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A YEAR IN REVIEW
2011-2012

Assistance for the anaesthetist

GAT committee elections

History Quiz
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 service 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 clinicians and nurses involved with the placement and competes 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 Critical Care**
This one-day course is aimed at critical care physicians and surgeons. The programme is suitable for those who already have some basic ultrasound experience as well as those who are new to the clinical applications of focused ultrasound at the patient bedside. The course is suitable for consultant and middle grade clinicians across the spectrum of specialties (Emergency Medicine, Acute Medicine, Surgery, Paediatrics and Intensive Care Medicine for children or adults).

**Programme**
- **Day 1**
  - Ultrasound appearance of the nerves
  - Nerve characteristics and set-up
  - Imaging and needle techniques
  - Complications to the brachial plexus / upper / lower limb
  - Workshops: using phantoms / models / cadaveric prosections (A)
- **Day 2**
  - Consent / training and image storage
  - Upper / lower limb techniques
  - Abdominal / thoracic techniques
  - Cervical block / aner / epidural / pain procedures
  - Workshops: using phantoms / models / cadaveric prosections (A)
  - (A) - Anatomy based courses / with cadaveric prosections

**Cost:** £275 (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 need further information please contact:

Deep Banks, 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

**All courses qualify for CPD Accreditation.**

Venue: SonoSite Education Centre - Hitchin

For full details of other training and education courses, dates and to register go to:

[www.sonoeducation.co.uk](http://www.sonoeducation.co.uk)

**ULTRASOUND GUIDED REGIONAL ANAESTHESIA - BEYOND INTRODUCTORY**

These courses are organised by Regional Anaesthesia UK (RA-UK) in conjunction with SonoSite Ltd for training in ultrasound guided regional anaesthetic techniques. Previous experience in regional anaesthesia is essential.

**2013 Course Dates:**
- April: 4 – 5, 12 – 13, 19 – 20, 26 – 27
- September: 23 – 24
- December: 5 – 6

All courses qualify for CPE accreditation.

Venue: SonoSite Education Centre – Hitchin

For further information and to register go to:

[www.sonoeducation.co.uk](http://www.sonoeducation.co.uk)

**The shape of things to come**

I make no particular apology for returning so soon after announcing my departure as editor – this time I am only appearing as a guest editor. Truly, I have no idea if Vice President one of the things I shall be hoping to do is to support the GAT committee during what seem likely to be challenging times. That ‘shape of training’ magazine follows close on the heels of the ‘shape of the workforce’ report. We carried several articles about the latter in September’s edition of Anaesthesia News. Pete Nightingale, Immediate Past President of the RCSA, is a member of the Shape of Training review, and he has agreed to update readers soon. The review is still at an early stage, and is expected to report by next summer. The GMC explains the background and themes for the review as follows:

In 2011, Medical Education England (MIEE) identified issues facing the future of postgraduate medical training (Phase 1). A steering group scouted out key themes against the structure of shape of postgraduate medical education and training.

These included looking at:
- the tensions between the needs of the service and the demands of training;
- the balance between generalist and specialist care;
- flexibility and value for money; and
- the need for innovation set against the risks of de-stabilisation if present arrangements were changed.

I may be developing a certain paranoia, and I totally accept that our jobs are primarily about providing a service to the public rather than providing us with employment, but I do not find these stated themes particularly reassuring. I urge you to visit the ‘Shape of training’ website to and either make your thoughts known to the review directly or to let your Linman have them, so that we can collate members’ views and feed them into the process. GAT will be seeking members views directly and making trainees’ views known to the review.

The ‘GASP’ Anaesthesia Sprint Audit of Practice is in the final planning stages, with a pilot currently in progress in some hospitals. The audit is being conducted by the AAGBI, the Hip Fracture Peri-operative Network and the National Hip Fracture Database (NHFD). Each patient will have a paper data collection form; data will then be entered onto the NHFD.

Anaesthetists, of all grades, can ensure that this audit is a success - we have them, so that we can collate members’ views and feed them into the process. GAT will be seeking members views directly and making trainees’ views known to the review.

