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Fire on intensive care caused by an oxygen cylinder

Anaesthetic confusion on the delivery suite

Trainee survey on workforce planning
And without a pulse oximeter, millions of lives are put at risk. They’re making contributions to send a pulse oximeter to an operating room in need. And they’re ensuring that all patients have access to the care they deserve.

77,000 ISN’T A SMALL NUMBER. BUT IT’S NOT AN IMPOSSIBLE ONE.

TODAY, TENS OF THOUSANDS OF OPERATING ROOMS DON’T HAVE A PULSE OXIMETER.

And without a pulse oximeter, millions of lives are put at risk. That’s why scores of hospitals, medical organizations and private donors are taking a stand against unsafe surgery. Others have increased their involvement in departmental management, introducing a Trainee Service Lead to improve trainees’ input into the management team and prevent trainee issues taking a back seat. A new flexible trainee reflects on finding himself as the only male, and suggests that in future there will be greater male participation in childcare, and increasing demands for flexible work patterns. The GAT/RCoA trainee committee survey outlines the views of trainees on the changes being proposed to consultants’ jobs. Essentially the Centre for Workforce Intelligence predicts an oversupply of anaesthetists and have recommended cutting our numbers in favour of more GPs. Not good news, either for our trainees or for our future patients.

I write this looking out over snow-covered fields, hoping that by the time it arrives on your doorstep spring will be in the air.

I read the description of the fire with a combination of horror and admiration. I must admit that I complete my mandatory fire safety training, secretly thinking that if I was faced with a real fire I’d read the label on the extinguisher to see how to use it. Clearly this wouldn’t work in practice; finding the extinguisher would be challenge enough with visibility of less than a metre and acrid smoke would make my eyes water. The article and pictures bring into stark focus the difference between training and the real thing. Advice from the Department of Health to leave the fire to the professionals, evacuate the area and shut the doors, didn’t seem to be the best plan. Instead it was the quick thinking of two trainees who put the fire out that prevented a much worse situation. Involving the clinical psychologist on the day of the fire to discuss events with the staff, was very helpful and something the writers suggest we should include in any major incident plan.

But it’s not just fire fighting where trainees come into their own; other contributions show resourcefulness in other aspects of practice. One presents a guide to the confusing abbreviations used in the labour ward, for those new to obstetric anaesthetic practice. Others have increased their involvement in departmental management, introducing a Trainee Service Lead to improve trainees’ input into the management team and prevent trainee issues taking a back seat. A new flexible trainee reflects on finding himself as the only male, and suggests that in future there will be greater male participation in childcare, and increasing demands for flexible work patterns. The GAT/RCoA trainee committee survey outlines the views of trainees on the changes being proposed to consultants’ jobs. Essentially the Centre for Workforce Intelligence predicts an oversupply of anaesthetists and have recommended cutting our numbers in favour of more GPs. Not good news, either for our trainees or for our future patients.
The President outlines the proposals made in the Doctors’ and Dentists’ Remuneration Body (DDRB) report on the future of Clinical Excellence Awards, pointing out the inequities of the current system and raising serious concerns about the idea of a management appointed grade of Principal Consultant. Whatever our views are of the system as a whole, he is clear that he will work hard on our behalf to make sure that any new system is fair.

Strong national leadership will certainly be appreciated in my department. A downhearted coffee room discussion on this topic was only trumped by rumours that the Trust was about to remove 100 places from the car park. The medical student doing her 6 week option in anaesthesia looked on with amazement as news spread round the theatre suite and the mood grew darker. She had been contemplating a career in anaesthesia, and still naively thought consultants and senior trainees might earn an element of respect. 3 days’ notice that we would have to park over a mile away didn’t seem to demonstrate this to her, and my rather weak attempt to give a positive spin by remarking on the solidarity amongst the anaesthetists, surgeons and theatre nurses in objecting to this, probably won’t do the trick. Personally I’ve given up the fight. My son has bought me a folding bike on Ebay and I’ll park on the street fairly near the hospital and cycle the rest of the way. I’m not relishing the prospect – I’m as fit as a South American sloth with a body that was never built for a bike. But with spring in the air perhaps I’ll change my mind – Principal Cyclist - now that is something to reward!

Dr Nancy Redfern

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2008 CEA Ratio</th>
<th>2011 CEA Ratio</th>
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<td>Medicine</td>
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<td>2.22</td>
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<td>0.37</td>
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Table: 2008 and 2011 National Clinical Excellence Awards Ratio for major hospital specialties if awards were distributed pro rata. The ratio for all specialties would be 1.0 (exact method of calculation given in footnote 1).
Whatever the merits or injustices of the current ACCEA system, the clear role of those leading our specialty is to do what they can to make sure that any system that emerges from the DDRB report is equitable. This is particularly true for the processes underpinning the promotion to any new grade such as that of Principal Consultant. Although there have been arguments in the past that awarding CEAs on a pro rata basis would steer the system away from one that focuses purely on clinical excellence, it is my personal view that the time is now right to insist that excellence awards and Principal Consultant posts be awarded to specialties on a pro rata basis. We comprise 16% of NHS consultants and our contribution to the health service in the NHS is no less than that of any of our consultant colleagues in other specialties. We must be prepared to argue this case and, if necessary, to fight for what is fair.

I will leave you with three final comments. Firstly, there are those that have said that in the past, the leaders of professional medical organisations have been a little hesitant in their criticism of merit award and clinical excellence systems, if any, are very different. The AAGBI will do what it can to promote the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatsoever in the CEA system, and that the interests of all our members. Finally, I know well that many AAGBI members have no interest whatever in the CEA system.

The AAGBI is currently a principal charity under the charities act 2005, with registered charity number 221963. The AAGBI is audits its accounts and reports annually to its membership and to the Charity Commission. The Annual Reports can be found on the website www.aagbi.org.The AAGBI’s Annual General Meeting is held in January each year and business is conducted at this meeting.

You are invited to submit an abstract for oral (free paper) or poster presentation at the Annual Congress. The deadline for submission is midnight on Monday 10 June 2013 and full instructions can be found on our Annual Congress microsite: www.aagbi.org/annualcongress. Thereafter, a preliminary review of the abstracts received will determine which ones are accepted for presentation at the Annual Congress in Dublin. Some authors will be invited to present their work orally, under the following three categories: audits and surveys, case reports, and original research. It is anticipated that more than 1,000 abstracts will be received, and that only a proportion will be accepted for presentation. The remaining successful authors will be invited to submit a poster. All abstracts received will be published in Anaesthesia in a form which will be available online, and there is the possibility that a number of abstracts will be selected for publication in the journal. 

Methods of calculation of figures in table:

A. Proportion of consultants in each specialty taken from the numbers of those eligible for Bronze Awards, page 20 of [3].
B. Major specialty defined as one that has >=5% of total NHS consultants.
C. Total number of awards given in 2008 and 2011 rounds taken from [2] and [3].
D. Total number of awards given in 2008 and 2011 taken from page 5 [2] and page 12 [3].
E. The CEA Ratio is that of the number of awards given per specialty (D) to the number of consultants made pro rata, i.e. D/A/C. 

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Dr William Harrop-Griffiths
Immediate Past Honorary Secretary

References
1. Dr William Harrop-Griffiths, Immediate Past Honorary Secretary

Dr William Harrop-Griffiths
Immediate Past Honorary Secretary
On the 21st November 2011, a fire occurred on our Intensive Care Unit (ICU) at the Royal United Hospital, Bath. An oxygen cylinder, laid on a patient’s bed to provide oxygen to her whilst she was being transferred to another hospital, was turned on and then caught fire. Her mattress and bedding immediately ignited, rapidly followed by the curtains around her bed, the floor and ceiling tiles. Within seconds the ICU filled with thick, black, acrid smoke; visibility was reduced to less than a metre and breathing became extremely difficult. The patient on the burning bed was pulled safety to two nurses and ten of the eleven ICU patients were evacuated within seven minutes. The eleventh patient, ventilated in a side room, was not immediately affected and was evacuated ten minutes later.

