New AAGBI guidelines:
– Malignant Hyperthermia
– Day Case Surgery

Southern Sudan - the Wessex link
2011 ULTRASOUND TRAINING COURSES

SonoSite, the world leader and specialist in hand-carried ultrasound, has teamed up with some of the leading specialists in the medical industry to design a series of courses, for both novice and experienced users, focusing on point-of-care ultrasound.

Introductory Ultrasound Guided Regional Anaesthesia
The two-day introductory course is designed to teach those who have little or no experience in the use of ultrasound in their normal daily practice. The course comprises of didactic lectures on the physics of ultrasound, ultrasound anatomy and regional anaesthesia techniques. The lectures and hands-on sessions will concentrate on the brachial plexus, upper and lower limb blocks.

Ultrasound Guided Venous Access
This one-day course is aimed at physicians and nurses involved with line placement and comprises didactic lectures, ultrasound of the neck, hands-on training with live models, in-vitro training in ultrasound guided puncture and demonstration of ultrasound guided central venous access. The emphasis is on jugular venous access, but femoral, subclavian and arm vein access will also be discussed.

Ultrasound Guided Chronic Pain Management
The course is aimed at chronic pain specialists, or other interested parties practising in chronic pain medicine who have little or no experience of musculoskeletal ultrasound and who wish to obtain an introduction to ultrasound in chronic pain medicine skills.

Fees:
£375 (two-day courses) includes VAT, lunch, refreshments and course materials.
£260 (one-day courses) includes VAT, lunch, refreshments and course materials.

If you have any questions or should need further information please contact:
Jes Tiller, SonoSite Ltd, Alexander House, 40A Wilbury Way, Hitchin Herts, SG4 0AP
Tel: +44 (0) 1462 444800 Fax: +44 (0) 1462 444801 E-mail: education@sonosite.com

For full listing of SonoSite training and education courses, dates and to register go to: www.sonositeeducation.co.uk

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Editorial

This month we have a couple of powerful articles giving the consumer’s view of healthcare. These give us useful feedback. I too have been a consumer of healthcare recently. I have to say that I felt very safe in the hands of my excellent colleague, and greatly appreciated all the modern trappings of safety: monitoring devices, checklists and so-on. Yes, even the dreaded hand gel. Not to mention the surgeon - who was also excellent. Was there anything I would have changed? Yes, of course, nothing is perfect. I was very cold in the pre-op holding area and anaesthetic room, and am now minded to consider pre-warming patients more seriously.

I was in a six-bedded orthopaedic unit overnight. One of the other in-mates had just had a hip replacement, and had a raised BMI. She was intermittently attached to a pulse oximeter for much of the night, which recorded saturations in the low 80s for longish periods – I wasn’t in a position to consider the matter all that carefully but can recall being somewhat alarmed by this; every so often I called a nurse, who attended, replaced the patient’s oxygen mask and left. The patient took it off as soon as the nurse had gone. I will now think twice about sending my own patients back to an ‘ordinary’ ward in similar circumstances. I certainly appreciated being in a 6-bedded area – the presence of other patients who could call for help was reassuring. Monitoring alone is not much use.

All this is thrown into stark relief by Frankie Dormon’s account of Wessex’s laudable efforts to provide support and help for the newly-emerging state of Southern Sudan, which became a country on July 9th 2011. I receive many reports of readers’ work overseas, predominantly in LEDCs, most of which are truly humbling. We simply do not have space to publish all of these, and I have recently instituted a more robust system for reviewing such submissions.
Editorial continued

In short, your article will be much more likely to be published if it contains significant learning points either for colleagues who may wish to follow in your footsteps or for colleagues in the UK and Eire. Reflect on what you have done – what would you do differently if you were to repeat the experience? It should also describe practice which is in line with current guidance from the AAGBI’s International Relations Committee and the Royal College of Anaesthetists with respect to working overseas.

I would also particularly welcome readers’ reports of life as an anesthetist or intensivist in countries which we don’t often hear from - India, China, South America, other European countries – all the better if you have some UK experience, so that you can compare and contrast the different systems. We can all learn from each other.

Lack of resources is not the only difficulty faced by colleagues around the world. The plight of Bahrain’s doctors continues to cause concern despite the end of the state of emergency there. On 13th June the American Medical Association’s (AMA) president, Peter Carmel, added his voice to those of the growing number of medical leaders who have commented or issued statements deploiring the apparent violation of the articles of the Geneva Convention guaranteeing the rights of physicians to treat those wounded in conflict; and on 28th June the College of Anaesthetists in Ireland issued a statement along similar lines. The AMA has a sample letter on its website which physicians are encouraged to send individually to the Bahraini authorities. Despite all this opprobrium, it is alleged that 47 medical staff are to stand trial for a variety of charges. It is very difficult to grasp what is actually going on as the situation is clearly complex and information is scarce and difficult to verify. Whatever the reality is; I am sure many members would wish to join me in voicing our condemnation of violations of the rights of the sick and injured to receive medical treatment in areas of conflict wherever they may be, and our support for colleagues who suffer oppression in the course of their work.

I would like to add my congratulations to those of our president to the successful candidates for election to Council and to AAGBI Office – I think we can be assured that we have a very strong team to take our business forward in the future. Commiserations and better luck next time to those who were disappointed.

Last but not least: for those of you taking a well-earned break this month - keep safe and enjoy yourselves!

Val Bythell

Photography Competition

We are delighted to congratulate Jonathan Cracknell, whose winning entry appears on this month’s front cover. It was a difficult job deciding which entry should win, and we commiserate with and thank all those who have submitted entries.

The front cover shows an Asiatic Black Bear undergoing the world’s first laparoscopic cholecystectomy in this species. The bear is being maintained on a circle system; with blood gases, capography and thermistor monitoring. The gall bladder had to be removed due to damage from bile milking. The photo was taken in December 2010 at a rehabilitation centre in Vietnam run by ‘Free the Bears’.

Jonathan Cracknell, BVMS CertVA CertZooMed MRCVS

BIAZA Elephant Mammal Focus Group Veterinary Advisor
Global Elephant Management Plan EEHV advisor
AAGBI elections were held recently and we were delighted in June to hear that Kathleen Ferguson (Aberdeen), Nancy Redfern (Newcastle) and Thomas Woodcock (Southampton) had been elected to Council. The election attracted very high quality candidates and I hope that those who were not elected this year will consider putting their names forward again next year. In terms of officers, William Harrop-Griffiths becomes the President Elect in September for a year before taking office, and Richard Griffiths becomes the Honorary Secretary Elect at the same time.

Website

One of the responsibilities of the AAGBI is to ensure that all members can gain appropriate CPD for revalidation in the most efficient way possible. If you visit or speak at any AAGBI events you will notice that many sessions are now being filmed, with the consent of the speaker. The idea behind this is to compile a library of lectures and seminars that can be viewed by members. With this project we hope to make it possible for members to access external CPD from their hospital or home at any convenient time. CPD points will be issued by the website, with a certificate that can be printed, referring to the appropriate parts of the RCoA Revalidation matrix.

When we discussed whether this development would reduce attendance at our events, we felt that whilst this was something we would need to keep under review, there are many other benefits of coming to meetings. Remember when supporting AAGBI events any proceeds generated return to your society and the benefit of the members and the specialty.

I look forward to welcoming many of you to the Annual Congress in Edinburgh (21-23 September). This is going to be a fantastic conference with many well regarded speakers, opportunities to learn, meet new and old friends and enjoy a memorable dinner in the newly refurbished Edinburgh museum.

Details of the Lifebox project have appeared in a number of AAGBI publications. This innovative project aims to improve the use of pulse oximeters in less well off parts of the world and encourage the uptake of the WHO Surgical Safety checklist. By working with hospitals and colleagues overseas, the project will both sell and donate oximeters. The organisation has just become a charity, helped enormously by the enthusiastic support of AAGBI Council. See www.lifebox.org where it will soon be possible to donate directly to the project. A donation with tax relief will provide an oximeter to a colleague overseas for less than £100.

We are all aware that the NHS is under very significant financial pressure currently and that our incomes are falling through salary freezes, pension reductions and the potential loss of clinical excellence awards. In private practice the drive by insurers to reduce and manage fees is producing situations where anaesthetists are being particularly disadvantaged. We have raised these issues with the Office of Fair Trading in their review of private healthcare. Particular thanks to Bernie Liban and William Harrop-Griffiths for leading on this work. With this economic situation, when Council debated the subscription levels for next year, I was delighted when the decision was taken to freeze membership subscriptions for a second year.

It is easy to get sidetracked on the negatives in our work, but in our day to day interaction with colleagues and patients we are sometimes reminded of why we studied medicine in the first place. Recently one of my young patients, Bea, came to theatre for her final anaesthetic during her treatment for leukemia, and asked to have a photograph taken in the anaesthetic room. She also kindly offered to write an article about having repeated anaesthetics and how we can make such a difficult time easier for families – her article is printed on page 9, along with evidence that Presidents do work after all! Thanks Bea for the inspiration!

A number of Council members went for our annual motorcycling trip to the Alps and this year it was my turn to end up on a tow truck with a broken motorcycle. It was an interesting (although regrettable) experience to become dependent on the Emergency services at the side of a motorway in France! However the rescue was seamlessly organized by a single phone call to my insurers Carole Nash, and the AA delivered the bike home a few days later. Although it was a Saturday and late at night, I was really impressed by the professionalism and cheerfulness of all involved! All to often we do not match this in the NHS.1

Dr Iain Wilson,
AAGBI President

Reference
I started as an anaesthetist at Kings College Hospital in 1970 and recollect fondly that each individual operating theatre/anaesthetic room complex had a small changing room for the medical staff with a table and chairs around which we could sit to partake of our morning coffee and afternoon tea. Those names are inadequate however because morning coffee was accompanied by a selection of biscuits (chocolate, bourbon, rich tea etc), and afternoon tea with a plate bearing a variety of fine sandwiches (salad, corned beef and or tongue, sandwich spread, etc) all prepared and sent up from the central theatre stores kitchen, and prepared with affection and care for the medical staff, and that meant the juniors as well as the consultants.

As mentioned in a series of previous articles of nostalgic recollections, I retired a few years ago having spent 37 years as an anaesthetist, during what I now think, could be described as the beginning of the ‘Golden Age’ of modern anaesthesia. However as all my still employed ex-colleagues remind me working conditions for the staff are not quite what they used to be. One of the most basic, and yet essential, human needs for those spending long hours administering anaesthesia is to be adequately fed and watered (or should I say coffeed?).

We are all familiar now with the problem of the surgeons finishing first and getting out to sit down in the coffee room before the anaesthetists who need to continue to be providing care for their patients until reflexes have returned, respiration and circulation is stable and the handover to the recovery nurse. (Of course in 1970 we didn’t have recovery nurses as such, but that’s another story) If the surgeon had been alert to the end of the case and it was tea or coffee time he (they were almost inevitably male back then) would have requested the tea/coffee be sent up, finished the dressings, and then gone out to the rest room and tucked in, eating the chocolate biscuits or the tongue sandwiches leaving little more than a few crusts and limp lettuce leaves. To avoid this dastardly act the Consultant anaesthetist would send the trainee out as the last few sutures were being placed in order to make up a small plate of a selection of the choicest biscuits or sandwiches to be locked away in a locker so that when the anaesthetists had their turn at the food there was something
enticing for them too. As in so many things in anaesthesia and surgery, timing was all-important. Failure to think ahead in this manner could result in a very empty plate when the anaesthetists got out of theatre at last, and that produced a rather grumpy Consultant for the rest of the session, and perhaps a reduction in training opportunities for the trainee.