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The Association of Anaesthetists of Great Britain and Ireland, founded in 1932, published its first recommendation on assistance for the anaesthetist in 1988. Since then the pace of change has quickened somewhat with The Anaesthesia Team being published in 1998. This document elaborated on the original recommendations and developed the concept of expanding the role of the nurse and Operating Department Practitioner (ODP) in a team approach to peri-operative care.

By the time of the 2005 review, such trained assistance was considered “essential for safe and effective provision of an anaesthetic service”. Introduction of nationally recognised qualifications (English National Board Qualifications (ENB), Diploma in Higher Education in Operating Department Practice, NVQ and SVQ level 3 courses) made significant inroads to ensuring a trained assistance workforce. Health and Care Professions Council regulation in 2004 delivered, for the first time, a standard of training and practice for ODPs across the UK.

With the abolition of the ENB qualification, Universities have undertaken to deliver replacement courses offering the necessary additional training of registered nurses; no standard competences exist. The AAGBI stated in the 2010 review that they would “like to see the development of nationally recognised competences for nurses assisting the anaesthetist”. Commissioned by the Scottish Executive Health Department, NHS Education for Scotland produced the Core Competencies for Anaesthetic Assistants in 2006. These were updated in 2011.

It is the opinion of the AAGBI that the competency training programmes detailed in the supplementary statement on assistance for the anaesthetist provide the standard of training necessary for the delivery of safe, effective, patient centred care. For ODP training the training package is clear. For nurses, any course undertaken should include all the competences outlined in the NES portfolio.

1. The Anaesthesia Team
2. The Anaesthesia Team (3) available at: http://www.aagbi.org/sites/default/files/anaesthesia_team_2010_0.pdf

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The connection that I made in my mind between the checklist and Revalidation is that the basis of these processes is not something new or – in all honesty – something very different or challenging. It is simply something that many – and probably most – of us have already been doing for some time. Revalidation should be a framework on which to hang the good clinical practice that we have been engaged in for many years. It is sad that it has had an excurisically lengthy build-up during which its introduction has been overcomplicated by the publication of far too many pamphlets, recommendations, guidance documents, matrices, CPD accreditation systems, online portfolios and other paraphernalia that seem to seek to obfuscate what should be a simple process. The AAGBI has issued a statement on CPD in the context of Revalidation that makes clear our approach to this issue: we will provide you with educational material that will allow you to revalidate as simply as possible, we will give you an easy way of recording this and other relevant information, we will respond to our members’ educational needs, we will not create complex and unnecessary regulatory and recording systems, and we will support you in translating the good practice that you have been practicing for many years into the language of Revalidation.

If you have any questions about the AAGBI and Revalidation, please email CPD@aagbi.org

Dr William Harrop-Griffiths, President
Here are some of the highlights from a very successful and eventful year at the AAGBI.

In September 2011 the AAGBI undertook a membership survey which attracted a high response rate of 25%. It was valuable in understanding the needs, views and opinions of our members and will guide future developments of the AAGBI’s membership services.

It was encouraging that 85% of respondents rated their experience of interacting with AAGBI as good or excellent and 91% said their subscription was good value for money.

COUNCIL

At the Annual Members’ Meeting in Edinburgh in September 2011, three newly elected council members took up their post:

- Dr Kathleen Ferguson (Consultant Anaesthetist, Aberdeen Royal Infirmary)
- Dr Nancy Redfern (Consultant Anaesthetist, Newcastle upon Tyne Foundation Trust)
- Dr Thomas Woodcock (Consultant Anaesthetist, Southampton University Hospitals NHS Trust).

The GAT Committee welcomed six new elected members who took up their posts after the GAT Annual General Meeting in Leeds in June 2011:

- Dr Annemarie Docherty (Borders General Hospital, Edinburgh)
- Dr Sarah Gibb (Royal Victoria Infirmary, Newcastle upon Tyne)
- Dr Ulika Parakkar (University Hospital of Lewisham, London)
- Dr Kian Tippur (Western Infirmary, Glasgow)
- Dr Caroline Wilson (Wexham Park Hospital, Slough)
- Dr Samantha Wilson (University College London Hospitals)

STRENGTH BY ASSOCIATION

The Association is committed to delivering value to its members at all stages in their professional career. Although the economic environment has been challenging, it has been very encouraging to see high retention levels throughout the year and our community of members grow. As of March 2012 we had 10,601 members.