The fire was put out by two doctors, using five fire extinguishers. The patient on the bed suffered burns to her lower legs but no other patient suffered ill effects. However, one member of staff was admitted overnight and another was kept in hospital for six hours with smoke inhalation injury. The Health and Safety Executive (HSE) investigation is ongoing and their final report is awaited at the time of writing.

Following this fire, BOC has released recommendations on the use of oxygen cylinders (table 1) and these have been endorsed in a statement by the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

The ICU staff have drawn up a list of issues that we are addressing in Bath and which could be considered by other ICUs and theatre suites. We should emphasise that the HSE investigation is still in progress and is likely to make recommendations of its own, however, this incident has many implications for patient safety and, in our view, a discussion at this stage is helpful.

We have improved the way we carry out fire training for our ICU staff. Fire safety training for all staff occurs at induction and thereafter every two years. We were fortunate that the consultant in charge at the time of the incident had undergone a new fire training session on the ICU when starting her consultant post; in addition, two new nurses, who were working their first ICU shift that evening, had been shown the ICU fire call point and fire extinguishers earlier that day. In addition to the Trust standard fire training, all our ICU junior doctors receive a ‘fire tour’ of our ICU, which is being built with water sprinkler systems and multiple corridors, providing alternative exit options (personal communication, D Holland, North Bristol NHS Trust), although specialists reviewing our fire feel that a sprinkler system would not have had an effect on a fire caused by an oxygen cylinder as in our case (personal communication, P Henry, BOC.). We were fortunate that our ICU is on the ground floor, enabling us to evacuate our patients in the service road outside. Due to the fact that visibility was so poor, many staff involved have asked whether we should install illuminated fire exit signs. All our ICU mattresses, bedding, curtains and flooring meet NHS standards (Ref 2) for fire retardant materials; however, this standard is tested with a match or small fire, rather than an oxygen-related fire, and some have asked whether there should be stricter NHS fire retardant standards for ICU equipment and materials.

It is not common in the UK for medical staff to be trained in the operation of a fire extinguisher; we understand that this is also true in industry (personal communication, D Molvsz, MHRA.) The Department of Health recommends that staff leave fire fighting to those who are experienced in the use of extinguishers, as described in The Regulatory Reform (Fire Safety) Order 2005 (ref 3). Their advice is to leave the fire, evacuate the area, shut the doors and await the fire and rescue service. If we had followed this advice, the whole ICU and possibly the entire surgical block would have caught fire; had this happened it is likely that there would have been numerous fatalities. In our opinion, there should be a national debate on whether ICU staff (and other frontline hospital staff) should be trained in the use of fire extinguishers. Our Trust fire training officer is happy to train ICU and theatre staff on the use of fire extinguishers, but at present it is not clear as to exactly who should receive this training and who should not.

Finally, we were extremely fortunate that the clinical psychologist attached to our ICU came into the hospital on the night of the ICU fire to debrief staff and to talk to those most severely affected. Many of the staff working that night had a severe post traumatic stress reaction, and have been receiving help from him and his team over the past year. We feel that getting such input at such an early stage had an enormous beneficial effect, and that including such psychologist input in major incident planning should always be considered.

Whilst all hospitals already have a comprehensive policy for major incidents, such plans are not entirely applicable to an internal emergency such as ours, where in patients and clinical staff are victims of the emergency. Therefore, we hope that our suggestions might contribute to a more robust approach to this kind of scenario more widely in the NHS.

Flora Kelly Consultant in anaesthesia and intensive care medicine Royal United Hospital, Bath

James McDonald ST3 emergency medicine Great Western Hospital, Swindon

References

FIRE ON INTENSIVE CARE CAUSED BY AN OXYGEN CYLINDER

We have rewritten (and tested) our ICU fire evacuation policy following the fire. The main changes are that we now plan to evacuate ICU patients to the Emergency Department (ED), rather than the medical admissions unit, and our plans take into account that staff may be injured themselves and so cannot be relied upon to care for ICU patients. The ED has multiple monitors, a number of transport ventilators and staff who regularly care for sick patients, often in significant numbers. The ED also has the ability to divert ambulances, giving it more flexibility than a hospital ward. We have installed a dedicated telephone line between ICU and ED to facilitate communication in an emergency, and are in the process of rewriting our theatre evacuation policy.

Our fire alarms and the fire control panel in switchboard have been upgraded to make it easier for switchboard staff to see where a fire call point is activated and to speed up communication with the fire and rescue services. We are considering a text-based system calling in medical staff in the event of a major incident, rather than relying on switchboard to call doctors individually.

New ICUs are designed with multiple side rooms and/or small beds of patients, which would be better at preventing the spread of a fire than our large open plan ICU. Indeed, during our fire, one patient remained safely ventilated in a side room throughout the incident. We are aware of one new ICU which is being built with water sprinkler systems and multiple corridors, providing alternative exit options (personal communication, D Holland, North Bristol NHS Trust), although specialists reviewing our fire feel that a sprinkler system would not have had an effect on a fire caused by an oxygen cylinder as in our case (personal communication, P Henry, BOC.). We were fortunate that our ICU is on the ground floor, enabling us to evacuate our patients in the service road outside. Due to the fact that visibility was so poor, many staff involved have asked whether we should install illuminated fire exit signs. All our ICU mattresses, bedding, curtains and flooring meet NHS standards (Ref 2) for fire retardant materials; however, this standard is tested with a match or small fire, rather than an oxygen-related fire, and some have asked whether there should be stricter NHS fire retardant standards for ICU equipment and materials.

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Whilst all hospitals already have a comprehensive policy for major incidents, such plans are not entirely applicable to an internal emergency such as ours, where in patients and clinical staff are victims of the emergency. Therefore, we hope that our suggestions might contribute to a more robust approach to this kind of scenario more widely in the NHS.

Flora Kelly Consultant in anaesthesia and intensive care medicine Royal United Hospital, Bath

James McDonald ST3 emergency medicine Great Western Hospital, Swindon

References

Table 1: Suggested best practices when setting up and administering medical gases
1. Set up the cylinder for patient use before placing it close to the patient
2. Place the cylinder in an appropriately designed holder
3. Avoid placing the cylinder on the bed next to the patient if at all possible; use extra care when there is no option but to place the cylinder on the bed

The most likely time for an ignition to occur is either when the valve is initially turned on or when a flow is selected. Hence the advice is to:
- a) connect the tubing and oxygen delivery device to the cylinder;
- b) slowly open the cylinder valve;
- c) select the prescribed flow rate;
- d) if required, check the gas is flowing;
- e) fit the oxygen delivery device to the patient.

Where possible, cylinders should be placed in holders designed to be fitted, usually, to the bottom of the bed (or to the back of wheelchair). The position of the holder needs to take account of how close the cylinder is to the patient. The holder should ideally keep the cylinder upright so that if there is an ignition its impact would be minimised.

Although cylinder holders and brackets are available, a suitable design is dependent on the specific bed or wheelchair being used. As the NHS uses many different types of hospital beds and trolleys, there is no single design that can be used in all situations and it remains an issue to be resolved. BOC Ltd are currently working with bed, trolley and wheelchair manufacturers to develop suitable cylinder supports.