Once the session was eventually completed, and back then most lists were half day lists, the Consultants would take themselves off to the Consultants Dining Room for their lunch, and as I was never a Consultant at that time I can say little about their refreshment options. The junior medical staff at Kings were well satisfied with their lunchtime opportunities, they could either go the Mess Dining Room where a choice of cooked main meals were available at greatly subsidised prices, or if the sun was shining, or thirst was greater than hunger, they could go the Cottage - a stand alone facility in the grounds of the hospital ruled over by Doris, which was basically a bar with a choice of filled rolls or sandwiches, hot pasties or crisps. There was generally time for either of these options because the lists were well controlled by the theatre sister who would insist that the list stopped in time for her nurses to have their lunch. Since all the patients for that day were admitted the night before, had already been seen by an anaesthetist and premedication prescribed. I don’t recall ever being accused of smelling of alcohol as I induced the first case for the afternoon, but perhaps the theatre staff were too polite to mention it!

The theatre kitchen really came into its own during the Christmas period, as it was the central point of the large preparation area in the theatre stores, the place where the surgical instruments were packed and wrapped prior to sterilization, and over the Christmas Break all the prep tables were taken out of the stores and with the large floor area available that area would host the best in-hospital theatre parties. The kitchen turned its hand then to making bridge rolls and opening boxes of Twiglets etc rather than the usual fare. The emergency theatres could be serviced from a separate area so the festivities made no impact on the service provision.

Adequate fluid and nutrition

With the current emphasis on all day theatre lists, lists which over run, reductions in anaesthetic trainees and in spite of the improvements in monitoring and training for non anaesthetist helpers it is becoming increasingly difficult to find time for the anaesthetist to get adequate fluid and nutrition particularly during the longer cases. On occasions I have been forced to ask for a sandwich and coffee to be brought to the anaesthetic room and eat them whilst I peek through the door at the anaesthetic monitors and patient, and I have seen a colleague eating beef curry and rice in this way too! Now that cannot be an advance over the system described above and widely used during the 70s.

I think the feeding of medical staff properly started to wane in the 80s when theatre suites became all the fashion and the medical staff lost more and more of the perks of the earlier times. At least the trainee doesn’t get sent out to forage any more.

Dr Michael Ward
Consultant Anaesthetist (Retired),
Oxford
Cavendish Medical Ltd are pleased to be holding some concentrated financial workshops at 21 Portland Place later this year. These sessions are designed with the busy Anaesthetist in mind - concise, informative and clear information delivered in an easy to understand format and leading to a simple but robust action plan to take away.

Who should attend?
Anyone worried about protecting pension and lump sum benefits or who wants to plan better for the future. These sessions are aimed at the senior Anaesthetist.

Why should I attend?
There is a limited window of opportunity remaining to organise financial affairs prior to the introduction of the new Lifetime Allowance (LTA) of £1,500,000. The Govt. has introduced a new form of pension protection that has to be initiated prior to April 2012. For senior Anaesthetists there may be significant issues to overcome related to the LTA, pension funding and retirement choices.

What will be covered?
The main themes that will be addressed are those that are most pressing for senior doctors:
- Understanding the NHS pension scheme and the benefits you can expect to receive.
- Understanding the changes to the NHS Pension Scheme.
- A review of the limits to pension funding, the “Lifetime Allowance” and “Fixed Protection” – who does this affect and what action is required by April 2012?
- CEAs and retirement options, how to protect your pension and lump sum benefits.
- Structuring the family’s finances to minimise tax and maximise returns.

Where and when will the workshops take place?
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To Book: We are offering these seminars free of charge to all AAGBI members. Places will be booked on a first come - first served basis. To book your place, please contact the events department on 020 7631 8804/8808 or email seminars@aagbi.org

Cavendish Medical Ltd is authorised and regulated by the Financial Services Authority.
My first experience of going to theatre (not the play kind!) was in Bristol Children’s Hospital when I was 11 years old. I had just been diagnosed with Acute Lymphoblastic Leukaemia. I was extremely scared as I had never been to theatre before. I remember being taken down the corridors by a nurse who was pushing my wheelchair. I was carrying ‘Floppy Dog’, my cuddly teddy, and my Mum & Dad were walking behind me.

I had to choose who to take in with me as I wasn’t allowed any more than one adult with me – I chose my Mum. When we got to the theatre room, the anaesthetists were very friendly, so I felt a bit better. They told me that the anaesthetic was penguin milk and that they had a stash of penguins in the room behind us. I can’t remember how many times I went to theatre, but it never got easier as it was a new experience for me and I seemed to go to different theatres and meet different anaesthetists each time. Poor Floppy Dog used to come out with bandages on his ears and tail!

After three weeks in Bristol I was transferred to the Royal Devon & Exeter Hospital. During my treatment for leukaemia I have to go to theatre quite often for lumbar punctures. I quite enjoy going now as I know the people in theatre, and we always have a laugh, but it wasn’t always like that.

My Mum remembers one time when I felt really sick, and we put it down to nerves. I used to get very moody and bossy with the anaesthetist, telling him that he wasn’t allowed to touch Wilma (my Hickman Line), they weren’t allowed to stand behind me just in case they did something to me and I wasn’t ready. Mum says that I used to say in a loud and bossy voice “I’m not ready yet, I’m not ready.” I am very chatty in the theatre room – probably nerves, but it makes me feel better and we always have a laugh.

Since my theatre trips began in January 2009, I have got a lot better about going to sleep. I have found that if you go to theatre in a happy mood, you wake up feeling better. It is also nice to see the same people each time – it makes it a lot easier. I have my own little routine before going to theatre – I always write my Mum a note with a shopping list for some nice food for when I wake up. That is one hard thing about having to go to theatre – not being able to eat - and wherever you go you can smell food.

Going to sleep is a strange feeling – when the anaesthetic is put into the line you get a ‘fuzzy feeling’ and you have a fuzzy feeling in your ears. I like the feeling of going to sleep, but I always try to say ‘Night Night’ to everyone in the room before I close my eyes – I always tell my Mum that I love her.

In recovery – where you wake up – the nurses there are lovely and they usually shout my name to wake me up! Then they stroke my hair. What I have learnt in my experience of going to sleep is that if you go to sleep feeling happy, not worried or upset, you wake up feeling a lot better.
What’s been happening with the Pre-operative Association…

Highlights of 2010 Pre-operative Association Annual Conference, Royal College of London, 30th September 2010

The 6th annual Pre-operative Association Conference was held at the Royal College of Surgeons in London. This national meeting provided a perfect opportunity to meet and share current practice through presentations, posters and networking across a wide audience. The conference attracted high profile speakers including the directors of the Enhanced Recovery Programme and the Patient Reported Outcome Measures (PROMs) Programme, and specialists in the fields of cardiology, endocrinology, bariatric anaesthesia and a medico-legal barrister from the MPS. In addition, a wide-ranging selection of abstracts was presented to the audience in the form of poster and oral presentations.

Professor Nick Black, founder of the UK Health Services Research Network, outlined the aims of the NHS’s Patient Reported Outcome Measures (PROMs) programme and highlighted the recorded results in the first few years of data collection. These included pre- and postoperative patient survey results on elective hip & knee replacements, varicose veins & groin hernia repair operations. This is an NHS initiative to produce patient reported data on their experience and outcome from these surgical procedures as a quality measure of hospital service received. Professor Black provided an informative overview of the implications of data interpretation and use in order to assess quality of a delivered service.

With obesity becoming a global healthcare issue, Dr Mike Margarson, secretary of SOBA-UK (Society of Bariatric Anaesthetists UK), discussed the management of the high risk obese patient. From his experience as a consultant anaesthetist at one of the larger UK Bariatric Centres, he gave an informative lecture on the pre-operative assessment of obese patients. High risk cardiovascular patient assessment and optimisation techniques were highlighted and the pitfalls of these techniques in the morbidly obese were stressed.

Another interesting and challenging area is the peri-operative use of antiplatelet agents. The complex balance between increased risks of thrombotic events versus the increased risk of peri-operative bleeding was explored in a comprehensive lecture given by Dr Wolfgang Bauer, specialist registrar in Anaesthesia from St. George’s Hospital London. He gave a detailed review of the commonly used agents (aspirin & clopidogrel) with their indications for use (emphasising the difficulties especially with coronary stents), and gave an excellent evidence based pro/cons view of stopping or continuing these agents in the peri-operative period.

Nicki McNaney, the National Transformation Lead of the Enhanced Recovery Programme, gave an informative presentation outlining the background, approach, and progress to date of this national programme. The DoH’s drive for this programme highlights the importance of effective pre-operative assessment. Early optimisation and patient preparation with risk stratification are all domains of quality pre-operative assessment. As part of an inter-professional group, pre-operative assessment provides an important central role in the patients’ surgical journey from admission to discharge.
Dr Jim Bain, a Wessex School of Anaesthesia Specialist Registrar, won the oral presentation prize for his audit on anaesthetic training in Pre-operative Assessment. His study showed that there was insufficient junior anaesthetic training in this area. It was recommended that incorporation of POA training modules within the RCoA curriculum is warranted, especially in light of such DoH’s initiatives as the Enhanced Recovery Programme, where pre-operative assessment plays a vital role in its success.

Other abstracts included diverse subjects ranging from audits on the usefulness of preoperative routine blood investigations to ‘Pre-habilitation’ for patients with diabetes for elective surgery. Dr. Gordon Caldwell, Consultant in Diabetes from Worthing Hospital, introduced their process of ‘Pre-habilitation’ of diabetic patients on the eighteen week pathway to elective surgery. This is achieved using a patient held record, similar to an antenatal record, where patients’ eating and activity levels are monitored alongside their diabetes control (HbA1c) & general fitness. Such information is merged with the GP database, so that consistent reviews of patients’ progress can be monitored & improvements made prior to elective surgery.

A medico-legal update was given by Dr Liliane Field of the Medical Protection Society. On the whole, there seems to be an increased number of claims in the UK, which interestingly was not related to an increase in adverse patient outcomes, but is associated with the economic downturn. The majority of claims were identified as ‘indefensible’ or ‘claim withdrawn’ in nearly equal proportions. Only a small number of claims were either successfully defended or lost. The common root cause of most claims was communication breakdown leading to patient dissatisfaction.

**The Pre-operative Association**

The Pre-operative Association was founded in 2004 by an alliance of inter-professional groups with an interest in providing pre-operative care of patients undergoing elective surgery. This organisation of specialists in the pre-operative field aims to help provide patients with high quality evidence based standardised care. The membership consists of healthcare professionals and lay people, and is managed by a representative professional board. Through continuing education, best practice dissemination and service improvements, the Association is committed to progressing effective developments in the preparation of patients expecting elective surgery.

**What’s going on in the future?**

The professional board are currently engaged in the development of evidence based guidelines for use in preoperative clinics, including such conditions as hypertension, anaemia & diabetes. It is anticipated that these guidelines will be adopted at local level in order to provide effective and optimal patient care. Website development for these guidelines is underway. The next Pre-operative Association Annual Conference will be held at the East Midlands Conference Centre in Nottingham on 10th November 2011. In addition to this, regular one-day educational meetings are being organised at the AAGBI, London, aimed at primary and secondary healthcare providers. The first of these new training days took place on 8th March 2011, focusing on Pre-operative Assessment for Enhanced Recovery, aimed at trainee doctors & nurses involved in management of surgical patients. A second study day on 28th June 2011 was aimed at nurses to develop appropriate clinical skills for pre-operative assessment. A third study day will take place on the 6th September 2011 for trainee anaesthetists. This new study day will cover topical issues in pre-operative assessment. The fees for these new study days are set at a very modest £50 for members & £80 for non-members.

Membership of the Association is open to all healthcare professionals with an interest in pre-operative patient care. The benefits of membership include being part of a growing community with links to other allied professional groups, ability to influence and obtain advice, keeping up to date with latest developments within the field, and reduced fees at Association meetings and the Annual Conference.