SPECIALIST SOCIETIES

The AAGBI staff provide secretariat and event services for 20 specialist societies. In the past year the team took on two new societies, the Society for Anaesthetists in Radiology and the Scottish Intensive Care Society, and introduced electronic election facilities as an added benefit for specialist societies.

21 PORTLAND PLACE

21 Portland Place is the London home of the AAGBI and the base for 26 AAGBI staff who work in specialist teams providing events and membership services; marketing, communications, secretariat and finance support.

The grade II listed building offers a range of meeting rooms, which were used during the year for 739 internal meetings, 261 external meetings (for 44 different clients), 45 specialist society meetings and 48 seminars. Office space is also provided for the World Federation of Societies of Anaesthesiologists (WFSA) and Lifebox, the new charity of which AAGBI is a founder member.

ENVIRONMENT

The AAGBI is committed to providing services in a way that ensures a safe and healthy workplace and minimises the potential impact on the environment. Our environmental policy outlines how we plan to do this, for example using more energy efficient lighting and encouraging recycling wherever possible.

In the last year we recycled a total of 8,780kg of paper, making a CO2 saving of 12,270kg – that’s equivalent to 122 trees saved!

Membership Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Ordinary</td>
<td>56%</td>
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<tr>
<td>Overseas</td>
<td>10%</td>
</tr>
<tr>
<td>Retired</td>
<td>4%</td>
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<tr>
<td>Honorary/Associate</td>
<td>1%</td>
</tr>
</tbody>
</table>

Total members 10,601

“Big up for AAGBI - the one annual sub I have no regrets in paying!”

AAGBI Consultant Member (Feedback from the 2011 membership survey)

Join us on Facebook and Twitter

This year we connected with anaesthetists, industry and the public on social networking sites Facebook and Twitter.

@AAGBI
AAGBI1
**SAFETY MATTERS**

One of the AAGBI’s principal activities is the advancement of patient care and safety in the field of anaesthesia. Over the last year the AAGBI’s Safety and Standards Committees have worked with like-minded organisations, industry and government to advise and act on safety matters that affect anaesthetists and their patients.

**Neuraxial connectors – position statement**

In August 2011 the AAGBI, RCoA, OAA, Regional Anaesthesia UK and the RCoA Patient Liaison Group issued a joint statement to support clinicians in the NHS in the process of introducing new neuraxial connectors for spinal needles and other applications.

**The use of capnography outside the operating room**

The AAGBI issued a statement to reflect the findings of NAP4 and guidance from the International Liaison Committee on Resuscitation. New advice relates to the use of capnography for patients in the ICU and emergency department, those undergoing moderate and deep sedation and those undergoing cardiopulmonary resuscitation.

**AAGBI and the Safe Anaesthesia Liaison Group (SALG)**

The AAGBI works with the SALG to promote learning from incident reporting. SALG launched the ‘Stop Before You Block’ campaign to reduce the incidence of wrong site blocks.

SALG continues to publish regular Patient Safety Updates to highlight safety incidents reported to the NRLS database.

**National Audit Project 5**

AAGBI together with the Royal College of Anaesthetists, launched in June 2012, the NAP5 which will examine Accidental Awareness during General Anaesthesia (AAGA). Professor Jaideep Pandit was appointed as the Joint Clinical Lead for NAP5 and is working closely alongside Dr Tim Cook, College Advisor for National Audit Projects (NAPs). Co-funded by the AAGBI, it has the potential to be the largest study of AAGA ever conducted.

**SUPPORTING COLLEAGUES OVERSEAS**

The challenges facing anaesthetists in many low-income countries include a critical shortage of trained providers, poor facilities and a lack of essential drugs, equipment and supplies. The AAGBI Foundation’s international programme has continued to develop during the year providing funding for projects and travel grants for anaesthetists from this country to gain experience working in low resource countries.

A major ongoing project is the SAFE obstetric anaesthesia training course which was written by members of the International Relations Committee. This has been funded by the British Council and the Tropical Health Education Trust and has been piloted with around 130 anaesthesia providers in Uganda. Further SAFE courses are planned in Liberia, Ghana, Zambia, Uganda, Rwanda and Bangladesh over the coming year.