There are times when there is no option but to place the cylinder on the bed. If this is the only option, setting up and turning on the cylinder before putting the cylinder on to the bed will minimise the potential risk of injury to the patient.
A national survey of anaesthetists (NAP5 baseline) to estimate an annual incidence of accidental awareness during general anaesthesia in the UK

This is the first publication from the NAP5 group tasked with examining accidental awareness during general anaesthesia, and describes the largest national survey conducted to date. It is also historic in that it is the first joint publication between Anaesthesia and the British Journal of Anaesthesia, reflecting its unique and vital importance as viewed by the AAGBI and the Royal College of Anaesthetists. Every single hospital in the UK contributed, and the experience of 7125 anaesthetists (82% of the total number of consultants and non-consultant career grades) in a single year (2011) is brought out.

What is fascinating is that, despite the comprehensiveness of this survey in terms of numbers of anaesthetists quizzed and the inclusion of every NHS hospital, only 153 cases of accidental awareness were reported, which equates to an incidence of about 1 in 15,000. This implies that the rate of accidental awareness, in the UK and in the year 2011 at least, is much lower than previously suggested from the literature. Only 46 cases of accidental awareness were reported during surgery itself, the rest occurring before surgery started or after its conclusion, and the authors confirmed that patients who experienced accidental awareness during surgery were considerably more likely to go on to register a complaint.

Why the incidence of accidental awareness should be so low is a matter of conjecture. However, it appears we can rule out a major contribution from specific monitors of depth of consciousness, as routine use was reported by less than 7% of anaesthetists. The authors speculate on whether UK patients may be especially resistant to accidental awareness by virtue of being particularly sensitive to anaesthetic agents or by nature of their psychological response to the experience. The low incidence may also be due to missing some cases that were not reported to anaesthetists, or were reported to anaesthetists not responding to this survey, but this also appears to be unlikely. An alternative explanation may be an evolution in anaesthetic practice since other published studies reporting a higher incidence were carried out.

Whatever the explanation for the very low incidence of accidental awareness reported by the NAP5 team in this survey, there is no doubt that we should all read their study closely, and we look forward to the publication of their prospective study of the causes and effects of a large number of cases of accidental awareness during general anaesthesia currently in progress.


Genetic variation and cognitive dysfunction one year after cardiac surgery

Over recent years our department has been working hard to balance the training and education needs of the trainees with the service requirements of the department. To help facilitate this, the role of Trainee Service Lead was introduced in February 2011. It was initially an expansion of the "Admin SpR" role which was previously given to a senior trainee who needed some management experience. It is now appointed to a senior trainee (STS+) at our hospital for 6 months or more in a competitive application process, including interview.

Since its inception, the role of TSL has been working to increase trainees’ input into the management team, to help facilitate this, the role of Trainee Service Lead was introduced in February 2011. It was initially an expansion of the "Admin SpR" role which was previously given to a senior trainee who needed some management experience. It is now appointed to a senior trainee (STS+) at our hospital for 6 months or more in a competitive application process, including interview.

One day per week is allocated to the role, and Workplace Based Assessments have been developed to allow completion of a Management Module to reflect the educational value of the post. We have found that there are many advantages of this role, both for the department as a whole and for the individual trainee appointed.

**Departmental advantages**

1. Improved training and education for trainees

In order to optimise the educational value of on calls, the first TSL restructured the on call rota allocations to match a trainee’s on call commitments to their daytime training module. This has maximised trainee’s exposure to all aspects of the curriculum of the module they are completing and has also enabled the completion of modules in 2 months, rather than 3 months (excluding intensive care). Compulsory modules are therefore completed more quickly, allowing trainees to spend more time in...
areas of their choosing. By limiting the number of trainees per module at any one time, it also ensures that trainees are more evenly spread across theatres and fewer moves out of module are needed. The only disadvantage of this is that getting the rota is even more of a challenge!

The daytime allocation of trainees to appropriate lists is also audited. The weekly rota is reviewed and the number of training lists each trainee has been allocated to and their number of supervised sessions is audited. The number of trainees per module at any one time is reviewed and the number of training lists each trainee has been allocated to is recorded: the “Time in Module” audit. This is completed for all trainees who have spent excessive time out of module or who have fallen below the recommended levels of direct supervision can be highlighted.

Finally, to improve the departmental educational programme, the role of Trainee Education Lead has recently been proposed and is being trialled. This is for a post fellowship trainee with an interest in teaching and medical education. It provides a link between the consultants who are involved in teaching and allows for coordination of various teaching programmes. It has improved the weekly whole-department teaching programme and the CME opportunities for consultants.

2. Increased departmental awareness of trainee issues

We have improved this by introducing specific, regular meetings at which trainees can raise any concerns or issues they have: the Trainee Forum. This is supported by the consultants who ensure trainees can be released from their lists to attend. There are also regular meetings to feedback issues arising at this meeting with the College Tutors, Management Team and Consultant body which allow time for discussion. The role was incredibly hard work and did spill over the allocated time. At times it could be frustrating, partly from trying to track down the information we needed and often because it changed at short notice.

In Summary

Creation of the Trainee Service Lead role is not “rocket science” but is a complicated process that demands on resources. The lessons learnt may seem obvious and predictable, however the role does acknowledge the value that trainees can be to the management team in a department and also trainees to take some responsibility for their education and training. In our department it has been a positive step forward. On a wider scale it is hoped that the development of the TSL role not only benefits our department, but also any department in which the former TSLs work in the future, either as a trainee or consultant.

Dr Emma Plunkett, SpR
Dr Kerry Cullis, Consultant Anaesthetist
Dr Kate Cliff, Deputy Clinical Service Lead for Anaesthesia
Queen Elizabeth Hospitals Birmingham

Acknowledgements

We would like to acknowledge the work of the Trainee Service Leads who were appointed before us, Nick Parry, Annabelle Whapples and Ruth Francis, as well as Kate CIR for creating the role and management module and mentoring us all.

References


2. Practical management experience

Being Trainee Service Lead is an excellent opportunity for trainees in our School of Anaesthesia to gain management experience alongside clinical work, which is often difficult as a registrar. Trainees get a better understanding of the roles and demands on the departmental management team earlier in their careers. Communication and negotiation skills are developed which are especially important for the representative aspect of the role. The completion of a management project allows the trainee to develop an interest in a particular area and to contribute to and improve how the department functions.

2. Competitive application process

This is good practice for senior trainees approaching the end of their training and who are looking to undertake a consultant interview. The recruitment process is coordinated by the out-going TSL and we have found that there is as much to be learnt by interviewing as being interviewed.

Personal experience

We are the most recent TSLs to have completed the role. We are LTFT trainees and were appointed to the post jointly in January 2012. It was the first time the role had been shared by two LTFT trainees and there was some nervousness about how it might work. Most of the tasks were completed jointly but there were some that it was helpful for one of us to take the lead on. We split the allocated time between us but also made sure we had a regular “management” session together to make sure we were both fully informed about everything going on. Simple things like a shared LinkedIn profile for documents and a specific email address to which we both had access were helpful. The feedback at the end of the 6 months was very encouraging and one of us was appointed as a consultant in the department during the time in post.

In August’s Anaesthesia News, we launched our Environmental Policy Statement outlining our commitment to provide services in a way that ensures a safe and healthy workplace that minimises our environmental impact. This includes taking a more environmentally friendly approach to educational events. We run over 70 events a year and we are already taking steps to reduce our carbon footprint whether in-house at 21 Portland Place or externally.

We have:

• Encouraged greater use of online booking,
• Reduced paper advertising and increased electronic formats;
• Printed materials on Forest Stewardship Council (FSC) accredited paper www.fsc-uk.org;
• Stopped producing the pocket guide (its content is now incorporated into the Event Application).

We plan to:

• Gain online feedback from delegates and exhibitors;
• Stop producing a USB memory stick which reduces carbon costs from shipping and material used (the USB’s content is now incorporated into the Event Application);
• Switch the event branding and remove electronic materials where we can rather than shipping material to events where it is not required.