Sharon Avery
Pre-operative Association Trainee Member
Specialist Registrar,
Wessex School of Anaesthesia

Rob Hill
Pre-operative Association Committee Member
Consultant Anaesthetist,
St Richard’s Hospital

Please visit [www.pre-op.org](http://www.pre-op.org) for further information & membership application. The Association looks forward to welcoming more members to these future events!
The Association of Anaesthetists of Great Britain and Ireland invites applications for the **SAS Travel Grant** for 2011. This is a grant (up to a maximum of £2000) exclusively given for SAS doctors to visit a place of excellence of their choice for two weeks. This is not meant for attending a meeting or a conference. All SAS doctors who are members of the AAGBI are eligible to apply for the grant.

Applicants should complete an application form and return it to the AAGBI. The successful applicant will be expected to submit a report of the visit which may be published in Anaesthesia News.

If alternative funding becomes available for a project already supported by the AAGBI, the AAGBI should be notified immediately.

Please contact Chloë Hoy (020 7631 8807 or chloehoy@aagbi.org) for an application form, or visit www.aagbi.org/research/awards/sas-grade-anaesthetists

The closing date for applications is Friday 21st October 2011.
It’s That Time Again!

As we have discovered during the history of the Annual Congress Charity Art Exhibition, anaesthetists are really creative folk and many of us pursue hobbies that result in fantastic art, photography or other craft. If this applies to you or one of your family, or you know someone in your department who is creative, then why not come and share your work with delegates at our annual congress in Edinburgh. Not only does it make you feel great to have your work appreciated, it is all in two very good causes.

The AAGBI Overseas Anaesthesia Fund (OAF)

The OAF was set up some years ago by the International Relations Committee (IRC) to enable members to donate directly to the provision of assistance for anaesthetists in the developing world. Assistance such as travel expenses for members undertaking teaching and funding for Primary Trauma Care courses in six African countries to improve survival rates in young adults. The fund also provides educational material in the form of CD-ROMs, books and journals to 50 different countries.

Year on year, the AAGBI, provides financial support and the OAF exists to help do more.

The Royal Medical Benevolent Fund (RMBF)

The Royal Medical Benevolent Fund offers help to colleagues and their families in need. Widows, orphans and families can benefit from financial support and/or specialist advice. Not only the elderly or very young occasionally need a helping hand, young doctors and their families can be vulnerable in the first few years of NHS practice, particularly if they have been working for relief agencies in the Third World. They have little to fall back on if they are unable to work due to chronic illness or accident.

The RMBF is particularly good at offering practical help designed to get colleagues or family back on their feet whenever possible, enabling them to retain their independence. The Fund also provides support for refugee doctors retraining to practise medicine in the UK.

Last year, in Harrogate, the AAGBI Art Exhibition raised over £1000 for these two charities, by means of sale of donated exhibits, greetings cards, and a prize raffle.

Please help us continue that success. Your work can be delivered to and transported from Portland Place or by either of us if you get it to us in time; or you can bring it along yourself at the beginning of Congress. It would greatly assist us if you register your work in advance regardless of transport method as it will enable us to plan the exhibition and provide a catalogue of contributors for visitors’ use during the exhibition. You are also more likely to get a plum site for your exhibits if you are registered in advance! A registration form can be found on the AAGBI website.

In recent years the exhibition has been opened out to include all manner of art and craft other than the mainstay painting and photography. We have had jewellery, needlework, knitting, beading, sculpture, pots - there seems to be no end to the creativity of anaesthetists and their families!

Please come along and support the Art Exhibition in Edinburgh in September. You can do this in so many ways. You can:

- Contribute by exhibiting some of your art or craft
- Donate for sale any you can bear to part with
- Buy a stunning work of art created by a colleague for a fraction of the market cost
- Vote for your favourite – prizes awarded at the end of conference
- Buy lots of raffle tickets in a prize draw for two very good causes
- Buy beautiful greetings cards
- Just simply visit and enjoy the talents of your colleagues

Last year in Harrogate we included a fun interactive art experience on the stand that proved very popular and we will certainly be repeating that. This year in Edinburgh, set in a land of beautiful scenery and a culture of world class art and craft we are hoping for even more exciting contributions from both North and South of the Border!

Come on! Get cracking and join in! You’ll enjoy yourselves - we promise!

Stephanie Greenwell and Di Dickson

Download an application form at: www.annualcongress.org/content/social-events
SAS HANDBOOK

The 2nd edition of the SAS Handbook is now published. This edition has been extensively revised by a working group specially created for this purpose, and is packed with relevant and comprehensive information.

The working group comprised BMA representatives, members of the Council of the Association and the Chairman of the SAS committee.

The Handbook is divided into three sections:

The first section gives a general account of the SAS Committee and its functions, describes membership benefits and explains the supporting mechanisms available for SAS doctors.

The second section deals with employment issues including job plans, contracts, revalidation, clinical governance, welfare and advice on dealing with complaints and medicolegal problems. There is a chapter giving specialty-specific guidance on employment issues for SAS doctors.

The third section deals with career progress and personal development for SAS doctors and has guidance on education, training, CESR, examinations, personal development, clinical audit, writing a paper, guidance on education, training, CESR, examinations, personal development for SAS doctors and has guidance on education, training, CESR, examinations, personal development for SAS doctors.

The 2nd edition of the SAS Handbook is now published. This edition has been extensively revised by a working group specially created for this purpose, and is packed with relevant and comprehensive information.

The strategy for equipment evaluation

In 1996, variant Creutzfeldt-Jakob disease (vCJD), a rare and fatal human neurodegenerative condition, thought to be linked to abnormal prion proteins, was described. These prions were found in lymphatic tissue, including tonsillar tissue; this was particularly relevant to anaesthetists due to the close proximity of laryngoscope blades, laryngeal masks and bougies to tonsillar tissue. It was discovered that these prions were not destroyed by commonly used sterilization techniques, and thus the use of reusable airway equipment posed an infection risk to patients. Subsequent recommendations were published by the AAGBI to change practice, and to use single-use airway equipment only.

The move to single-use equipment has led to the manufacture of a plethora of airway equipment, some of which may be inferior to the original re-useable airway devices that were previously available. Although harm to the patient has been decreased by reducing infection risk, there may still be significant harm posed by using airway equipment.

The 2nd edition of the SAS Handbook is now published. This edition has been extensively revised by a working group specially created for this purpose, and is packed with relevant and comprehensive information.

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The deluge of airway equipment available increases choice, but how is one able to choose a safe and efficacious airway device, amongst the variety of devices available on the market? Companies manufacturing these devices are not always required to undertake rigorous safety testing on these devices; it is often sufficient for the manufacturer to demonstrate that their device mimics a pre-existing device.

The article by O’Sullivan et al describes the formation of a working party entitled the Airway Device Evaluation Project Team (ADEPT); they state that the function of ADEPT is not to legislate which devices are allowed to be marketed, but to provide clinicians, who are involved in purchasing airway devices for their trusts, with an infrastructure of guidance. The authors suggest that the purchase and choice of airway equipment in the future should be based on a minimum level of evidence; if this minimum level of evidence is not available, then this may encourage manufacturers to fund and support clinicians in formally evaluating and conducting research of these devices. Thus, ADEPT is not only providing guidance in the purchasing of airway devices, but is encouraging the development into a “national research network.” The formation of this research network should help attain a higher quality of evidence in this area, with the ultimate goal being to ensure that anaesthetists make the right choice, in terms of safety and efficacy, when purchasing airway equipment.

The formation of a working party entitled the Airway Device Evaluation Project Team (ADEPT)...

The Difficult Airway Society ‘ADEPT’ Guidance on selecting airway devices: the basis of a strategy for equipment evaluation

The maintenance of circulatory homeostasis in patients following cardiac surgery remains a challenge in modern day clinical practice, particularly in patients with severely impaired left ventricular function. Continuous cardiac output monitoring in these patients may be useful in guiding their response to therapeutic management in the postoperative period. Since the 1970s, pulmonary artery balloon tipped catheters, have been used for this purpose, thus enabling the clinician to assess cardiac function by the bedside. The placement of a pulmonary artery catheter and the use of the thermodilution technique became a standard for measuring cardiac output, against which other methods have been compared. However, subsequent studies in the early 1980s associated the placement of pulmonary artery catheters with a higher morbidity, and no real long-term benefit. Thus, less invasive techniques to monitor cardiac output have been developed, including the lithium dilution technique, arterial waveform analysis and the combination of these two techniques.

The lithium dilution technique for cardiac output monitoring still requires central venous access; following an injection of lithium, the area under the curve allows calculation of the cardiac output. Arterial waveform analysis allows cardiac output measurement from an arterial waveform derived from an arterial cannula. In the study by Mora et al, the LiDCO pulse contour technique is compared with the thermodilution technique using a pulmonary balloon tipped catheter. The LiDCO pulse contour technique involves a combination of the lithium dilution technique, which is used for calibration in the first instance, and then pulse contour analysis of an arterial waveform to provide continuous cardiac output measurements. Although this technique has been validated for measurement of cardiac output in various clinical situations, this is the first study comparing the LiDCO pulse contour technique with the thermodilution technique using a pulmonary balloon tipped catheter. The LiDCO pulse contour technique involves a combination of the lithium dilution technique, which is used for calibration in the first instance, and then pulse contour analysis of an arterial waveform to provide continuous cardiac output measurements. Although this technique has been validated for measurement of cardiac output in various clinical situations, this is the first study comparing the LiDCO pulse contour technique with the thermodilution technique using a pulmonary balloon tipped catheter, in patients with a poor left ventricular function.

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B. Mora, I. Ince, B. Birkenberg, K. Srichtldze, E. Pernicka, H. J. Ankersmit and M. Dvoreschak

Validation of cardiac output measurements with the LiDCO pulse contour system in patients with impaired left ventricular function after cardiac surgery*

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The advantages of the LiDCO pulse contour technique is that it is less invasive than the pulmonary balloon catheter; in this study, the authors demonstrate that in patients with a poor left ventricular function, the measurements for cardiac output derived using the LiDCO pulse contour technique correlate with those using the thermodilution technique. Though, these advantages need to be considered in the context of this particular study; the results are encouraging but further validation of the LiDCO pulse contour technique is still necessary in this group of patients before we discard the pulmonary artery balloon catheter completely.
My previously very fit mother had been admitted three days previously following a collapse and episodic breathlessness. She was only in her fifties, so it came as a shock when a pulmonary embolism was confirmed by CT. It was puzzling that this had happened ‘out of the blue’ – to this day her only risk factor appears to have been a long-haul flight three months earlier.

She had been started on therapeutic anticoagulation and stepped down from Coronary Care to a medical ward, where we had been visiting her that morning. Not wanting to suffer the hospital refectory we’d popped out to the town for lunch whilst my mother endured some physiotherapy and, as it turned out, a prolonged asystolic arrest.

When we arrived back on the award, the news of the arrest was broken to us. I felt strangely numb. We were told of the seriousness of the condition and that she was being transferred to the Intensive Care unit. All I could ask about was the specifics of the arrest, its duration, and what drugs had been used.

Being an anaesthetic and critical care trainee I was automatically risk stratifying, diagnosing, prognosing, and medicalising the situation. This was my automatic response. Little did I know that the next half an hour was about to change this for good.

We met two consultants in the relative’s room on the unit following her transfer. The first, on reflection, was an abject failure in terms of giving us the information we required. He talked at length about the risk factors for PE, long-term anticoagulation, and further imaging to exclude the “cancer” that was likely to be underlying all this. He was totally oblivious to the real question at the forefront of our minds – is our beloved relative, mother to me, wife to my father, future grandmother to my children going to live or die today?

The second consultant has remained the model for me when I have to deliver bad news - when the roles are reversed and I’m the doctor updating relatives in a critical care environment.