The Overseas Anaesthesia Fund (OAF) enables individuals and organisations to donate directly to AAGBI programmes that support training and promote safer anaesthesia in developing countries.

We would like to thank all our donors who have helped raise £47,495. With your help we have been able to:

- Distribute 2,251 books to 17 countries.
- Provide over £31,000 to support 19 trainee anaesthetists in Uganda. Over the life of the project we have been able to fund 29 anaesthesia training posts and 9 MMed graduates.

**Lifebox**

AAGBI is proud to be a founder member of the international charity, Lifebox. Lifebox is a not-for-profit organisation saving lives by improving the safety and quality of surgical care in low-resource countries by ensuring that every operating room in the world has a pulse oximeter.

“**These young men and women are the new face of anaesthesia in Uganda. The more we can improve our numbers, the more we can develop our speciality. We are noticing better outcomes all the time**”

Dr Stephen Ttendo, Head of Department at Mbarara University Hospital, Uganda
The AAGBI is committed to providing opportunities for anaesthesia professionals to keep up to date with their professional development and continues to develop new resources for its members. In the last year we have made significant steps in the direction of online and e-education services.

Conferences and seminars

In the past year the AAGBI has run 73 educational events including 56 one day seminars, 14 regional Core Topic events and four major conferences. We have seen over 4718 delegates come through our doors.

Our Annual Congress in Edinburgh was the largest attended meeting since WSM London in 2007 with over 780 delegates; a 37% increase from the previous year.

In January this year, we launched our events app for iPhone, Blackberry and Android. The app, which will now be available at all major meetings, allows you to plan your personal itinerary, tag your favourite speakers and exhibitors, and follow the event on Facebook and Twitter. Over 81% of delegates downloaded the app.

In March 2012, the AAGBI released Core Topics in Anaesthesia 2012 co-produced with publisher Wiley-Blackwell with input from 20 expert contributors and edited by Dr William Harrop-Griffiths, Dr Ian Johnston and Dr Leslie Gemmell, members of the AAGBI Council.

AAGBI Publications

Anaesthesia
Anaesthesia is the official journal of the AAGBI, published by Wiley Blackwell. It is international in scope and comprehensive in coverage. The journal has a very high impact factor of 2.958 demonstrating the relevance of articles to the anaesthesia community. 78% of members say the journal Anaesthesia is what attracted them to join the AAGBI.

Guidelines
88% of members rated our Guidelines (also known as Glossies) as the most important part of their membership subscription package. Our Guidelines cover a wide range of clinical and non-clinical issues. In the last year we have produced four Guidelines including:
- Ultrasound in Anaesthesia and Intensive Care
- Day Case and Short Stay Surgery 2
- SAS Handbook
- Malignant Hyperthermia

Guidelines are available for download from the website and there is now a limited print run and hard copy distribution to reduce the environmental impact.

Heritage Centre

The AAGBI Heritage Centre has seen a 21% increase in visitor levels from the previous year with The Daily Telegraph calling it one of London’s 50 best alternative and quirky museums: “Its collection of anaesthesia-related objects chart an impressive evolution in medical development and should be of interest to anyone in the medical field.”

Since 2010 the Heritage Centre has been recording interviews with anaesthetists that have made a significant contribution to the specialty and this year the project has continued. Now a number of oral history podcasts are available to listen to from the AAGBI website including:
- Dr James Limb on his new drip set for patients
- Dr Richard Shefford, Consultant Anaesthetist at the Royal Orthopaedic Hospital NHS Foundation Trust.