We are considering:

• Installing water coolers instead of using bottled water;
• Enforcing a zero-waste policy so that exhibitors take home all their waste;
• Offering a ‘green exhibitor award’ or charging exhibitors a fee for excessive waste to encourage less waste;
• Encouraging delegates to car share, use public transport or sign-up to a city bike scheme;
• Reducing building energy by making sure that lights and machinery are switched off when not being used.

We realise that this is just the start, and as an organisation, it is important that The AAGBI is committed to reducing its carbon footprint.

Nicolette Bates,
Marketing and Communications Manager, AAGBI

The AAGBI’s environmental impact and approach to sustainability is central to our organisational practice. Our website contains a hub of information for anaesthetists concerned about reducing the environmental impact of their clinical practice (www.aagbi.org/about-us/environment). However, we want to play our part in making sure that green anaesthesia goes beyond the operating theatre.
Anaesthetic Confusion on the Delivery Suite

Having started a new post in August, in a new hospital, in a new labour ward, with a number of junior anaesthetists new to obstetric anaesthetic practice, we became acutely conscious of just how confusing the profusion of abbreviations and acronyms used at handover and more generally on the labour ward can be. Many are widely used but seem to be specific to individual units.

At handovers, questioning looks frequently exchanged between the anaesthetic team members, supplemented by whispered questions to clarify what a previously unheard or forgotten acronym or abbreviation means. We have composed a short scenario to highlight just how many of these acronyms are in use, and how bemusing handovers can get, particularly to the new ST 1/2 setting out on their first obstetric placement.

The unborn babies themselves may be problematic, they may have Rhesus↓ D, FM, or ↓ AFI and require close CTG monitoring for FHR or FSE if there are trace problems or “decels”, these may be an early sign of APH. There could then be a need to check a BLS to determine the need for cat 1 or cat 2 C/S. There may even be CDCM twins, triplets or quads following IVF. NNU may need to be informed.

TOF, LSCS or ERPC under CSE, GA, SAB or Epi to top up may result in PPH. This in turn will require assessment of EBL and serial FBGs and coags and potentially a t/t of RBCs PRs, FFP and cryo.

After those most awaited three letters, DEL, appear, the problems still may not be over; a trip to theatre may be needed for MRAP!

Sadly alongside the nervous, expectant parents there may also be those admitted with an IUD, potentially requiring a PCA.

Discussion

Of the 300 words in the paragraphs above, 63 are abbreviations! This passage may be somewhat contrived but we believe it is not too far from the reality of what a labour ward handover can sound like.

Abbreviations are widely used in medicine to make handover sheets or notes concise and save time. It has been highlighted that abbreviation can lead to serious morbidity and mortality, especially in prescribing.

Other work has shown how ambiguous abbreviations can be. An audit published in 2008 showed that only 14-20% of abbreviations were standardised (medical dictionary). In addition there were multiple or alternative meanings for up to 12% of abbreviations used. Interpretation of abbreviations by staff is also poor; only 56% of junior/middle grade doctors correctly interpreted the abbreviations in an audit, and in a survey of gastroenterologists only 37% of abbreviations were correctly interpreted by doctors of all grades.

We hope this short article will be of use, reassuring trainees new to obstetrics that it is not uncommon to be baffled by the abbreviations commonly found on labour ward. We encourage them to seek clarity when in doubt, and seek to interprete abbreviations used were standardised (medical dictionary).

References


Glossary

AFI Amniotic fluid index (indication of volume of amniotic fluid based on ultrasound)
APF Acute fatty liver of pregnancy
APGAR Assessment of health of newborn. Devised by Dr Virginia Apgar
APH Anti-partum haemorrhage
ARM Artificial rupture of membranes
BMI Body mass index
BL Blood glucose; Boehringer Mannheim company that produced first test strips
BMI Body mass index
cat1 Category 1 caesarean section- immediate threat to life of mother or fetus
cat 2 Category 2 caesarean section- no immediate threat but at risk
cat 3 Category 3 caesarean section- no immediate threat and not at risk
CDP Cephalo-pelvic disproportion
CS Caesarean section
CSE Combined spinal-epidural
CTG Cardiococgram
DCOA Di-chorionic, di-amniotic twins
“decels” Decelerations
DEL Delivered (on our unit frequently DE denotes baby delivered, with the L added only once placenta is delivered)
EBO Estimated Blood Loss
ERPC Evacuation of retained products of conception, also “Evac” (see also MROP)
EFL Epidural for Labour
FBS Fetal Blood Sample
FGM Fetal growth monitoring
FHR Fetal Heart rate
FM Fetal monitoring/Fetal medicine
FSE Fetal scalp electrode
GBS Group B streptococcus
GDM Gestational diabetes mellitus
HELPP Hypertension, elevated liver enzymes, low platelets
IOL Induction of labour
IUD Intrauterine death
IUGR Intrauterine growth retardation
IVF/ICSI In-vitro fertilization/Intrauteroplastic sperm injection
LSCS Lower segment caesarean section
MLC Midwifery led care
MLU Midwifery led unit
MTO C Medical Termination of pregnancy
NNU Neonatal unit
OAU Obstetric assessment unit
OPD Operating department practitioner
PCR Protein creatinine ratio
PET Pre-eclamptic toxaemia
PPD Pelvic girdle pain (previously SPI)
PH Pregnancy induced hypertension
PPH Post partum haemorrhage
PPROM Prolonged premature rupture of membranes
PROM Premature rupture of membranes
SAB Sub arachnoid block
SABR Situation, Background, Assessment, Recommendation
SCBU Special care baby unit
SPD Symptysis pubis dysfunction
SRM Spontaneous rupture of membranes
SVD Spontaneous vaginal delivery
T/F Transfer or transfusion
TOF Trial of Forceps or Tracheo oesophageal fistula or Traction of Falds
TOL Trial of Labour
VBA Vaginal birth after caesarean section

©Illustration by Gemma Gill

Anaesthesia Meets April 2013 • Issue 309
The Wednesday Core Topics day can be a bit of a struggle for me as I arrive in London early in the morning after an overnight flight. Fortunately, there was plenty to keep me interested and awake, and there is always coffee available during the breaks. I particularly enjoyed Professor Elliott’s lecture on Tracheal Transplants – not only did he describe his exciting developments in the field but he heavily emphasised the value of teamwork in providing health care. I had to check the programme to confirm he really is a surgeon!

Thursday brought a session on ageing – of great personal interest to many anaesthetists, including myself. Dr Jagger’s work encouraged us that it may be worth living beyond 85 after all. Another session was on morbid obesity - less of a personal issue perhaps, but an ever-increasing problem in everyone’s field of practice and I picked up a few practical tips. Later in the day Dr. Zideman shared his Olympic experience with us. Having been lucky enough to have my own Olympic experience and watch Great Britain win an Olympic gold medal at Eton Dorney, it was fascinating to learn about all the behind the scenes preparations. As a specialty, we particularly recognize the need to be ready for every eventuality.

On Friday there were noticeably fewer delegates, ostensibly because of the heavy snow rather than following the dinner at the Savoy the previous evening. Those of us who fought our way through a very pretty London to get there were treated to an excellent Anaesthesia Journal session. Alicia Dennis had travelled even further than me to get there, John Carlisle deterred us all from faking research by showing how easily he can find us out and Steve Yentis stepped in to replace a speaker stymied by the snow storm. The resulting discussion of a controversial research article was of particular interest to me as Chair of my hospital’s Ethics Committee.