He’d entered and said very little. He described the heroics of the resuscitation team, the graveness of the situation and his concern about long term anoxic brain damage. It was that simple. He was also proven right, both clinically and in delivering the key pieces of information critical to us at that time. I didn’t care about the specifics of the investigations and treatments she was receiving. I really didn’t want to be thinking about them at all. What I wanted to know was what every concerned relative wants to know. Are they going to die? Are they going to be the same if they survive this? Are they receiving the best care?

Meeting a patient’s loved ones now I try to be more like consultant 2 and less like consultant 1 and give them the information that is important to them, not the information that is important to us, as health care professionals. People don’t want to know the finer details of how we are treating their relatives, they want to know the ‘bottom line’ and its implications. So I recommend cutting to the chase, not gilding the lily, and avoiding getting bogged down in the intellectual fineries of our speciality when speaking to relatives. It just makes you look like you’ve missed the point otherwise!

My mother, four years later, remains alive but in full time nursing care. She is not now the person she once was. I believe this to be her last important lesson to me.

Dr Rob Whittle,
ST6 Anaesthetics and Intensive Care,
Newcastle Upon Tyne
Your comments please – AAGBI sets up a new working party with the OAA on obstetric anaesthetic services

Council of the AAGBI has established a new working party with the OAA that will meet over the next few months to review the 2005 edition of Guidelines for Obstetric Anaesthetic Services. The working party would welcome comments from members on the subject. As usual, any draft reports produced by the working party will be posted on the website for members’ comments before final publication.

This working party, chaired by Council Member Dr Felicity Plaat, has been tasked with updating these guidelines in the light of changes in workload, staffing and training in the past five years and new requirements from CNST.

If you would like to comment please email workingparties@aagbi.org. Your comments will be passed on to the chair of the working party.

Ultrasound in Anaesthesia and Intensive Care: A Guide to Training

It is being used increasingly in anaesthesia and intensive care for regional anaesthesia, central venous cannulation, echocardiography and thoracic scanning to name some of its uses. The majority of anaesthetic practitioners will have had varying amounts of training and be gaining their experience as they practice. This raises the issue of Clinical Governance and “The safe introduction of new technologies” as outlined by the DoH Interventional procedures programme: H5C 2003/011.

The latest publication from the AAGBI is called Ultrasound in Anaesthesia and Intensive Care: A Guide to Training. This is a guidance document produced by a joint Working Party of the Association of Anaesthetists of Great Britain and Ireland, the Royal College of Anaesthetists and the Intensive Care Society. It aims to address these issues.

It acknowledges that established clinicians will undergo a different training pathway (clinical practice pathway) to trainees (trainee pathway) and suggests training guidance for both groups that individual anaesthetic departments can implement and satisfy their Trust’s clinical governance procedures.

It recommends that each department establishes a lead clinician for US training and clinical governance and suggests useful guidance how best this may be achieved.

10th Anaesthesia Conference

Organised by British Association of Indian Anaesthetists www.baoia.org

Saturday 1st October 2011 - Open to all irrespective of their origins

Annual Scientific Programme

Politics of anaesthesia - 2011, Dr Iain Wilson, President of AAGBI
Incredible India – Anaesthesia in modern India, Prof V Ramkumar, Manipal, India
Human factors in anaesthesia and productive outcome, Dr James Clarke
What’s new in regional anaesthesia? Dr John Barcroft
It’s not just gadgets – Airway extubation, Dr Ravi Dravid
Delirium in intensive care, Dr Valerie Page
Cardiopulmonary exercise (CPX) testing, Dr Alex Oliver
Live demonstration of CPX testing, Drs Alex Oliver, Ravi Rao Baikady, Mr Nick Chapman

• Free Paper and Poster Presentations • Spouse and Children’s Programme
• Indian Banquet and Entertainment

Organising secretary: Dr Devaraj Acharya, Consultant Anaesthetist, Watford General Hospital, Vicarage Road, Watford, WD18 0HB. Email: devgoly@hotmail.co.uk Tel: 07795 386738

Venue: Wembley Stadium London
New AAGBI/BADS Guidelines

Day Case and Short Stay Surgery: 2

Day surgery is increasingly the treatment of choice for an ever widening range of surgical procedures. It is a safe and beneficial form of care for many patients with co-existing conditions which might previously have been regarded as contraindications to day surgery.

Day surgery aims to improve care so that an overnight hospital stay is unnecessary. This may be the optimal form of care for as many as 80% of elective operations. Most anaesthetists will therefore encounter these patients at some time. Even where discharge on the day of surgery is not possible, applying the same care principles can improve the quality of recovery and keep the duration of hospital admission to a minimum. Recently, this philosophy has also been applied to patients undergoing major inpatient surgery, to optimise patient preparation, minimise perioperative trauma and thereby enhance recovery. Day case services when delivered appropriately not only improve the quality of patient care and enhance the patients’ experience, but make economic sense.

These guidelines have been produced jointly with the British Association of Day Surgery (BADS), capitalising on years of experience in providing safe and efficient care for day and short stay surgery patients. They include up-to-date selection criteria for day and short stay surgery. As such, they not only replace previous guidance on day surgery from the AAGBI, they also supersede earlier guidelines on patient selection from the NHS Modernisation Agency and the Royal College of Surgeons.

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Caffeine Tracker

This is the story of how I developed one of the 350,000 apps on the Apple store and lost some money…

January 2009

When I started anaesthesia (in 2004) the first duty of the day was to see the patients, check the machines and draw up drugs. However, by 2009, a new competency had emerged: buying Costa coffees for the team. It dawned on me that the most popular drug in theatres wasn’t propofol, it was caffeine. I’d learnt the pharmacokinetics of induction agents, opioids, muscle relaxants etc, but I was clueless concerning xanthine alkaloids. Wouldn’t it be great to know your caffeine levels at any given time? Were they too high leading to palpitations and tremors? Were they too low giving rise to apathy and tiredness? Most anaesthetists drink coffee. Most anaesthetists have iPhones. The answer had to be an app to model caffeine pharmacokinetics. If I could make enough to buy a Lamborghini then all the better.

September 2009

Literature search completed. A surprising amount of data is available on caffeine metabolism. It turns out that caffeine is used to measure p450 activity, and hence is featured in much research. Logistical regression of 863 coffee drinkers in Germany (1) revealed that smokers, heavy coffee drinkers, the obese, women, and those on the oral contraceptive pill all metabolise caffeine at different rates. All this could be factored in to my model. Coding software is not my forte. The last time I programmed a computer was in about 1988 on my ZX Spectrum (20 GOTO 10 etc) so I found a company in Cheltenham that programmed apps. They gave me a cynical response to my initial enquiry then stopped answering my calls. Probably a wise move!

November 2009

Found a company in Bristol called ‘AlwaysOnMessage’. They sounded enthusiastic but were not interested in a ‘Dragons Den’ style deal. I met the managing director, appropriately at a
December 2009

Scoured the internet for data on the caffeine content of coffee, tea and energy drinks. E-mailed coffee shops inquiring about their products’ caffeine levels. Most had no idea. I decide to find out for myself and contacted a laboratory in Germany who would analyse coffee samples for €20 a go. Toured Bristol and Cheltenham collecting 20 espressos to package up and send abroad.

January 2010

Results back from Germany. Compiled spreadsheet of drinks and their caffeine levels. Produced formulae to model rate of metabolism.

April 2010

Received first version of the app, corrected spelling mistakes and suggested improvements to graphics. Wrote disclaimer.

December 2010

App developers stopped answering my calls and emails. Wrote desperate letter to managing director. Received gushing apologies. Members of the company have been shown the door following numerous complaints from clients. Final versions of the app are delivered and approved.

January 2011

After signing multiple lengthy contracts with Apple (all unread) app is finally ready for release on the Apple store. During the ‘Free to download’ introduction period up to 100 downloads per day are logged. iPhone users from Brazil to China are discovering their caffeine levels. I am convinced that fame and fortune is sure to follow. I type in ‘Caffeine tracker’ and my App comes up on Google search. I am now alive and well in cyber space. The reality check comes when I start charging £1.79 (officially known as Tier 3). Downloads are now in single figures. Looking at the app store most of the big sellers are 59p (Tier 1 in Apple speak). I adjust my price and expectations accordingly. Sales still poor.

February to April 2011

With a very limited marketing budget I do my best to promote the app. Press releases go out to newspapers and magazines: ‘Mail on Sunday’ health pages, Pregnancy News, Men’s Health, The Coffee Chronicles etc.

No one gets back to me. I sign up to Google’s advertising department ‘Adwords’. This is how the Californian megacorp make their billions. Unfortunately it requires a degree in statistics to try and target your audience and I fail. Google are so keen to keep their product appealing to internet users that even the adverts have to appeal to them. If not, you slide down the ratings and off the bottom of the screen. Facebook was the next target for my foolish Dollars.

Despite the lack of financial rewards I don’t regret the time and money spent. A couple of weeks ago I received an email from someone, probably an American, who thanked me for the time and effort spent making the App. That was good to read.

When I started, I allocated a sum of money to the project that I was prepared to wave goodbye to forever. In this, at least, I appear to have been wise. After many years of sweat in the world of medicine it’s refreshing and satisfying to explore other worlds of knowledge and enterprise. Now I’ve had some experience my next project will be easier. I realize that all you have to do is make a start and keeping going. And if it fails, at least I’ve got an interesting dinner party tale to tell.

References


Dr Edward Bick
Airway fellow, Department of Anaesthesia, Charing Cross Hospital

My top tips for anyone thinking of doing something similar (in no order and with no guarantee of success):

1. If you have a flash of inspiration don’t let it go.
2. Check it hasn’t been done already. Most things have.
3. Allocate a budget that you’re prepared to see go up in smoke.
4. Don’t let it distract you from the day job (you may need to stick with it)
5. Tell everyone your idea. People haven’t got the energy to steal it and they’ll tell you what’s good and what’s bad.
6. Be a perfectionist (I wasn’t)
7. Enjoy it!
Keeping Out of Trouble

It is time for a confession – even I have been in trouble during my 29-year career in anaesthesia. There have of course been lots of minor episodes of trouble, like the time when I accidentally dissolved an antibiotic in a long-acting non-depolarising neuromuscular blocking drug (pancuronium) instead of water and gave the resulting mixture five minutes before the end of the operation. I was stuck in the recovery room ventilating the patient’s lungs for two hours afterwards and was the butt of not a small amount of ridicule from my peers, and subsequently the subject of a trip to the lead clinician’s office for a rap across the knuckles. There have also been more serious episodes, including one accusation of gross professional misconduct and one of attempted murder – I kid you not! Tempt me into a public house one day and ply me with a beer or several and I will reveal all. Suffice it to say in summary that I was innocent of both charges but learned a lot about life in the process of defending both cases. The truth in anaesthesia (and critical care and pain medicine and any other medical subspecialty) is that it is much better to keep out of trouble than it is to learn to be adept at getting out of trouble once you are in it. I have a few tips for keeping out of trouble that I will share with you.

**Look after your patient and yourself**

Although a relatively recent novitiate into the motorcycling fraternity, I have already learnt some of its mantras. One of my favourites is: don’t ride drunk, don’t ride tired, don’t ride sick, and don’t ride upset. The principle is that riding a motorbike requires a great deal of concentration if you are going to stay on it and avoid an impromptu flying lesson that will undoubtedly end in pain and physical damage. You cannot concentrate on this important task if you are drunk, tired, sick or distressed. There are obvious parallels to treating patients, with one notable difference. With motorcycling, you risk your own life; when treating patients you risk their lives - but you also risk your career. If you find yourself required to work but feeling impaired for whatever reason, tell someone and see if you can find a way of not treating patients until you feel well enough to do so. As a trainee, there should always be a consultant to whom you can turn and who can rearrange service cover to make sure that patients are protected and that you are given the chance to recover.