Research opportunities

The AAGBI Foundation is one of the UK’s largest single grant providers for anaesthetic research. The AAGBI’s latest research strategy is to prioritise supporting the following key areas:
- Patient safety
- Innovation
- Clinical outcomes
- Education and training
- Related professional issues (e.g. standards and guidelines, working conditions, medicolegal issues, etc)

In the past year we allocated £167,000 for research funding through the National Institute for Academic Anaesthesia (NIAA)

Getting new ideas realised

Promoting innovation

At WSM London 2012 two anaesthetists, Dr James Limb and Dr Graeme McLeod were presented with the inaugural Prize for Innovation in Anaesthesia and Critical Care. The winners were chosen from over 20 applicants by a panel of experts including Monty Mythen, Kevin Fong and Bernard Liban and won up to £20,000 to further their product.
Office of Fair Trading (OFT) investigation into the private healthcare market

In the last year the AAGBI has been in dialogue with the OFT on their market study into private healthcare. In June 2011 the AAGBI surveyed its members and the outcome formed the basis of a formal response to the OFT. In December 2011 the AAGBI welcomed the decision to refer the OFT to the Competition Commission. However, the AAGBI did not accept the OFT’s criticism of Anaesthetic Groups (AGs) and continues to advocate the advantages of AGs in promoting patient safety. During the current Competition Commission investigation, the Association expects to play an active part in contributing information and views on behalf of the profession.

A VOICE FOR THE PROFESSION

As a professional association, the AAGBI is constantly active in representing the interests of anaesthetists and acting as a voice for the profession.

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Health and Social Care Bill

The AAGBI surveyed its members’ opinions and responded to the Health and Social Care Bill during its passage through parliament to becoming the Act in March 2012. In its position statement the AAGBI opposed any change that might threaten the fundamental principle that NHS care should be provided to all, free at the point of care, on the basis of need.

Consultation on increase in pension contributions

In July 2011 the Department of Health (DoH) initiated a consultation on its proposed increases in pension contributions for 2012-2013. The AAGBI submitted a response on behalf of its members which outlined that 78% felt that anaesthetists had considerable concerns that the proposed pension changes would not be in their and other healthcare workers’ interests. The AAGBI endorsed and supported the BMA’s response and encouraged members to vote for or against industrial action if they felt strongly.

As a professional association, the AAGBI is constantly active in representing the interests of anaesthetists and acting as a voice for the profession.

We would like to say a huge thank you to all our members for their continued support!
It is always encouraging to find that anaesthetists can be so creative and this year in Bournemouth there was no exception. Slightly smaller than in previous years, the exhibition featured 52 interesting and varied pieces, ranging from pretty hand-made greeting cards through to quilts, bobbin lace, inspiring photographs, a jeweller made from fused glass and beads, precious metal clay and gold test, amethysts and freshwaters pearls. For the first time we exhibited digital paintings, Giclee prints and a performance video.

The AAGBI Art exhibition provides a welcome interlude for delegates seeking a peaceful break from the science between sessions and an opportunity to browse an accomplished selection of art, photography and craft. There is also an opportunity to buy selected prints and a performance video.

First prize - through popular vote - was awarded to James Nickells with a group print entitled ‘Island White Smoke’. James was kind enough to let us sell another interesting print entitled ‘Circle of Bob’.

Second and third prizes - went to a painting ‘Sunday Best’ by Rachael Collins and an etching by Alexander Fraser, son of Samantha Shinde. Rachael was recognized by an award (just enough to let us sell her stunning etching which was also awarded ‘Best Artwork in Show’.

‘Highly Commended’ - were awarded to Andrea Weigert’s collection of beaded and fused glass jewellery; to Samantha Shinde for her precious metal, amethyst and freshwater pearl necklaces and ring; and to Jean Breckonridge for her soap lace collar ‘Up and Away’. Ruth Spencer who, as usual, wowed us with her stunning photography was awarded ‘Best Photograph in Show’ for ‘Fisherman at Dawn’ - Konal tribe which was also sold. I was surprised and delighted to get so many votes for one of my quilts, ‘Stained Glass Windows’.

Dr David Zideman, a consultant anaesthetist with more than three decades of experience, was appointed to one of the most senior medical positions of the Olympics: Clinical Lead Emergency Medical Care for the 2012 London Games. Working with the London Organizing Committee of the Olympic and Paralympic Games (LOCOG), Dr Zideman was responsible for setting up the emergency care system for all athletes, officials, the Olympic and Paralympic families and spectators (estimated at over 200,000 per day in Olympic Park alone) at all Olympic and Paralympic venues. This involved being part of a team who recruited more than 4000 medical volunteers (2000 volunteers in the emergency medical teams) from all parts of the health service. ‘I planned an emergency medical service that included the recruitment of volunteers, the selection and provision of equipment, and undertook the training of all our volunteer staff,’ says Zideman. He had to match the professional skills of his team members to each individual sport, to ensure an effective and efficient service, for example, in the boxing arena compared with swimming at the Aquatics Centre. ‘It was all about having the best possible system for optimising pre-hospital care for anyone in an Olympic or Paralympic venue who became seriously ill or was injured,’ he adds.