One of the real highlights of the meeting for me was the GE Healthcare Lecture, given that day by Mr. Nigel Edwards of the King’s Fund. He is an engaging speaker and I found it fascinating that so many of the issues and concerns he raised regarding the future of the NHS are the same as those facing Bermuda’s health care system, despite the many differences in the way we actually provide our services. The AAGBI was offering free mentoring sessions to members during conference hours so I availed myself of the opportunity. I wasn’t quite sure what to expect – or whether I would really find it useful – but by the end of the session I felt my mentor had helped me to organise my thoughts around my particular question, and given me a number of suggestions as to how I might move forward. I will definitely be seeking a follow up session and would highly recommend the service.

Many of the lectures will soon be available on the AAGBI video platform so I’m sure more than a few of you are wondering why anyone would bother to attend in person any more. The WSM is about far more than just the lectures. There are opportunities to ask questions of experts – in public or behind the scenes during the coffee and lunch breaks. It is a chance to catch up with old friends and colleagues, and perhaps to make some new ones. I went to my first WSM five years ago to meet my old chum Jim Carter, who worked with me in Bermuda twenty years ago. This year I bumped into Peter Wallace in the lift – now retired, he gave me my first job in Anaesthesia in Glasgow well over twenty years ago. The venue is excellent – perhaps not the most comfortable seating but you are supposed to be awake for most of the day. It is a spectacular location in the heart of Westminster, within walking distance of most of London’s most famous landmarks. The lunch is always worth staying around for and the biscuits (arguably the best means to rate a conference) are both delicious and plentiful. The Industry Exhibition is an opportunity to see and sometimes even to try out the latest equipment. I find reps become very enthusiastic when I tell them where I work and always offer to come and set everything up in person for me. I spotted a new piece of equipment this year – a very natty AAGBI cycling top.

I have already booked my study leave for 15-17 January 2014. Have you?

Dr Elaine Campbell FRCA
Consultant Anaesthetist,
King Edward VII Memorial Hospital,
Bermuda

Why on earth would anyone travel over 3000 miles from Bermuda to London in January every year?

Not for the weather obviously, and not, as my colleagues suspect, to do some post-Christmas shopping, but to attend the annual AAGBI WSM of course. This was my fourth visit and it has now become a regular fixture on my calendar.
The highlights of the meeting for me were the 3 keynote speakers:

- Prof Martin Elliott gave a truly inspirational lecture about technical transportability.
- David Zederman’s passionate talk about his Olympic experience made us want to relive the summer of the games all over again.
- Nigel Edwards gave a brilliant talk about leadership development and health policy.

I normally write my reflective notes as I listen to the lectures, but for these 3 keynote speeches, I just sat back and enjoyed the wonderful content and delivery styles.

All 3 of these lectures have been fast tracked for the video platform, as well as Dave Murray’s lecture on the National Emergency Laparoscopy Audit and Tom Pierre’s thoughtful provoking talk on anaesthesia and the environment. We have also fast tracked the BATS (British Anaesthetic Trauma Society) and quality improvement lectures for those of you that missed these sessions because of the snow. Please visit http://videoplatform.aagbi.org.

WSM was our biggest conference ever but I have a feeling that the Annual Congress in Dublin will be even bigger. If the city itself doesn’t entice you to come along, then a combination of a crazy cycle ride, pints of Guinness, and a really interesting programme surely will?

Dr Samantha Shinde, Chair of the Education Committee

In the November issue of Anaesthesia News, Dr Hunningher proposed a radical vision of flexible consultant work patterns as potential solution to the looming shortage of consultant posts for trained anaesthetists. But will men and women embrace flexible working with equal enthusiasm?

While the precise details of flexible working at consultant level may vary, the question remains of whether LTFT consultant contracts would prove equally attractive to both male and female CCT holders. Some men might jump at the opportunity, after 7 years or more of full-time training, the prospect of having more time to devote to family. fishing / the golf course (delete as appropriate) will appeal to those yearning for a better work-life balance. Others may be strongly averse to accepting a salary reduction – arising when financial outgoings such as mortgage payments and childcare may be more acute, or the perceived loss of status as primary family breadwinner. Perhaps surprisingly, the Centre for Workforce Intelligence’s ‘Shape of the Medical Workforce’ published earlier this year, has little to say about the role of LTFT consultants in the future NHS workforce. They acknowledge that ‘the percentage of female consultants has increased’, and will continue to do so; however, they imply that LTFT consultant posts are likely to remain a rarity, asserting that ‘trainees who train flexibly often choose to work as a full-time consultant’.

No figures are provided to support this claim, and given the growth in LTFT training, it seems premature to conclude that most LTFT trainees will choose to work full-time as consultants. Meanwhile, none of their seven scenarios for the future of the medical workforce makes provision for increasing numbers of LTFT consultants.

The future make-up of the UK’s Anaesthetic consultant workforce is fraught with uncertainties, but I believe we can reasonably expect it to reflect three clear trends throughout the western world: namely greater female participation in the workforce, greater male participation in childcare, and increasing demand for flexible work patterns. Other countries have long encouraged the male of the species to look beyond the traditional role of working to provide for the family. Sweden, for example, has offered 480 days of paid ‘shared parental leave’ for each child since 1974. The Coalition government’s ‘Working to Care’ report in 2007 enthused about ‘flexible parental leave’ and whilst the envisaged extension of parental leave to a year’s maternity leave (due to take effect in 2015) is clearly a step in the right direction, much more needs to be done to help men participate.

Whatever the underlying reasons, the preponderance of female LTFT trainees clearly has implications for workforce planning. LTFT consultant posts are still a rarity, and the time of writing bmjcareers.com has 16 adverts for consultant anaesthetists of which only one mentions the possibility of part-time working. However, LTFT training has seen significant growth among Anaesthetic trainees in recent years, which implies a likely increase in future demand for LTFT consultant posts. Moreover, creating more LTFT consultant posts (as suggested by Dr Hunningher) would provide a means to fill the inevitable void of consultant vacancies for new CCT holders, and Anaesthetics – as an inherently shift-based specialty – is particularly amenable to flexible working patterns.

1. http://www.rcseng.ac.uk/training/anaesthesia/less-full-time-training-tlt

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

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

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

Closing date: 01 March 2013

For further information and an application form please visit:
www.aagbi.org/international/irc-funding/travel-grants

or email secretariat@aagbi.org
or telephone 020 7631 8807

Closing date: 28 May 2013

And what is your idea?
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"My idea: Design that matters."
One laser that has gained widespread utilization during the last 5 years is the high-powered potassium-titanyl-phosphate (KTP) laser for the treatment of symptomatic benign prostatic hypertrophy. This laser system is coined “greenlight photosselective vaporization of the prostate (PVP)” and is commercially marketed and manufactured as GreenLight-Pro® and GreenLight HPS® (American Medical Systems, Minnetonka, Minnesota).

The KTP laser beam is fully transmitted through aqueous irrigant and is preferentially absorbed by the oxygenated haemoglobin present in prostatic tissue. This mechanism delivers the energy to simultaneously cause fragmentation of prostatic tissue and coagulation of blood. The end result is associated with a more favourable risk profile compared to transurethral resection of the prostate (TURP), including reductions in bleeding, capsular perforation and elimination of TURP syndrome.3

However, as with many lasers the operator and theatre staff are required to wear eye protection during the procedure to negate the potential effects of aberrant laser radiation. The KTP laser beam produces light at a wavelength of 532 nm, which falls within the visible spectrum and is perceived as green. The recommended eye protection filters out green light, rendering the visual field in a red glow. This has important implications for the colouring of syringe drug labels used in theatres. Labels that include green within their colour will change colour when exposed to green light, thereby causing potential errors in medication and administration. The KTP laser is a high-powered laser and should only be used by trained and experienced operators. It is important to ensure that protective eyewear is worn correctly and that it is tested before each use. It is advisable to check the effectiveness of protective eyewear by using an appropriate test method. 