However, looking after yourself goes beyond just making sure that you are fit to work on a particular day. It extends to developing a lifestyle that means that you are as fit as you can be all the time. You need enough sleep, a reasonable amount of exercise, time for friends and family, a good diet, a passion outside of medicine and a lifestyle free from drugs, smoking and anything more than a modest amount of alcohol. These may seem like trite recommendations, but a visit to the General Medical Council’s website, and in particular the judgements of the Fitness to Practise panel, will show you that many of the doctors who go off the rails ignore these trite recommendations. Your health and sanity is very much conducive to the health of your patients. If you find yourself failing to live up to these recommendations, I would strongly advise you to seek some help of some sort, even if it is talking to a sympathetic friend who knows you well enough to support you and point you in the right direction.

**Don’t get out of your depth**

No anaesthetist can do everything and no anaesthetist can be expected to be able to do everything. This is true for all anaesthetists but is particularly true for trainees. There will be times in the professional career of every anaesthetist, whether they are a consultant, specialty doctor or trainee, that their skills, knowledge and experience will not be sufficient to provide a patient with the best care available. When this happens to you (and note that I say ‘when’, not ‘if’), you must seek help and advice from others. There should be a consultant available to you 24/7 to offer advice and physical support. Okay, some consultants get a little grrouchier when called at 4.00 am. However, just think how much grouchier they will be if you call them at 5.00 am having really screwed up a case and are already far more grouchier themselves. If you are going to be times in the professional career of every anaesthetist, whether they are a consultant, specialty doctor or trainee, that their skills, knowledge and experience will not be sufficient to provide a patient with the best care available. When this happens to you (and note that I say ‘when’, not ‘if’), you must seek help and advice from others. There should be a consultant available to you 24/7 to offer advice and physical support. Okay, some consultants get a little grrouchier when called at 4.00 am. However, just think how much grouchier they will be if you call them at 5.00 am having really screwed up a case and are already far more grouchier themselves.

**‘Fess up**

This is an obvious one: if you mess up, ‘fess up. Take responsibility for your victories and your mistakes. It is an entirely natural tendency to avoid contact with a patient whom you may have harmed or annoyed as a result of an error. Don’t do this. Patients and their relatives will understandably see this as you being evadeive and defensive. Talk to a consultant about what happened.
and then go and see the patient and their relatives and explain the situation honestly. Sometimes, it may be appropriate for you to face the patient alone; sometimes you should have a consultant or other senior member of staff with you. At this meeting, you should apologise for what happened if this is appropriate. This does not amount to an admission of negligence, and your honesty and openness will often satisfy the patient and persuade them not to take any further action.

### No one’s perfect

This follows on from the above point. No one is perfect; everyone makes mistakes. Making a mistake doesn’t usually mean you are a bad person or a bad doctor; it just means that you are human. By all means make every effort to avoid mistakes, but do not be too hard on yourself if you do make a mistake under difficult circumstances. Similarly, be understanding of others who make honest mistakes.

### Don’t get proud

A wise man (my father-in-law) once told me: “never, ever think you are the best anaesthetist in the world, just be very grateful indeed that you are not the worst – there will always be people better and worse than you are”. Even if you are very good indeed, there will be days when nothing goes right - when it feels like you are wearing boxing gloves and none of the lines will go in. Don’t get proud – get someone else to help you. The person you ask to help you doesn’t always have to be more experienced than you. I have often had difficulty putting a line in and have asked a trainee to help, only to watch the trainee put it in at their first attempt. This is good for the trainee and good for the patient and, after a while, your pride will get immune to the odd difficulty putting a line in and have asked a trainee to help, only to watch the trainee put it in at their first attempt. This is good for the trainee and good for the patient and, after a while, your pride will get immune to the odd difficulty putting a line in and have asked a trainee to help, only to watch the trainee put it in at their first attempt. This is good for the trainee and good for the patient.

### Keep good records

When you make clinical decisions, you are - I am sure - going through a problem-solving process and reaching logical conclusions that dictate your management. However, years down the line, if something goes wrong and you have to defend your practice, your memory will have faded. If you are a good practitioner, then good, contemporaneous record keeping is your best protection (if you are a lousy practitioner, of course, then it can damn you for all eternity, but you’re not, are you?). Good records will also mean that the next doctor who sees your patient will know what’s going on and will be able to provide continuity - especially important in the new age of shift-working. A good rule of thumb is that an anaesthetist who does not know you but who has read your anaesthetic chart should be able to give an identical anaesthetic based on the information in the chart. A good, tidy and complete anaesthetic chart, in particular, is often the mark of a good, tidy and complete anaesthetist.

### Treat consent seriously

From both the ethical and legal viewpoint, the process of consent is becoming increasingly important. You are responsible for explaining what you are going to do to your patient, telling them what you hope to achieve by it, what might go wrong, and what the alternatives are. Be guided by this simple question: “If I were this patient, in their position and with their concerns, what would I want to know in order to make a decision about this treatment?”. The debate between written and verbal consent is too complex to consider here (read the AAGBI booklet on the subject), but the most important precaution is to keep a record of what has been discussed; patients have notoriously terrible memories about what they’ve been told and, if a recognised complication occurs, you’ll want to be able to demonstrate that you warned them about it in advance.

### Follow guidelines

You may think you know best - and, to be fair, sometimes you do - but a lot of experts went to a lot of trouble to draw up those guidelines, and it’s their support that you need when things go wrong. They are more likely to smile favourably on you if you weren’t following some maverick path of your own at the time. Of course, you are a professional, and of course guidelines can’t deal with every situation, but if you are going to deviate, make sure that (a) it’s for a good reason and (b) you make a good note of why you did it.

### Communicate

No anaesthetist is an island. We can only work well if we work with others, so ensure that lines of communication between you, the surgeon, the theatre staff, the wards, the labs and the myriad of other essential members of the team do not break down. The anaesthetist is arguably best placed to act as the hub for sharing and disseminating information. It’s a noble and important role; fill it with distinction.

### Never refuse a coffee break

When I started anaesthesia, I was told that there were three golden rules (in the following order):

- Never refuse a coffee break
- Maintain a clear airway
- Give oxygen

I have often thought the order might not be entirely correct, but I have never knowingly refused a coffee break when it was safe to leave the patient with another anaesthetist. You never know when your next break will come and you will function better if you have frequent breaks.

### Be nice

It is a fact of life that the nice doctor who makes an error is far more likely to come out of it smelling of roses than the nasty doctor. You are bound to need the help and support of your colleagues at times, and they won’t rush to help you if you’ve alienated them. The same applies to patients, who seem to be far more forgiving if they like you.

### Listen to the GMC (really)

The very first line of the GMC’s key document Good Medical Practice says this: “Make the care of your patient your first concern”. This is the best advice available if you wish to keep out of trouble. I am sure that you could add to this list of pieces of advice that will help others keep out of trouble. However, I will leave you with one more morsel of advice that is worth heeding if you want to stay out of trouble: treat others as you would wish to be treated yourself – and this holds true for both your patients and those with whom you work.

### Be safe out there!

William Harrop-Griffiths
AAGBI Vice President
Consultant, Imperial College Healthcare
NHS Trust

This article is an extract from the new GAT handbook
Southern Sudan
- the Wessex link

On 3rd September 2010 I joined a team of four nurses to visit Wau in Southern Sudan. Poole Hospital have forged a link with this 500 bedded teaching hospital in the North West of Southern Sudan. We are part of a wider Southern Sudan link developing in Wessex, which started with St Mary’s on the Isle of Wight linking with the main hospital in Juba, the Capital. Recently Winchester hospital has linked with a third hospital, Yei.

The main objectives had been developed following two previous visits. They were to continue with teaching and supporting the nursing staff, in particular teaching basic nursing care, including observations and hygiene. We wanted to focus on maternity, and paediatrics. The maternal mortality rate in Southern Sudan is 2054 per 100,000 and infant mortality 135 per 1000. In addition my role was to work with both doctors and nurses to highlight the benefits of early recognition and treatment of the deteriorating patient. We were not visiting to carry out surgical procedures or manage patients.

Before I was allowed to qualify as part of the team I had to persuade our Link organiser that an anaesthetist had the necessary skills to teach basic recognition on a multidisciplinary level. With 20 years of experience of teaching PALS, EPLS, ALERT and AIM I finally persuaded the group that I would be a useful team member and was able to start planning.

My personal objective was to develop a series of A4 laminates, based upon the WHO Emergency Treatment and Triage course on which to base all my teaching for both nurses and doctors. The laminates provided clear algorithms for emergency recognition and management using the ABCDE approach. I also developed fluid management charts for both the well-nourished and malnourished patient. I wanted to bring the nursing and medical care under one umbrella to encourage team working, a strategy which has been so successful in UK over the past few years.

Nothing could have prepared me for the desperate conditions we encountered. Everything that one would expect to find in a hospital was absent, except the patients. No running water, no oxygen and minimal pathology support. The lab had a microscope for FBC and thick films for malaria and an old colorimeter for Hb. Basic equipment, fluids, cannulae and drugs were mainly sourced from the local pharmacy by the patient’s relatives. Small scraps of paper were used for patient notes and patient observations charts were virtually unknown.

We set to work, teaching nurses, doctors, midwives, anaesthetic nurses, and student nurses, anybody who would listen. We were able to give ward-based support during the day, with a highlight being the day we found an oxygen concentrator and used it for a small boy with an aspiration pneumonia following convulsions due to cerebral malaria. The oxygen gave him enough energy to cough with some physiotherapy and I believe we saved his life.

**Modern delivery techniques**

Our midwife taught modern delivery techniques, showing their midwives the importance of hygiene and monitoring the progress of labour, although the simple partogram was beyond the scope of the visit.

We taught simple neonatal resuscitation, showing how to save a life with a few puffs from an ambu bag for a flat baby who was going to be left for dead. She went home well 2 days later. We saw the benefits of teaching triage when a patient arrived at the outpatient’s area virtually unconscious. She was taken straight into the doctor, assessed and moved to a new area set up adjacent to outpatients for the acutely unwell. The relatives were swiftly despatched to pharmacy with a prescription for a cannula, fluids, antibiotics and quinine. Within 20 minutes she had an IV running with antibiotics and her blood was under the microscope looking for malaria.

It was really exciting to see that they had acted upon our advice from a previous visit. In the evenings we visited two church-run nursing schools which have recently started to take students again after the war. We were encouraged by the calibre of the students and the standard of teaching and see these students as a valuable resource for the future. I personally saw future anaesthetic nurses in the making!

I returned for a second visit in May, hoping to tap in to renewed energy following the recent referendum which has confirmed that Southern Sudan will split from the North. This will result in huge opportunities for the South, which historically has missed out as resources were concentrated in the North and Khartoum.

We were encouraged to see that some of our developments were still in place. The new maternity unit had opened and looked cleaner and airy. We saw some observation charts and a partogram!. There was further evidence of triage in out patients and some significant improvements in pathology but other changes remained uncompleted and morale was still very low.

The south has to develop their own Medical School and Postgraduate training facilities. They lack suitably trained senior and junior medical staff and are currently looking to the UK to help them to develop an entire medical training infrastructure in as short a time as possible. The government of Southern Sudan (GOSS) plans to fund a two year period of postgraduate training in the UK for doctors who can demonstrate ability and commitment by passing UK Part 1 exams and gaining GMC registration.

During the second visit I interviewed around 15 doctors from Juba and Wau, who are keen to come to the UK. My initial impression is that few would be able to integrate effectively with our trainees and a long period of supernumary work would be required before they could function alongside UK graduates.
I think initially there will be greater value in securing funding for shorter clinical attachments, of 6-8 weeks. A few may then go on to fulfil the criteria for a longer period of UK training. In addition a complete post graduate training facility will be created in Juba to ensure that any funding for overseas and local training is used appropriately. Wau and Malachal will be the additional teaching hospital sites.