During the Games Dr Zideman would visit up to four venues per day, and would participate and provide clinical support and advice to his volunteer teams. ‘Working for LOCOG at the Olympic and Paralympic Games was a unique experience that has been the pinnacle of my career and I am very proud to be a part of it. I was delighted to report that across the entire Olympic and Paralympic games, we did not have to perform a single general anaesthetic or emergency tracheal intubation.’

Dr Zideman adds that the comprehensive training system for volunteers was an essential element in the training. “The very simple scenarios thereby familiarising themselves with the venue and pieces of equipment they might not be familiar with. Most importantly it ensured that they got used to working as a team with other volunteers who might change on a daily basis.” He hopes that the lessons learnt from London 2012 will be carried forward to the Olympics in Sochi and Rio.

We raised nearly £1000 for the two charities, the AAGBI Overseas Anaesthesia Fund and Royal Medical Benevolent Fund, by sale of raffle tickets and art works kindly donated by exhibitors.

Dr Dickson and I would like to thank everyone who helped make the exhibition a success, Association Staff present at Congress, all our visitors to the stand, everyone who bought a raffle ticket, cards or art works and of course all our exhibitors without whom we would have had a purely academic sort of Lecturer at the exhibition but immensely rewarding, not only to us, but hopefully all those who contribute and enjoy the display.

And to all those (and there were many) with a variety of artistic ideas as to why they had not submitted (left it too late again, will definitely bring something next year, couldn’t get it on to contribute art and craft work. We would also like to provide an opportunity for digital download and display of photographs, video performance etc to those who have interesting, they have it on a USB stick (“if only I had the time to print and mount it”) if anyone has any other ideas they would like to share with us to help improve the exhibition, make it more accessible and bring it up to date, please feel free to get in touch, dianadickson@aol.com.

Stephanie Greenwell

Dr William Hamper-Griffiths, AAGBI President presents Dr David Zideman with his Honorary Membership Certificate
CPD STUDY DAY: PAEDIATRIC ANAESTHESIA

Date and venue: 13 February 2013
RCOA, London
Registration fees: £195 (£150 for registered trainees and affiliates)
Event organiser: Dr N Morton

- Care of the surgical neonate: lessons from NCEPOD 2012
- Useful sedation techniques outside the operating theatre
- A practical guide to TIVA in children
- Does awareness occur in children and should we measure depth of anaesthesia in children?
- A systematic approach to paediatric airway problems
- New devices for the normal and abnormal paediatric airway
- Pain management in children: what is the latest evidence?
- Improving pain at home after surgery in children

Prizes include:
- Oral Presentation Prize
- Case Presentation Prize
- Audit Prize
- Anaesthesia History Prize
- RSM Prize

To find out more visit www.gatasm.org/content/oral-poster-prizes
Closing date for all prizes: 14 January 2013

www.gatasm.org

GAT PRIZES AT OXFORD 2013

GAT Oral and Poster Prizes
Trainee anaesthetists are invited to submit an abstract for oral or poster presentation at the GAT ASM. The authors of the six highest-scoring abstracts in the preliminary review will be invited to present their work orally and will be eligible for Dräger Oral Presentation Prize. A cash prize will be awarded to the winner.

The remaining successful authors will be invited to present a poster. Entries will be allocated into one of the following three categories depending on the grade of the presenting author: Foundation Year Trainees, ACCS/Core Trainees, ST3+ Doctors. A cash prize and a certificate will be awarded to the winner in each category. The judges also reserve the right to award discretionary certificates.

Case Presentation Prize
Trainees are asked to submit an abstract of an interesting case that they have been involved in, and which has learning points that may aid other anaesthetists in their management of similar cases. The three best submissions as judged in the preliminary review will be invited to present their work orally at the ASM and the audience will also be eligible for the Dräger Audit Prize. A cash prize and a certificate will be awarded to the winner in each category. The judges also reserve the right to award discretionary certificates.