Figure 3 Appearance of syringe drug labels from AAGBI website after protective eyewear

Dear Editor,

Protective eyewear in green light laser prostatectomy and its effects on the colouring of syringe drug labels.

K.S. Ang, Consultant Anaesthetist, Department of Anaesthesia, Western General Hospital, Edinburgh

D. Duncan, Consultant Anaesthetist, Department of Anaesthesia, Western General Hospital, Edinburgh

References:


We used a graphics editing software (Adobe Photoshop®) that filters out green light to examine the colours of syringe drug labels published on the Association of Anaesthetists of Great Britain and Ireland website (Figure 3) and noted comparable changes (Figure 4).

Figure 3 Appearance of syringe drug labels from AAGBI website

Figure 4 Appearance of syringe drug labels from AAGBI website post-green light filter using Adobe Photoshop

Whilst the potential clinical consequences of these colour changes can be quickly contemplated in routine theatres, it is much more room for error under pressure in an emergency situation.4 We recommend that anaesthetists who work in such theatres be aware of the colour distortion that protective eyewear presents, when used in green light laser procedures.

Dear Editor,

We would like to bring to your attention a complication regarding tourniquet release after lower limb arthroplasty.

A 22 year old woman with significant juvenile rheumatoid arthritis was scheduled for a bilateral knee replacement. Preoperative blood tests, ECHO, CXR, and ECG were within normal limits. She had an uneventful induction with propofol and fentanyl while her airway was secured with a Proseal LMA and anaesthesia was maintained with Sevoflurane in an oxygen/nitrous oxide mix. Surgery commenced on the right knee with a tourniquet pressure of 300 mmHg. She had two Litres of 0.9 % Normal Saline as maintenance IV fluid. Total tourniquet time was 64 minutes. Then, 3-5 minutes following tourniquet release, the oxygen saturations became 76% on 0.5 FS.1, with sudden onset tachycardia of 140/ min and a blood pressure of 180/100 mmHg. Given her sudden clinical deterioration she was intubated (grade 3 Laryngoscopy with evidence of pink frothy sputum) and ventilated with 100% oxygen and PEEP of 5 cm of H2O. The three lead ECG showed multiple ventricular ectopics. A chest x ray obtained in theatre demonstrated acute pulmonary oedema. Twenty milligrams of intravenous furosemide was given with good diuresis. Once oxygen saturations improved, the trachea was extubated in theatre without any complications. The procedure was completed and the contra-lateral knee replacement was abandoned with the patient being admitted to our High Dependency Unit (HDU). Her stay in HDU was uncomplicated; she maintained saturations of 96% on 2L of Oxygen. Post-operative blood tests were normal with a negative twelve hour Troponin I. The patient was transferred to ward the following day and was discharged after the fifth day.

Acute pulmonary oedema can be either cardiogenic or non-cardiogenic with cardiogenic pulmonary oedema being the commonest. In this case, we have, by the process of exclusion, proposed a diagnosis of non-cardiogenic pulmonary oedema (NCPE). Additionally, we postulate that pathogenesis is due to an Acute Lung Injury (ALI) secondary to the ischemic reperfusion (IR) injury whereby the release of inflammatory mediators follows the tourniquet release. The exact pathophysiology is not understood, but aberrant activation of neutrophil mediated injury is thought to play a central role.5

At present there is no clinically effective intervention for this condition other than supportive care but ongoing research on the use of propofol and N-acetylcysteine promises promising results.6 Our group is currently undertaking a systematic review to determine the magnitude of attenuation of this IR via different anaesthetic modes. Currently, there is no general consensus regarding which type of anaesthetic technique (TIVA vs. volatile for example) can best protect patients from this complication.

References:
Long-Term Effect of Infection Prevention Practices and Case Mix on Cesarean Surgical Site Infections.

Anesthesia News April 2013 • Issue 309

Bird GT, Farquhar-Smith P, Wigmore T, Potter M and Gruber PC.

Outcomes and prognostic factors in patients with haematological malignancy admitted to a specialist cancer intensive care unit: a 5 year study


Background

There is often a reluctance to admit to ICU patients who develop critical illness in the background of haematological malignancy due to an assumed poor prognosis. A prospective UK study indicated that 7% of all patients admitted to hospital with a haematological malignancy developed severe illness, although around 1.5% of general adult ICU admissions have a haematological malignancy.1 Recent advances in chemotherapy, haematopoietic stem cell transplantation and critical care have led to better outcomes for these patients. However, some of these radical treatments may themselves increase the risk of developing a critical illness. This study evaluates the mortality rates within ICU in 6 months in patients admitted to the Royal Marsden cancer unit ICU, and attempts to identify potential predictors for in-hospital mortality.

Method

This was a single centre cohort study conducted over a 5 year period. Data was collected on all patients admitted to the ICU from October 2004 to September 2009, with haematological malignancy as a primary or concurrent co-morbidity. Variables collected included patient characteristics, type of haematological malignancy, reason for admission, APACHE scores, number of organ failures, type of organ support received and laboratory values. These patients were followed for a period of 6 months from the point of ICU admission. Data were statistically analysed using computer software and factors predictive for in-hospital mortality were identified.

Results

One hundred and ninety nine patients with haematological malignancies were admitted to ICU in the 5 year period. ICU in-hospital 6 month mortalities were 67/199 (33.7%), 91/199 (45.7%) and 118/199 (59.3%) respectively. The most common cause for ICU admission was respiratory failure (33.7%) and 51.9% patients required respiratory ventilation. Cardiovascular support with vasoressors was required by 51.5% patients.

Multivariate analysis indicated that invasive mechanical ventilation (DR 3.03 95% CI 1.22-6.90) and a 2 organ failures (DR 5.62, 95% CI 3.2-13.7) were independent predictors of in-hospital mortality.

Other predictive factors of in-hospital mortality identified with univariate analysis included in-hospital time before ICU admission of greater than 6 days (P=0.02), nonal replacement therapy (P=0.001), use of biologicals (P=0.01), invasive fungal infection (P=0.04), graft or host disease (P=0.007), platelets>20 x10^9/L (P=0.03), and EBV DNA>10^5 copies/ml (P=0.001). Other factors that were found not to be predictive of in-hospital mortality included duration of ICU stay >5 days (P=0.25), post-haematopoietic stem cell transplant (P=0.19), type of haematological malignancy (P=0.41), age (P=0.51) and neutropenia (P=0.06).

Discussion

This study raises a number of interesting discussion points. It identifies some factors which may be helpful in predicting which patients may benefit from ICU care, but also questions the question of where these patients are best managed. It also challenges the notion that patients with haematological malignancies have poorer outcomes than the average ICU patient population.

Factors which may predict outcomes in ICU patients is an important question and has been the subject of many prior studies. Factors such as multi-organ failure, invasive mechanical ventilation, prolonged hospital stay prior to ICU admission and inotropic support were all identified in prior larger studies as factors predicting ICU mortality. Other factors previously identified as being predictive of ICU mortality which were not deemed important in the current study included severe sepsis, increasing age, haematological diagnosis (Hodgkin’s lymphoma), haematopoietic stem cell transplant and a low QOC.1,2,3

The perception that patients with haematological malignancy admitted to ICU carry a high mortality rate is challenged in this study. The average ICU mortality rate of admissions to general adult ICUs varies from 20% to 80% according to case mix and referral patterns with average figures of 35%. According to this study, average ICU mortality of a patient admitted with a haematological malignancy is 33.7%. In comparison to other patient groups such as those admitted post cardiac arrest, among (where mortality rates can be as high as 80%), these mortality rates may be considered favourable.