As services develop the doctors of Southern Sudan will need our help. The process has started with a meeting at the end of May of Southern Sudanese doctors from around the world. We are linked in with these ambassadors and they are very keen to work with UK doctors, in particular our Links in Wessex, recognising that this project is too large for them alone.

At Poole we are planning to trial offering posts to suitable doctors for clinical attachments in the first instance. The clinical attachments for surgeons, physicians and a technician will require careful planning and educational supervision. We will rotate them through theatres, intensive care and the wards. In addition we will hope to teach them basic ultrasound, communication skills and leadership skills.

A couple of suitable doctors who have already passed Part 1 Membership in Obstetrics and Gynaecology will be offered longer training in Obstetrics and Gynaecology. The Government of Southern Sudan will need to provide some of their funding and they fully understand that they will be unable to work independently until they have fulfilled our local competencies.

I hope that in the future I will be able to report on a developing infrastructure in Sudan including a postgraduate training programme, a network of teaching hospitals, equipped appropriately and a growing functional team of hospital doctors, including anaesthetists supported by anaesthetic nurses being trained in hospitals with adequate anaesthetic equipment including oxygen and monitoring.

I also see a role for UK doctors to spend time in Sudan supporting the teaching and working alongside the Sudanese doctors. We could support the development of beacon wards, where patients have regular observations and monitoring. We could give hands-on training to the anaesthetic technicians. Such developments will be dependent upon securing funding from the Government of Southern Sudan to ensure basic equipment is sourced and available, internet access is secured and appropriate accommodation provided. Currently the living arrangements are basic and expensive. ($120 per person per night). We struggled with no running water or electricity at our hotel for several days when outside temperatures were in the forties.

The hospital in Juba has started to move forward but the rest of the country is in a desperate situation. At Poole we are committed to working with Wau Teaching hospital and their doctors, ensuring that developments occur across Sudan and not just in their capital. Over the next few years I see a need for UK doctors to teach in Southern Sudan. I also see a need for supervisors in UK to take on Sudanese doctors on Clinical Attachment.

Dr Frankie Dormon
Consultant Anaesthetist
Medical Lead for Poole Africa Link

Please note: The IMT scheme is to be limited to max of 12 months because of immigration changes.
We are now practicing medicine in a technological age with developments progressing at a rapid pace. In recent years, most anaesthetists have been simultaneously using pagers, mobile phones or personal digital assistants (PDAs) to maintain communication with the hospital and access medical information. Many of these devices are now becoming obsolete with the introduction of the “smartphone” which has the capability to combine multiple functions into a single handheld device and offers advanced computing technology.

The history of the smartphone does not chronologically span a long duration of time but its pace of development has revolutionised anaesthetic training and practice. Gone are the days of newspapers and crosswords during long operations, these have been superseded by mobile internet and online reading. No longer are trainees’ pockets bursting with loose sheets of paper holding crucial pieces of information such as paediatric drug doses or anaesthetic lists to be recorded in the Royal College log book months later, or burdened down with FRCA textbooks and Oxford Handbooks. All are now available instantaneously at the touch of a screen in a single handheld device wherever and whenever it is needed. This is an exciting and empowering technological advance not just for anaesthetic trainees and consultants but for patients alike. However, all new technology has its drawbacks, and the smartphone is no exception. I will endeavour to explore how the development of mobile wireless devices and smartphones have become engrained into our clinical practice, the numerous applications that exist that can be used to our advantage and some of the potential pitfalls which we must be aware of surrounding this technology.

The Smartphone is born...

Pagers were the primary mode of communication used by the medical profession up until the 1990’s when mobile telephones became more widely available. Some anaesthetists also purchased a personal digital assistant (PDA) to facilitate storage of patient information, calendars and as a reference tool. But imagine if instead of carrying multiple devices, this could all be combined into one? The first ever smartphone was the IBM ‘Simon’, released to the public in 1993. Besides being a mobile phone, it also contained a calendar, address book, world clock, calculator, note pad and the ability to send and receive email. This phone had no buttons but instead utilised a touch screen. By today’s standards, the technology was relatively basic but at the time its features were highly advanced. In 1996, Nokia released its Nokia 9000, a collaborative effort with Hewlett-Packard combining their costly PDA with Nokia’s best selling phone of the time. Nokia’s innovation continued with the incorporation of a camera and Wi-Fi, then Global Positioning System (GPS). The first device to be labelled a “smartphone” was released in 1997 by Ericsson. Palm, Symbian and Blackberry all developed their own models for the newly-emerging smartphone market. One of the most successful was the Blackberry, released in 2002, as it was the first smartphone optimised for wireless email use. By December 2009, it had 32 million customers subscribing1.

Steve Jobs at Apple Inc. had meanwhile been focusing efforts on designing a smartphone that could be controlled primarily via a touch screen and tasked engineers to develop a touch screen that could be utilised by such devices. In the mid 1990’s the Newton Message Pad was an early form of hand held device manufactured by Apple. Some of its concepts and functions were incorporated into the iPhone.

Instead of focusing energy into developing a follow-up Newton PDA, Jobs had Apple focus on the iPod and iTunes software, launched in January 20012. Jobs and Motorola released the ROKR E1 in September 2005, the first mobile phone to incorporate iTunes. After only a year Apple discontinued support for the ROKR as it felt the phone’s development was being compromised by using non Apple designers3. The iPhone was first revealed at the Macworld conference and Expo in San Francisco in 2007, with the first iPhones going on sale in the USA in June 2007. Since then over 33 million phones have been sold worldwide and the number of European iPhone users rose by 161% in the year running up to April 2010. It has been awarded various awards, including the Invention of the Year in 2007 by Time Magazine4. O2 won the exclusive contract for UK iPhones, with sales launched in Nov 2007. 18 months later 3G was added to improve browsing speeds and a third party application plan released enabling anyone to write applications (apps) for the phone.

The Android operating system for smartphones was released in October 2008; an open source platform backed by Google and other software developers. Android is the flagship behind the Open Handset Alliance, a major consortium of 48 companies including Motorola, Samsung, T-Mobile and Intel that will promote and develop mobile phones running on the Android operating system. The first non Apple phone of this type was the HTC Dream, released in October 2008 with third party apps becoming available via the Android market at this time. Google’s Android is designed to compete with other mobile handset platforms, most notably the Apple iPhone5.

Increased efficiency, reduced paper...

Quick to capitalise on the convenience of the smartphone was the company iMobileMedic. The ability to provide documentation and a written record as proof of our competency to practice has become a tedious necessity. Anaesthetists
The explosion in smartphone technology has been harnessed as a potential educational and diagnostic tool by many individuals in the anaesthetic speciality.

The iGeneration

"Smart" Anaesthetists:

An additional benefit with storing data in this format means that the amount of paper required for documentation can be vastly reduced: important for the current environmental and financial climate.

In documenting records in this way, users should be aware of potential pitfalls. Data must be backed up regularly and stored in an additional printed format to prevent loss of information should the device be lost or technical faults occur. Confidentiality of patients must be maintained and care so be taken to avoid recording details that could identify a specific patient individually.

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The Hopkins Antibiotic Guide has been available for many years, mostly for the Palm OS and Pocket PC 2003 platforms. The guide has 3 main sections: syndromes, pathogens and antibiotics providing clinically orientated, highlighted information regarding the diagnosis and management of infectious diseases.

MedHand International in conjunction with renowned publishers including Oxford University Press seized the app market with vigour. Formed in 2001 by a General Practitioner and mobile development expert they created Dr Companion, originally for the Palm OS Platform, released in 2004. Growing demand from consumers to use the product on other mobile devices lead to a multi platform version; completed in 2006. The company now markets a whole “mobile library” available to download to handheld devices including the Oxford Handbook of Anaesthesia. Considered an essential reference text by numerous anaesthetists, this previously bulky text can now be carried around with ease in ones pocket for reference at the touch of a screen. Also beneficial to our specialty are the Oxford Handbook of Critical Care and The British National Formulary, to name a few.

Our anaesthetic colleagues of the future may no longer require traditional printed textbooks at all. The Welsh Deanery has recently invested £500,000 in supplying their foundation house officers with smartphones. They have offered all their doctors an iDoc, which is essentially a smartphone with 20 medical textbooks downloaded onto it. They believe that the phone could save the NHS money by saving on continually updating print copies of textbooks, as well as ensuring all their trainees have access to the most current medical information thus providing the best possible care for their patients.

Textbooks are not the only resource available in this portable, cost effective and environmentally favourable format. Some Medical journals accessed by anaesthetists have been released as a smartphone application. From June 2010 the New England Journal of Medicine became available with the British Medical Journal following suit from January 2011.

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Podcasts: The Trainees’ best friend?

This explosion in smartphone technology has been harnessed as a potential educational and diagnostic tool by many individuals in the anaesthetic speciality. Quick to capitalise were two entrepreneurial Nottingham graduate anaesthetic registrars, Rebecca Leslie and Emily Johnson. Both were spending up to 2 hours per day commuting whilst studying for the Primary FRCA and felt the time could be put to much better use. Obviously it was not possible to read a text book whilst driving but a well structured podcast could provide an innovative new revision tool for trainees enabling revision at times when it had not been previously possible thus maximising all learning opportunities. They gleaned information on the spectrum of questions asked and how to structure the answer from recently successful candidates which were then validated by experienced consultants. Dr Podcast became available to download in 2008 with 90 individual recordings covering topics for the primary exam including physics, pharmacology and physiology. The huge success of the primary podcasts was just the beginning of this new age of revision with podcast for the Final FRCA being released shortly after. The latest addition to the podcast family, are those for medical and surgical exams with other specialities pending for later this year.

Continued next month...

Dr Claire Gaunt
ST3 Anaesthetics,
St George’s Hospital, London

References

**Anaesthesia News** has received some excellent photographs in response to our call for images for the front cover; so much so that we have decided to run a competition for six months from June to November 2011.

**A prize of £100 worth of Amazon™ vouchers will be awarded each month (from June to November 2011) to the winning entry.**

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Please email your image to anaenews.editor@aagbi.org (subject line: PHOTO COMP ENTRY)

**Competition Rules:**

1. All submissions must be in a digital format and entrants own work.
2. A maximum of 1 image is allowed per entrant throughout the entire competition.
3. Entries from all countries are allowed.
4. Digital images to be submitted in JPEG format, high resolution - good enough to be printed in A4 size.
5. All emails to be labelled with TITLE/DATE TAKEN/PHOTOGRAPHER NAME/SHORT DESCRIPTION.
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7. Image refining via the usual adjustment, levels, lighting etc. is acceptable. However major manipulation is NOT allowed.
8. Winners will be notified by email.
9. All images retain author copyright and will not be passed on to third parties without prior agreement with author.
10. All queries to be made via email at anaenews.editor@aagbi.org and titled PHOTO COMP QUERY.
11. MODEL RELEASE - Any photographic competition entries that contain identifiable people/faces/features must have a signed letter (by the model) or model release agreeing to be featured on the front cover of Anaesthesia News magazine - should the photo be a competition winner.
12. The editors decision is final.

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Management of a Malignant Hyperthermia Crisis

The AAGBI has produced safety guidelines for several years; one such guideline is for the Management of Malignant Hyperthermia Crisis published in 2007; the AAGBI is now pleased to introduce the updated version of the MH crisis management safety guideline.