New for 2013
Medical Students poster prize: Medical students are invited to submit an abstract for poster presentation on a theme related to Anaesthesia/Pain/TU. A cash prize will be awarded to the winner.

RSM Prize, supported by the RSM Section of Anaesthesia
Further details will be available online shortly.

All awards, whether shortlisted for oral or poster presentation, will also be eligible for the Dräger Audit Prize. Audits should demonstrate good understanding of the principles of clinical governance and evidence of completion of the audit cycle.

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

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

CLOSING DATE FOR ALL PRIZES: MONDAY 14TH JANUARY 2013

Full details can be found on the GAT website www.gatasm.org/content/oral-poster-prizes
If you have any additional queries, please contact the AAGBI Secretariat on 020 7631 8807/8812 or secretariat@aagbi.org

References

As an anaesthetist who performs occasional spinal and epidural anaesthesia or analgesia, the case reported by Kilfen et al makes for extremely humbling reading. I am fortunate to work in a department where the topic of which antiseptic and which concentration to use for neuraxial anaesthesia has been debated for some time, so the issue is prominently on my ‘radar’ despite the fact that the technique is not a daily undertaking for me. For those who have to work in greater isolation, the eloquent editorial by David Bogod reviews the issues and highlights just how meticulous we must be. When learning spinal and epidural injection techniques, it is too easy for the novice to focus predominantly on the processes of identifying landmarks, needle insertion and the ‘feel’ of the procedure. Yet, as these reports of arachnoiditis highlight, the most devastating risks may actually arise during preparation for the procedure. As Kilfen et al and Bogod clearly state, these risks must be carefully considered and communicated during the consent process. Moreover, we have an absolute duty to continue to question how such incidents arise and how they can be reduced.

On a slightly less down-to-earth topic, McMahon and colleagues compared the precision and accuracy of non-invasive versus invasive blood pressure measurement in the challenging environment of aeromedical transfers. This topic has been hotly debated for many years, with arterial blood pressure measurement frequently being favoured on the grounds of ‘greater accuracy’ and reduced energy consumption (and therefore battery drainage). The latter is becoming less of an issue given the increasing use of inverters and alternative power sources during long transfers, which preclude the need for equipment to function purely on in-built battery power. It would appear from the results of this study that the assumption of accuracy may also need to be reconsidered, and that non-invasive blood pressure measurement may indeed be a safe and suitable alternative to invasive arterial pressure monitoring during patient transfers.

Jonathan Handy, Editor, Anaesthesia

WED 03 - FRI 05 APRIL 2013

Attending GAT ASM not only covers your curriculum needs, as all lectures and workshops are coded to the curriculum, but gives you the opportunity to boost your CV by submitting an abstract for poster or oral presentation.

www.gatasm.org

Dräger Oral

On a slightly less down-to-earth topic, McMahon and colleagues compared the precision and accuracy of non-invasive versus invasive blood pressure measurement in the challenging environment of aeromedical transfers. This topic has been hotly debated for many years, with arterial blood pressure measurement frequently being favoured on the grounds of ‘greater accuracy’ and reduced energy consumption (and therefore battery drainage). The latter is becoming less of an issue given the increasing use of inverters and alternative power sources during long transfers, which preclude the need for equipment to function purely on in-built battery power. It would appear from the results of this study that the assumption of accuracy may also need to be reconsidered, and that non-invasive blood pressure measurement may indeed be a safe and suitable alternative to invasive arterial pressure monitoring during patient transfers.

Jonathan Handy, Editor, Anaesthesia

References
What were our three biggest achievements in the last year?

1. This year’s temporary, travelling exhibition has been very successful and popular; the theme was on the misuse of our powerful anaesthetic agents – A Blessing in Disguise – Misuse of Anaesthesia.

2. The Oral History project continues to gather historical data in the form of interviews of the great and good of anaesthesia. The latest additions to the oral histories are Dr David Zuck, Professor Stanley Feldman and Dr Maldwyn Morgan.