This study also raises the pertinent question of whether patient outcomes may be improved if this complex group of patients were managed in specialist cancer ICUs. Whilst crude mortality rates are difficult to compare across different studies, the ICU mortality at this specialist cancer unit was lower than previous figures collected through ICNARC data (43%) and Scottish ICS Audit Group data (39%). This may be a reflection of the increased case load; in this study the percentage of patients with haematological malignancy admitted to ICU was 5.9% as opposed to 15-16% in national data collected for admission to general ICUs. It is now widely accepted that treatment in specialist centres confers a survival benefit. NICE recommends specialist conditions be managed in such centres, for example neurological centres in the case of head injury. It would follow that the same may be true for cancer patients where multidisciplinary expertise can be provided in dedicated cancer ICUs.

Anna Petsas
ST4 Anaesthetics, Oxford Deanery

References

The Department of Health (DH) workforce strategy document ‘A High Quality Workforce’ recommended the establishment of the Centre for Workforce Intelligence (CfWI) in 2010, as the ‘national workforce planning and development resource for the health and social care system’.

In February 2012, the CfWI published “Shape of the Medical Workforce: Starting the debate on the future consultant workforce”. Aiming from their previous 2011 report “Shape of the Medical Workforce: informing medical specialty training numbers”, the CfWI suggested that to meet future medical needs, intake to General Practice would need to be increased to the detriment of trainees in hospital-based specialties. This reduction, along with changes in service delivery and utilisation, would impact on the future consultant workforce.

Due to the length of medical training the future consultants of 2020 are already in their final years of medical school or early years of postgraduate training. Decisions therefore need to be taken years in advance to avoid over or undersupply. The 2012 report outlined, using data obtained from mathematical modelling, the likely outcome of 7 scenarios upon the consultant workforce. These are outlined below:

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Overview</th>
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<tbody>
<tr>
<td>Scenario 1</td>
<td>Business as usual</td>
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<tr>
<td>Scenario 2</td>
<td>Shift to General Practice</td>
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<tr>
<td>Scenario 3</td>
<td>Change in retirement age</td>
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<tr>
<td>Scenario 4</td>
<td>Set level of demand</td>
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<tr>
<td>Scenario 5</td>
<td>Training consolidation period</td>
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<tr>
<td>Scenario 6</td>
<td>Consultant-present service</td>
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<tr>
<td>Scenario 7</td>
<td>Graded career structure</td>
</tr>
</tbody>
</table>

These models incorporated existing workforce data (e.g. Office for National Statistics, NHS Information Centre for Health and Social Care) to generate a supply and demand model for the consultant workforce as a whole. Different scenarios, generated after a consultation exercise with major health service stakeholders, were then applied to the model.

The projected results for scenario 1 suggest that if no changes occur in recruitment or consultant working practices, there will be an increase in the consultant headcount by 60% to over 60,000 doctors by 2020. This represents an oversupply of trained doctors against the projected demand. These projections are worrying for trainees looking to join the consultant workforce in the next decade.

The presidents of the Royal College of Anaesthetists (RCoA) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) have responded to the report with concerns over the validity of some of the tabled scenarios. All scenarios, if enacted, are likely to affect current trainees more than our senior colleagues. GAT and the RCoA trainee committees therefore conducted a membership survey both to gauge trainee and junior consultant opinion about these potential changes, and to raise awareness of the report’s potential implications.

This article aims to highlight the main survey results.

The full survey report can be downloaded at www.aagbi.org/professionals/trainees

A survey of current trainees and those who received their CCT within five years of the survey date, was conducted over a 3 week period (26th October to 16th November 2012). 2165 individuals took part with 1796 complete responses obtained. Of those respondents who supplied their grade there were: 1741 trainees, 325 consultants and 94 were made up of locum consultants, specialist doctors and fellows.

Responses to the questions:

1. What are our memberships views on the seven 'modelled' scenarios?

The seven scenarios were ranked in order of acceptability. 1906 complete responses were submitted. Free text comments revealed that some trainees thought all the options were unacceptable. Despite evidence that maintaining the status quo (scenario 1) will become unfeasible, it was the most popular option (mean ranking 2.81) whilst the implementation of a graded career structure (scenario 7) was the least popular (mean ranking 5.98) (figure 2).
The CfWI state that it is unlikely that the status quo of transition from trainee to consultant will be maintained, and that compromises will have to be made by current and future trainees. We presented six examples of compromise and asked respondents to rank which ones they considered most or least acceptable. These included changing sub-speciality, changing location and taking up a non-consultant post for varying time periods:

- 37% indicated they would be willing to work within a different anaesthetic subspecialty (choosing either “strongly agree” or “agree”) and
- 36% would relocate within the UK. 1475 out of 1966 (79%) responded that if a graded consultant structure were to be introduced (scenario 7), they would consider emigration or leaving the NHS (either “agree” or “strongly agree”).

60% of respondents would accept a time-limited non-consultant post with good prospects of a consultant post afterwards; however, 2/3 (64%) disagreed with taking up a time-limited non-consultant post where the options for advancement were unclear and 72% rated taking up a permanent non-consultant post as unacceptable (“disagree” or “strongly disagree”).

Conclusion:
Trainees and newly appointed consultant anaesthetists are concerned about future employment. Despite the evidence put forward by the CfWM for the need for change the main scenarios put forward (4-7) were deemed unpalatable by the majority of survey respondents. “Business as usual” was considered to be the most acceptable solution, despite the potential for a stalling of the previous decades’ consultant workforce expansion. The second most popular choice was to “set the level of demand” by using Royal College guidelines. The high ranking of this choice is difficult to understand, but may be due to the report stressing it would “find solutions for current trainees”.

However, scenario 4 details the deployment of trainees in alternative service delivery models, such as using excess trainees in a “trained doctor-delivered service”; in other words, trainees becoming permanent non-consultant career grades. Setting the retirement age at 60 was considered the third most acceptable choice; however, this is unlikely under current employment law.

The worrying scenario is naturally number 7. The graded career structure has the potential to irreparably damage the medical workforce. Over generations, junior doctors have worked diligently through long, anti-social hours in order to progress to the consultant grade, where respect and a salary commensurate with their standing were expected. ‘Grading’ consultants, whereby those newly appointed would no longer be able to achieve the same position as their more junior counterparts of longer standing, has to be considered as potentially damaging.

Firstly, trainee satisfaction may take a significant hit, and as the survey has shown, nearly three-quarters of doctors have said they would consider emigrating if scenario 7 were enacted. Secondly, it would serve to split the consultant workforce into factions, reducing cohesion and the teamwork so often espoused for optimum patient care. Creating tiers of seniority runs a risk of removing the unified consultant voice that has often called for reason in the face of NHS political changes. The most acceptable compromise to respondents in altering the way they would practice in the future was opting for a temporary career change.

With the joint review on medical and dental school intakes having been published in November 2012 by the Department of Health and the Higher Education Funding Council (the Shape of Training Review’s interim report due in April of this year, it seems appropriate to consider the options for controlling the medical workforce in medicine should begin at an undergraduate level. 1264 trainees (80%) agreed or strongly agreed that this concept was a potential solution to the problem of excess trained doctors.

With the joint review on medical and dental school intakes having been published in November 2012 by the Department of Health and the Higher Education Funding Council the Shape of Training Review’s interim report due in April of this year, it seems appropriate to consider the options for controlling the medical workforce in medicine should begin at an undergraduate level. 1264 trainees (80%) agreed or strongly agreed that this concept was a potential solution to the problem of excess trained doctors.

References:
Anaesthesia News
April 2013 • Issue 309

What were our three biggest achievements in the last year?

• Achieving the highest ever attendance, for any of our conferences, at WSM 2013, and doubling the number of trainees attending the GAT meeting in Glasgow. This achievement, as well as our Core Topics and Seminars programme, firmly places us as the major player in Education for Anaesthetists in the UK and Ireland.