The AAGBI has changed the appearance of their guidelines to make them visually more appealing and has developed a standard operating procedure approach to their structure. The original AAGBI MH guideline has been adapted along these lines. The guideline has been set out in a tabulated form, similar to the LA Toxicity guideline, to make quick reference to specific treatment points easier. The treatment management itself has been clearly demarcated into the following sections:

- Recognition
- Immediate management
- Monitoring & treatment
- Follow up

The production of a safety guideline usually involves the setting up of a working party that then produce draft recommendations for consultation and eventually Council approval. The MH guideline was produced by a new process. The AAGBI is developing a Patient Safety Network to enable patient safety information to flow between the AAGBI and anaesthetic departments. As a result of an audit carried out within the Network, the development of a more user-friendly guideline for MH was suggested.

The development was started in the Wrexham Maelor Hospital by Drs C. Edmondson and S. Gill. They also included a modification of the Australia and New Zealand MH Resource Kit namely a guide to task allocation for the anaesthesia team dealing with the MH crisis and a checklist for the contents of the MH crisis management kit. The guideline plus supporting documents were then presented to the Council of the AAGBI and went through the usual process of wide consultation and eventual approval and production of the safety guideline for distribution.

Crisis management

Early recognition of the onset of MH crisis and early treatment increases the chance of survival. It is therefore very important to maintain awareness of MH amongst the anaesthetic team. The prominent display of a guideline for MH management will serve as a reminder of the potential for a MH crisis. The opportunity to encounter certain rare life-threatening anaesthetic emergencies such as MH in actual clinical practice is limited. There has been an increased use of high-fidelity simulators to train individuals and teams and the practice of the use of safety guidelines within a simulation exercise is highly recommended. The task allocation can also be duplicated within the simulator as a multidisciplinary team exercise.

Dr Les Gemmell
AAGBI Immediate Past Honorary Secretary

The AAGBI is grateful to Dr Stuart Gill and Dr Campbell Edmondson for their contributions to the guidelines.
PORTSMOUTH AIRWAY WORKSHOPS

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- The Paediatric Difficult Airway
- Fibreoptic intubation
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- Supraglottic devices
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- Surgical airway
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Approved for 5 CEPD points

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Fee £300 - includes lunches, refreshments and course dinner.
Early application recommended.
OAA information for mothers: A New App

Communication and language are important markers of the quality of healthcare received by patients who do not speak English. The confidential enquiry into maternal death¹ has highlighted the changing nature of motherhood in the UK and in 2005 more than 20% of women who had babies in the UK were themselves born outside the UK.

For some women the consequences of language barriers are very serious and it is well established that women who do not speak English are at risk of serious morbidity and mortality. A key recommendation from the most recently published confidential enquiry is that ‘professional interpretation services should be provided for all pregnant women who do not speak English.’² While all trusts must continuously strive to meet this recommendation it may not always be possible in the emergency situation and/or out of ‘routine hours.’

The Obstetric Anaesthetists’ Association has always been committed to providing high quality information for mothers about all aspects of obstetric anaesthesia. The ‘Information for Mothers’ sub-committee have worked over the last few years to produce specific information on pain relief in labour, anaesthesia for caesarean section and more recently information for pregnant women with a high BMI. Probably one of the most useful aspects of this information is the many foreign language translations that are available (mostly undertaken by volunteers and to whom the OAA is extremely grateful!)

This information has always been easily accessible via the OAA website (www.oaaformothers.info/). In a communication world that is increasingly dominated by smart phones there is now an exciting new way to access this information with the OAA mobile web ‘app’ for Smartphone and iPad users. Translations in up to 35 languages are available with more on the way! It’s simple to use: either tap the web address into safari and follow the prompts (http://mobile.oaaformothers.info/) or use a QR reader or ‘Redlaser’ app from your smart phone to scan the barcode below.

Nuala Lucas

References
South West Regional Anaesthesia Course
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A one day meeting situated in the heart of York examining all aspects of caring for the High Risk surgical patient throughout the peri-operative period.

The meeting will be of interest to both consultants and trainees

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Landmark and US guided techniques. Practise on live models & phantoms, various US scanners. Choice of Workshops for beginners and advanced practitioners, including:
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A new multidisciplinary Specialist Society has registered with AAGBI. Senior consultant Dr Fred Stukinway has been elected as first President. The membership is drawn mainly from anaesthesia, orthopaedics and management.

Fred explained that the idea of the society developed from a conversation with his regular surgeon Mr Crusty, consultant surgeon with a special interest in hand surgery (all types).

“I had taken leave to attend an AAGBI meeting and Mr Crusty had a young anaesthetist replace me for the day. Apparently things did not go particularly well.” It transpired that on a normal day the Crusty / Stukinway team can perform around 15 procedures finishing by 1600, all under the “Stuk” special to be consistent with next mention.

“On the day in question, the first patient was very late on the table as a regional block was provided which took some time to develop” explained Sister Vicki Stern. Mr Crusty then insisted that all he needed was “Stuk specials” for his work, but the young consultant insisted that he would do the anaesthesia his way. An unfortunate stand-off occurred when Mr Crusty removed the U/S machine and hid the “stupid device”. Several patients were cancelled.

“Mr Crusty is particularly fond of the Stuk special” explained Fred, “No-one talks to him, or complains of pain and we work quickly. We thought that perhaps others would share this opinion, and that a specialist society might be useful to preserve traditional values in anaesthesia, instead of the sort of wiffle-waffel techniques being introduced without any control”.

The society has quickly gathered support from senior members of the profession and from many orthopaedic surgeons. “Thank goodness, at last!” exclaimed Arthur Plasty, President of the RCOS. “For some years now many members have been sure that US was risky and caused long delays on the lists and here at last are many others with similar views.”

The inaugural debate “In the Kingdom of the blind, the one eyed man is king” was comprehensively won by the NUTS when Fred explained is his Scottish accent, “Aye, but even he widnae go oot in a whiteoot”. The motion was carried, and the society recommended to NICE that until colour US was available with tissue recognition similar to a GPS, US should be removed from clinical areas.

Of course the message from this society is alarming and could lead to the withdrawal of US from clinical practice, a trend being fought by the Society for Ultrasound Realists (SOURS). Their President, Ernest Blokit, was furious. “These are just a bunch of old farts who can’t be bothered to learn. The new range of Kinult machines are poetic, making anaesthesia safer with only a small time penalty. The uses are increasing all the time. Just today I was teaching the use of US to detect the TOF produced by a peripheral nerve stimulator!”

Scoop is sure the debate will go on for some time……
A Risk Assessment Tool: for Children – The ‘NARCO’


The retrospective study published by S. Malviya et al on the topic of an objective approach to risk assessment in children was an interesting read. Clinical scoring systems provide a standardized, reproducible measure of a patient’s functional status. As highlighted by the authors, this helps in planning health care, allocating resources and clinical decision-making. The authors state that ASA-Physical status was not intended to assess surgical risk, and it does not consider the impact of the surgery on perioperative outcomes. Paediatric anaesthetists have already identified several limitations of the ASA-Physical status including: difficulty defining ‘functional limitation’ in children, lack of consideration of congenital abnormalities, non specific timings of assessment and concerns of its reliability and validity. However, studies support the association of ASA-PS scores in children and number of adverse event. Logistically I feel a new grading system designed specifically for children is needed and one that incorporates preoperative surgical risk factors as well, in predicting an overall perioperative outcome.

The NARCO uses a system based approach on assessment of the following systems: Neurological, Airway, Respiration, Cardiovascular and Other, with a subcomponent for grading surgical severity (SS). 340 consecutive surgical cases were selected and findings showed that both the ASA-PS and NARCO were predictive of a child’s need for escalation of care, hospital admissions, adverse events and mortality. I noted that the validity of both scoring systems was increased when combined with the SS score, however only slightly.

I agree such scoring systems can prove to be cumbersome in a busy preoperative setting. However, I feel a simplified NARCO grading system along with a simple preoperative SS score can facilitate better assessment. Not only will it help clarify global perioperative risk in children, but also pin point exactly which factors pose the risk.

References:

Iram Ahmed,
Trainee, Great Ormond Street Hospital, London


Perioperative respiratory adverse events are a major cause of morbidity and mortality in paediatric anaesthesia, and this large prospective cohort study aimed to examine the risk factors for these events.

All children (n=9297) who had general anaesthesia for elective or urgent procedures at Princess Margaret Hospital, Western Australia, over a year were included. The anaesthetist in charge completed an adapted questionnaire preoperatively, and the anaesthetic management as well as all perioperative adverse respiratory events were recorded.

Interesting Findings:
- As consistent with previous cohort studies, upper respiratory infection (URTI) was associated with an increased risk for perioperative adverse respiratory events when symptoms were present or had occurred within 2 weeks.
- However, symptoms of URTI 2-4 weeks before the procedure, was associated with a decreased risk of adverse respiratory events.
- A positive respiratory history (symptoms of nocturnal dry cough, wheezing with exercise, wheezing greater than 3 times in the past 12 months) was associated with an increased risk of bronchospasm, and to a lesser extent laryngospasm, than any other adverse respiratory events.
- A family history of atopy, asthma or smoking was associated with an increased risk of perioperative adverse respiratory events.
- The study also found that there was lower risk associated with intravenous induction vs inhalational induction, inhalational vs intravenous maintenance, airway management by a specialist paediatric anaesthetist vs a registrar, and the use of a face mask vs tracheal manipulation.

Problems with the study were:
- The anaesthetist was not blinded to the questionnaire results (as it would obviously be unethical to exclude the preoperative information) therefore the anaesthetist could adjust the anaesthetic management according to the findings.
- There is obviously selection bias and patients with severe respiratory symptoms may have been excluded (cancelled) from the study.
- The average age of the children included was 6.21 years and 40% of the children included were 7 years of age or older. As the incidence of adverse perioperative respiratory events is known to increase with decreasing age, perhaps the study needed to include patients from a narrower age range and a younger mean age.
- The incidence of bronchospasm was 2 % (vs only 4% for laryngospasm), which seems relatively high compared to everyday practice.
- The obvious problem with a prospective cohort study is that a causal relationship between two variables cannot be interpreted. For example, the relative risk of bronchospasm and laryngospasm was shown to be higher if the vocal cords are sprayed with lignocaine. This does not necessarily mean that lignocaine spray causes laryngospasm One can only make an association. Prospective cohorts can be useful to help build a picture to confirm or refute a current practise which we believe to be correct i.e. cancelling a child with a symptomatic URTI.

This large prospective cohort study has some interesting findings and although it is important not to draw too many conclusions, in collaboration with other cohort studies, if cancelling a patient with an URTI one should be able reschedule for any time after two weeks.

Kate Haines,
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Pro – Con debate: intravenous vs inhalational induction of anaesthesia in children

M Zielinska, H Holtby, A Wolf

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60% of children experience anxiety in the preoperative period which can have long-term behavioural implications. The reasons behind this are a complex mix of “hospital stressors”. Paediatric anaesthetists will know that the concept of “mask phobia” is as much of an issue as “needle phobia” particularly in frequent flyers.

An “ideal” induction agent should be acceptable to the patient (painless, quick), safe with minimal impact on cardio respiratory function and have minimal postoperative problems such as delirium and altered behaviour.

**IV Induction:**

- **Advantages** Fast
  - Avoid claustrophobic mask
- **Disadvantages** Pain with cannulae (overcome with EMLA/ Ametop)
  - Pain on injection (propofol) – reduce with small dose IV lignocaine
  - Hypotension and Bradycardia (avoided with careful titration)

**Inhalational Induction:**

- **Advantages** Painless
  - Requires minimal manual dexterity
  - Incremental and Reversible effects
  - Psychological benefits if child “on board”
- **Disadvantages** Smell
  - Postoperative delirium and behavioural disturbances

Patient factors such as a difficult airway, full stomach, difficult IV access, risk of MH or muscular dystrophy, requirement for neurological protection, and child and parental preference will influence the choice.

This article highlights there is no right or wrong way to induce anaesthesia in paediatric practice. However it is not simply a “technical exercise” but involves a series of successive evaluations in order to provide a tailored approach.

