been connected to the wall oxygen supply via standard oxygen tubing prior to our arrival.

We acknowledge that all members of staff who participate in resuscitation should be familiar with the use of the airway equipment. However, this incident could have been avoided altogether by stocking the arrest trolleys with masks that do not have inflation ports.

Intrathecal/epidural syringes and oral syringes have already been the subject of recent NPSA safety alerts [1,2] after serious untoward incidents. Solutions now exist where the potential for repeat harm is much reduced. Much work is already currently underway in looking at reducing risk in clinical processes [3]. Designing or engineering out medical error from clinical areas ensures that the risk of harm is reduced.

Although the patient did not survive, in this case the outcome was not affected by the event as the mask was on the bed and not the face when it burst. The patient was ventilated with oxygen from a separate port. A report was filed with the NRLS [4] and local clinical incident reporting system.

Dr Nawal Bahal,
Paediatric Anaesthesia Clinical Research Fellow,
The Royal London and Great Ormond Street Hospitals

Dr Sanjay Saikia,
Paediatric Anaesthesia Clinical Research Fellow,
The Royal London and Great Ormond Street Hospitals

Dr Barry Clifton
Consultant Paediatric Anaesthetist,
Barts and The London NHS Trust’

References:
1 NPSA safety alert NPSA/2009/PSA004A
2 NPSA safety alert NPSA/2007/19
3 Designing Out Medical Errors (DOME). http://www1.imperial.ac.uk/surgeryandcancer/divisionofsurgery/research_themes/dome/
Orthopaedic Surgeon wins NHS Innovator of the Year 2011

A delighted Clive Prickly was presented the NHS Innovator Award last night by the Secretary of State for Health for his Human Traffic project work at Grimsdyke NHS Trust.

In his acceptance speech, Clive was kind enough to describe how his revolutionary ideas for improving patient flow and safety in hospitals had taken effect.

“I was leaving theatre to enter the anaesthetic room to investigate why the anaesthetist was taking so long to perform a perfectly simple GA. I was enthusiastically approaching the left hand door, but was totally unprepared for the ODP who came charging through the same door resulting in a collision of both a physical and psychological nature.”

Unfortunately the sight of Mr Prickly being bowled over by Timmy Mussel was unusually humiliating.

According to Mr Prickly in the root cause analysis which followed this event (and his black eye), no one should ever push the right hand of a pair of doors as anyone with any sense knew that doors should be opened using the UK driving convention. As a keen driver he argued this with a passion and was somewhat frustrated with the hospital safety officers’ responses to his request for some sort of solution that “even mere imbeciles could understand”.

Like many changes in the NHS, it took a dedicated individual to design a suitable system, and on Monday the 15th of February staff arriving at Grimsdyke noticed immediately that all double doors were now marked with a no entry sign on the right door to ensure that staff did not collide while trying to use the same door from different directions.

It was at this point that Clive really began to enthuse about the potential of his creativity. The following weekend the hospital corridors were painted with a dashed white line down the centre and double white lines wherever narrowings or collision risks occurred. Corridor junctions were now hatched with yellow hatches and stop signs. Give way signs and warnings of hazards were also featured.

“I even put double yellow lines to stop physicians loitering and obstructing the corridor, although this took a bit of training to get them used to doing something useful for once instead of occupying my beds”.

The Chief Executive Justin Post accepted that the idea possibly had some merit, but only really became an enthusiastic supporter of the Human traffic project after a Care Commission visit described the innovation as “Best Practice” and were highly complimentary about Justin’s use of orthopaedic expertise. “Most unusual for this level of interest and cooperation” was noted in the final report by Ms Ernestine Tutting.

Although the initial phase of the project was partially successful, Clive was disappointed (livid) with the behaviour of some of the junior doctors who were seen to overtake on the wrong side of the corridor, refuse to stop at crossings and at times were even observed to stand on his double yellow lines.

“I knew that we needed some type of enforcement to ensure safety was properly observed” explained Clive, “so I asked my old colleague Infection Control Sister Prittlestick if she would mind becoming a Traffic Warden for the corridors. This she did with the sort of dedication and assertiveness that she has used with other policies”. Astonishingly Clive and Sister Prittlestick have forgotten their past differences (white coats, ties, watches, hand washing to name a few) and they have now become a united front on the project with whistles ready to enforce the traffic laws. A new uniform has been designed for the purpose along with a cap and notebook for miscreants.

As soon as the NPSA were made aware of the importance of the work, they launched a special measure to introduce it throughout the NHS in England and Wales – “Workshops galore are planned nationally and internationally!” enthused Suzi Chattianice.

Many patients are delighted with the change made to the hospital, although one elderly lady Miss Connie Fused expressed some difficulty after receiving a ticket for turning right into the day case unit without a clear hand signal causing a near collision with an overtaking senior surgeon. However after a discussion with Sister Prittlestick she paid for her infringement at the local fines office in the orthopaedic department. “I suppose it all goes to a good cause – what is an ortho-research fund?”

From our correspondent Scoop O’Lamine
We’re keen to find out from you, our members, what you think about us, our work and the service we provide you. It’s been some years since we carried out a survey and we need to ensure that our activities continue to reflect your needs, views and opinions so the AAGBI can continue to support you and your career for years to come.

Please help us out by either filling in the survey online at www.enventure.co.uk/aagbi/survey.htm

Or

fill in the paper copy and send it back using the freepost envelope provided.

The survey should only take 10-15 minutes to complete. We really appreciate you taking the time to respond.

If you have any questions about completing the questionnaire, please call the survey helpline on 0845 345 9110 or email Matthew at our market research company aagbi@enventure.co.uk
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