• Launching the Event app and online portal for our conferences.

• Restructuring the GAT meeting so that there is educational content for every trainee of every grade, and fixing the price of the meeting at £195 for 3 years.

What current challenges are we facing?

• Dispelling the myths about Revalidation and supporting the GMC’s 4 domains in all of our educational activities.

• Providing value for money in this time of economic gloom.

What are our priorities for the coming year?

• My priority is the development for our new Education platform project. This will bring together, via a single sign on login, the wide range of our AAGBI CPD content: video/slides, videos/audio lectures, GASCAST podcasts, ATOTW and more. In addition, we plan to create a repository for all of your reflective learning whether it be from AAGBI meetings, critical incidents, or departmental lectures, and will be done via an app or an online portal. This will be the equivalent of your ‘bottom drawer’ for revalidation paperwork, but in a neat little repository on line, ready to fling into whatever revalidation portfolio your Trust decides is flavour of the month!

Gaining recognition from hospitals, that the work done by our members in delivering the GMC’s 4 domains at our meetings, whilst not of direct benefit to the Trust, supports the Revalidation process.

The Education Committee is responsible for the educational strategy of the AAGBI. Educational events include Seminars, regional Core Topics meetings, and the annual Winter Scientific Meeting (WSM) London and Annual Congress, details of which can be viewed at www.aagbi.org/education.

A major focus of the Education Committee is to develop online learning for all. In addition to podcasts and the Anaesthesia Tutorial of the Week, we have an online video platform (http://videoplatform.aagbi.org), where you can view lectures from seminars and major meetings online. With the prospect of revalidation we know that there will be greater demand for CPD. At the same time, we realise the increasing difficulty in getting time away from work and hospitals decreasing financial support for study leave. We hope we can help with your learning requirements from the comfort of your own homes!

The deadline for submissions is midnight on Monday 10 June 2013.
NEW for 2013!

Anaesthesia Cases

Case reports remain an important route to publicise difficult or interesting cases. They are not just the first port of call for trainees wanting their first publication, some of the most interesting cases in medicine were first published as case reports – just think of Christian Barnard in 1967, or Denborough reporting the malignant hyperthermia for the first time in 1962.

The AAGBI recently launched Anaesthesia Cases, a new free service for members.

This is a new educational resource of case reports to allow rapid publication of interesting, informative, or notable cases in anaesthesia, critical care and pain.

The web-based submission, publication and search functions will allow users to both submit and access reports through computers, tablets and smartphones at all times. If you are faced with a tricky case and want to see how others have managed the same situation you will be just a few clicks away.

Anaesthesia Cases is an online, editorially-reviewed, journal of case reports in anaesthesia, pain medicine and intensive care.

Users are able to submit and search case reports – a brilliant resource for trainees and consultants!

Submit a case report today

www.anesthesiacases.org

The site is linked to the journal Anaesthesia and all submissions will undergo careful review and editing. Reports that are particularly noteworthy will be published by the journal. Other reports, providing they are not duplicates, spam, or libelous (I), will be published online. Each report will have a unique URL that can be used if the report needs to be referenced.

Searches will include all case reports published on the site and those published in Anaesthesia since 2012.

The site editor is Mike Nathanson and the assistant editors are Serene Chang and Judith Dinsmore.
Irish Congress of Anaesthesia
ANNUAL MEETING 2013

Key-note speakers include:
Lee Fleisher, US
Lukas Kirchmair, Austria
Manoj Karmaker, Hong Kong
Manfred Greher, Austria
Rupert Pearse, UK

Further details on WWW.ANAESTHESIA.IE

CALL FOR ABSTRACTS
• Equity – Anaesthetists in Training (Out of Fellow of the College of Anaesthetists of Ireland (in good standing) – Consultants and Non-Consultants.
• “Free” means – case reports, series of cases or clinical investigations
• The absolute time limit for receipt of applications is Friday 29 March 2013 at 17:00 hrs.
• Abstract forms available from www.anaesthesia.ie

Further details on WWW.ANAESTHESIA.IE

THE CONVENTION CENTRE DUBLIN, 17 - 18 MAY 2013
This two day meeting is the most prestigious and important in the College’s academic calendar. It will feature:
• Key-note addresses from international experts
• Current issues / update sessions
• Workshops / simulator sessions
• Free papers and posters
• Excellent social programme

St George’s Day Anaesthesia Forum
Tuesday 2pm, 23rd April 2013
at St George’s Healthcare NHS Trust
Blackshaw Road, London SW17 0BT
Lecture Theatre F, 1st Floor Grosvenor Wing

To celebrate the work of
Prof George Hall
(on his retirement)

The following will contribute to the programme:
Dr J-P van Besouw
Dr Joan Desborough
Dr Judith Dinsmore
Dr William Fawcett
Prof Mike Grounds
Prof Jennifer Hunter
Dr Phil Newman
Dr Gianna Nicholson
Dr Barbara Phillips
Dr Heidi Robertshaw
Dr Neville Robinson
Prof Peter Salmon

For more details please call Department of Anaesthesia
St George’s Hospital, tel. 0208 725 0051/3317
/ email Bernard.Liban@nhs.net

www.anaesthesia.ie
www.doctorsupdates.com

The AAGBI responds to the Mid Staffordshire public inquiry
Following on from the tragic events at Mid Staffordshire NHS Foundation Trust, the AAGBI has issued its response to the Francis report. We are asking anaesthetists to raise any patient safety concerns and continue in their role as patient advocates. We are calling on every healthcare professional to think about the following: “Would you want this sort of care for your family?” You can read the full statement on our website.

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EBPOM 2013

Meetings Calendar

- **Monday 1st July 2013**
  - 3rd Mastering Cardiac Output Monitoring Course, London

- **Tuesday 2nd July 2013**
  - The Great World Fluid Debate, London

- **Wednesday 3rd July 2013**
  - EBPOM Day 1: 12th Evidence Based Peri-Operative Medicine Congress, London
  - 8th National Cardiopulmonary Exercise Testing Course Day 1, London

- **Thursday 4th July 2013**
  - EBPOM Day 2: 12th Evidence Based Peri-Operative Medicine Congress, London
  - 8th National Cardiopulmonary Exercise Testing Course Day 2, London

- **Friday 5th July 2013**
  - LSORA (London Society of Regional Anaesthesia) Course, London
  - Cardiopulmonary Exercise Testing Forum, London

Invited Speakers Include

- **Angela Bader, USA**
  - Making surgery safer - Surgical checklist development in the developed world
  - Shared decision making in perioperative care

- **Donal Buggy, Ireland**
  - Anaesthesia and Cancer surgery
  - Preoperative cardiac risk evaluation - where do we stand now?
  - Learning valuable lessons from large datasets!

- **Lee Fleischer, USA**
  - Perioperative kidney injury - prevention and prognosis
  - Perioperative Blood management - Evolution

- **John Kellum, USA**
  - ENIGMA II - Implications for practice
  - Measuring quality of recovery after surgery and anaesthesia

- **Ross Kerridge, Australia**
  - Genetics and epigenetics in perioperative medicine

- **Paul Myles, Australia**
  - Advancing perioperative haemodynamics
  - NAP3 - Has the pendulum swung too far?

- **Andy Shaw, USA**
  - Bringing Health Services research to clinical practice
  - Long term implications of perioperative intervention

- **Maurizio Coccoli, London**
  - Postoperative fluid management – no easy answer!
  - Enhancing recovery/Accelerating Recovery?

- **Tim Cook, Bath**
  - Postoperative critical Care - Should all surgery go there?
  - Quality improvement in perioperative care - Emergency laparotomy

- **Mike Grocott, Southampton**
  - Anaesthesia and the patient safety landscape
  - Dingle Conference