Psychological factors are extremely important. The level of preoperative anxiety can impact more than the actual induction technique, and should be the main centre of interest for those anaesthetising children.

Two strategies to reduce pre-operative anxiety involve pharmacological and non-pharmacological methods.

The anxiolytic midazolam has been shown in a number of studies to be more effective than parental presence. Potential adverse effects are paradoxical excitation and delayed recovery times. Recent studies have shown the benefit of clonidine over midazolam as it produces less perioperative sympathetic stimulation and postoperative pain. An important judgement call for the anaesthetist is to discern children who would benefit from premedication.

Non – pharmacological aspects encompass the parent / caregiver. Transference of mood and anxiety from parent to child occurs normally. Parental anxiety will therefore be integral to the child’s experience. Parental presence at induction remains controversial. In a recent Cochrane review 60% of studies showed parental presence did not improve anxiety levels.

Distraction techniques are useful and indeed more so than excessive empathy. Excessive numbers of people interacting with the child can also be detrimental. Other useful techniques are hypnosis and parental preparation with video media. Offering choice to the ‘competent’ child, so enabling a degree of control can help.

This paper was very interesting in its factual review of the subject and highlighting of the psychological components which are equally important to consider.

Caroline Cook,
Trainee, Great Ormond Street Hospital, London

**Comparison of 6-min walk test distance and cardiopulmonary exercise test performance in children with pulmonary hypertension.**

Astrid E Lammers, Gehard-Paul Diller, Dolf Odendaal, Sheila Tailor, Graham Derrick, Sheila G Haworth

Arch Dis Child 2011;96:141-147

The 6-min walk test (6MWT) is the distance a person can walk at a constant, unhurried pace in 6 minutes. It is used to assess the degree of exercise limitation and evaluate response to treatment in patients with pulmonary arterial hypertension (PAH). Cardiopulmonary exercise testing (CPET), unlike the 6MWT, reflects maximal exercise. The peak oxygen consumption (pVO2) predicts prognosis in adults with PAH but there is little data on 6MWT and CPET in children.

This retrospective study looked at 41 consecutive exercise tests in children with PAH to assess the relationship between their 6MWT distance and their CPET variables. All children had a reduced exercise capacity judged by 6MWT (reduced to 47.7±16.7% predicted) and CPET (pVO2 reduced to 31.5±12.2% of predicted).

The main finding was that there was a linear correlation between 6MWT and pVO2 (R2 = 0.71 (p = 0.006)) only at low levels of exercise capacity, up to a 6MWT distance of approximately 300m or pVO2 < 20ml/kg/min. This indicates that the 6MWT distance reflects maximal exercise capacity in these children. In children with a 6MWT distance >300m or pVO2 >20ml/kg/min there was hardly any association between these variables (R2 = 0.17, p = 0.042) and in addition, the maximal heart rate in each of this group of patients was significantly higher during CPET than during 6MWT indicating that the 6MWT reflects submaximal exercise capacity in less impaired children.

This study shows that performing 6MWT and CPET in children with PAH is feasible and safe (there were no adverse events during the study). These findings have implications for clinicians when assessing children with PAH and suggests that CPET should be considered as a complimentary test in children with a 6MWT >300m as in these children the 6MWT represents a submaximal exercise test. These findings also have implications for clinical trials in PAH which routinely use 6MWT as an end point.

Gagan Atwal,
Trainee, Great Ormond Street Hospital, London

**July Particle:** We incorrectly published the author’s name on a Particle last month: Nina Ashraf-Kashani, CT1 Anaesthesia, Imperial School of Anaesthesia wrote the Particle about Standard cardiopulmonary resuscitation versus active compression-decompression cardiopulmonary resuscitation with augmentation of negative intrathoracic pressure for out-of-hospital cardiac arrest: a randomised trial.

Our apologies go out to both Nina Ashraf-Kashani and Dr Peadar O’Donohoe for this error.
Dear Editor

DID PRIVATE PRACTICE PAY?

I read Dr Tighe’s article about Private Practice with interest (Anaesthesia News, June 2011), and have compared it with my own experience.

When I was appointed as a maximum part time Consultant in 1953 I was paid nine and a half elevenths of the fulltime salary, with a deduction from the starting salary as I had not yet reached the age of 32. My pay amounted to £1,332 (*£28K) per annum (full time equivalent £1,542). The fact that a year would not count as a full year for pension purposes was not appreciated at the age of 31.

Prices however were much lower; my three-bedroom house in a large garden with outbuildings forming a stable, garage and washhouse cost £3000 (*£64K), for which I was able to obtain a 100% mortgage.

The maximum allowable charge for an anaesthetist to private patients in NHS private beds was restricted to three guineas (£3.30p – £66) for a minor operation, four and a half guineas (£4.95p) for an intermediate, and seven guineas (£7.70p) for a major operation. This resulted in the anomaly that if the patient was unfit for anaesthesia a consultation fee of five guineas (£5.50p) was paid, more than the fee for the anaesthetic in some cases.

In private nursing homes, the fee was usually 10% of the Surgeon’s fee plus two guineas.

Extra income was available for anaesthesia in dental surgeries, 50p if 1-3 teeth were extracted, £1 if four or more. I was not prepared to anaesthetise for a to dental clearance, for which a larger fee was available. The dentist usually provided an anaesthetic machine, nitrous oxide and oxygen and a tongue forceps, (which I fortunately never had to use.) The anaesthetist paid for intravenous induction agents, disposable syringes and needles, and volatile agents such as halothane, vinylsethene, or trilene. The occasional “emergency” dental anaesthetic for a painful abscess on a week-end for 50p was not profitable! School dental clinics on a sessional basis were also available. At one time I was giving over 1000 dental anaesthetics a year.

An advantage of private practice was that certain expenses (telephone rental, some car expenses, wife answering the phone etc.) which were mainly incurred for NHS purposes but not paid for by them, caused the private practice to make a loss, which reduced my total tax bill for several years.

An unexpected bonus was that my wife and I became personal friends of one of my first private patients and her husband.

*Approximate equivalent values in 2011 calculated using the calculator available at http://www.thisismoney.co.uk/historic-inflation-calculator

Dr David Rowlands,
Retired consultant anaesthetist

PC OR MAC?

It seems impossible not to notice the recent flux of articles concerning Apple computers (PC or Mac or ?[1]), phones or music players (ipod touch [2]) and applications (iNAP3 [3]) that have graced the pages in anaesthesia, anaesthesia news and the Royal College website!

The article by Dr Madden [1] although attempting to provide a balanced review of PCs and Mac’s has finally provoked submission of this letter. Discussions and arguments regarding the pros and cons of a Mac, PC or vice-versa have been going on for decades and a quick internet search will certainly provide more fuel for the fire. In the past Apple had their own processors for their Macs but they now use Intel processors so are essentially PCs running the Apple operating system (OS) as opposed to Windows.

It is argued that the Mac OS is more stable than a PC running windows but remember Apple control the hardware and hence have a narrow range to cater for operating system-wise in comparison to the diversity in hardware of a PC. Usually, this should not be a problem if you intend to add or remove hardware as there will be accompanying driver software supplied or available with the OS. The flexibility in being able to change hardware in PCs such as graphics and sound cards was perhaps more useful in the days gone by as many PC manufacturers now use onboard hardware to cut costs with external USB options being viable alternatives.

The cost of a computer has decreased dramatically over the years with portable computing in the form of laptops, netbooks and tablets (which I remember first presenting in the late 1990’s) being comparable to desktops and smartphones! With the latter capable of running versions of office and logbook whilst allowing one to “surf” the internet, email, play music and video conference amongst other things!

Software allows one to interface with the hardware and there are numerous options available particularly more so for Linux and windows OS which includes free (public domain or open source) software or applications (or apps as they are called now!)

Security is an issue whether using Windows, Apple or Linux operating systems although one should point out that software fireworks and antivirus software comes preinstalled with windows or can be freely downloaded from well established websites such as Tucows [4] and Snapfiles [5]. Hardware fireworks to protect from unauthorised access to the computer may be provided through a router through which one connects to the internet.

Regarding viruses, malware and the like, PCs are considered “notoriously susceptible to attack” although it could be argued that this is simply because there are more people using PCs globally!

There have been reports of malicious Trojan software being installed onto a Mac without permission and with increasing popularity of this OS it is inevitable more will develop [6].

So, Mac or PC? Think about cost, the hardware specification, ease of use and familiarity..! Not just because it looks pretty, everyone seems to have one and it has a picture of a fruit on it!

Yat Wah Li, Specialty Registrar Anaesthesia, Walsall Manor Hospital, Stoke-on-trent School of Anaesthesia

Competing interests: The author is an owner of a succession of PC’s and MP3 players (before ipods and podcasts!), Psion SMX; Palm PDA; and Symbian based phones; currently using a desktop PC, netbook and kindle! The author has however used an iegg!

References:
1. Madden AP. PC or Mac or ? Anaesthesia News 2011;286(May):25-26
4. www.tucows.com
5. www.snapfiles.com
Dear Editor

KEEP OUT OF SIGHT AND REACH OF CHILDREN

It is well known that Whitechapel has been home to some of the more ‘colourful’ members of society – Jack the Ripper and the Kray twins are amongst its famous alumni. Yet if the Pharmacy department at the Royal London Hospital are to be believed the East End harbours more sinister and desperate criminals than these. Hiding under the seemingly innocent title ‘children’ these individuals are clearly not to be trusted and any preparation containing morphine would provide too great a temptation for the little hooligans. After all a controlled drug that is kept under lock and key and signed out by two separate individuals would surely only add to its allure.

Thomas Gough (SpR 5) and Annie Hunningher (Locum consultant)
Barts and the London NHS Trust

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontypidd) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Brian Steer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005, Dr Martin Coates (Plymouth) in 2006, Dr Gareth Charlton (Southampton) in 2007, Dr Neville Robinson (London) in 2008, Dr Fred Roberts (Exeter) in 2009 and Dr Sudheer Medakkar (Torquay) in 2010.

Nominations are now invited for the award to be presented at WSM London in January 2012 and may be made by any member of the Association to any practising anaesthetist (and those who have retired in the last two years) who is also a member of the Association.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at honsecretary@aagbi.org by 5pm on Friday 16th September 2011.

The AAGBI wants to encourage as many members, especially trainees and career grade anaesthetists, to submit abstracts for oral and poster presentation at the major meetings of the organisation, the GAT Annual Scientific Meeting, the Annual Congress and the Winter Scientific Meeting (WSMLondon).

For the first time, there will be a poster competition at the WSMLondon, in January 2012. As usual, there will be an assessment process, which will be carried out mainly by Council members. There will be different categories so that audit, surveys, case reports and original research can be tackled separately.

At the WSM, prizes will be on offer for the “best in class”; there will also be a reception for all trainee poster presenters, at which they will have the opportunity to meet Council members and some of the editors of Anaesthesia.

All WSM 2012 abstracts accepted for oral or poster presentation will be published online as an Anaesthesia supplement and the best will also make it into print.

For further information, please contact: secretariat@aagbi.org
Join the AAGBI for our Annual Congress 2011. This year’s Annual Congress has a full scientific programme, multiple streams of didactic lectures, practical workshops as well as the industry exhibition and annual dinner and dance.

Programme highlights include:

- The John Snow Lecture with Allyson Pollock, Professor of International Health Policy at the University of Edinburgh
- Launch of the new AAGBI Hip Guideline
- Anaesthesia Heavyweights sessions with Dr Mike Grocott, Professor Monty Mythen and Dr Andy Tomlinson
- Helicopter medics session
- Sports medicine for the 2012 Olympics
- Simpson memorial Lecture with Professor Rob Sneyd
- World Anaesthesia Society session
- Medico-legal session