3. Over the last year, the AAGBI Foundation gave places to three Heritage Interns. The interns are volunteers who work with the Heritage Centre manager Trish Willis, in return for this the additional support they receive training and mentorship to help build their CVs.

What current challenges are we facing?

1. The Anaesthesia Museum was awarded Accreditation in 2008 by the Museums, Libraries and Archives Council (MLA). Accreditation Return for the successor body to MLA, Arts Council England. Accreditation is the standard by which museums are measured. Being an accredited establishment is beneficial if bidding for heritage lottery funding and is often a condition of loans from other museums.

2. The ‘year in the life’ oral history pilot project has been started which attempts to capture data on current trainees going through current training programmes; further review of this project is needed to decide how to keep capturing this data over the ensuing years.

What are our priorities for the coming year?

1. To create the new temporary/travelling history exhibition.

2. Maintain the intern programme.

3. To catalogue the acquisitions.

I have chaired the Museum, Library and Archives Committee over the last two years. The Committee meets twice a year and is responsible for supervising the AAGBI’s extensive collection of historical equipment, books and memorabilia and also maintaining the Association’s archives. The Anaesthesia Museum grew out of A. Charles King’s private collection of historic anaesthetic apparatus, which he donated to the Association of Anaesthetists of Great Britain and Ireland in 1953. The collection has since grown to include around 4,000 artefacts which span the entire history of the profession; the earliest object in the collection is a resuscitation set from circa 1774.
A Day in the Life of a Heritage Intern

I’m a recent history graduate and for much of my degree I chose to focus on the history of medicine and so it was little surprise that the history which I feel holds relevance for almost everyone. It is perhaps hard for us to relate to the signing of the Magna Carta but we all will, at some point in our lives, require medicine or the help of a doctor. I’m hoping to work in the world of heritage and museums so when I spotted that the AAGBI was offering a Heritage Internship I jumped at the chance to apply. It offered the perfect opportunity to experience the day-to-day running of a heritage centre and in an area I find truly fascinating.

During my internship I have been able to experience things that are so often inaccessible in a museum. Even on my first day I was given the keys to unlock the glass cabinets. I was able reach inside to feel the weight of a glass syringe and smell the bright orange rubber cover of a keys to unlock the glass cabinets. I was able reach inside to feel the weight of a glass syringe and smell the bright orange rubber cover of a sphygmomanometer (I still can’t). She even managed not to laugh at my face as I stared at the Clausen trumpet and its short confines. I was able to handle objects and records of worth, something I doubt I would have had the chance to be part of such a close-knit association, and I hope helping hand once I graduate from university. I have felt lucky to have work alongside and so helpful, teaching me skills that will give me a possible career path after graduation.

As part of an oral history project I was lucky enough to listen in on a set of recordings being taken. The first was a past President’s recount of his life’s work in anaesthesia. Almost 50 years to the day that he began practising! It was a great opportunity to hear his stories of using the drugs and equipment that I had been cataloguing in the museum, some of which are no longer in use or are almost entirely unrecognisable now.

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The same day we recorded the thoughts of a current tramee Anaesthetist. The two accounts of course differed greatly but what struck me most was hearing the first recording as a collection of memories, already long in the past and the contrast of listening to current, present day feelings. Capturing both is not only interesting but so important to building a well rounded and ongoing history of anaesthesia.

As the Annual Congress was approaching I helped Trish with the preparation to transport a temporary exhibition to Bournemouth. Along with an extensive inventory, even more so to be able to individually store equipment in acid free paper to avoid decay. As we were unable to take controlled drugs out of the museum, we took photographs to contribute to the exhibition instead. So much thought and planning goes into the whole process to ensure that every item is safely transported and accounted for. It was a far greater task than I had imagined!

No one day of my internship has been the same. Each day I have learnt new and interesting things about both the history of anaesthesia and the work that goes into running the Heritage Centre. Next on my itinerary is a trip to Highbury Cemetery to check out the condition of John Snow’s grave! I really appreciate the time and effort Trish has invested in me and the whole experience has exceeded my expectations. I am now extending my internship as there is still so much I would like to learn about heritage management and I have enjoyed my time so much at the Association.

Henniotts Griffiths

As a history student, the internship really appealed to me and offered me something new which met the skills and tasks I was to acquire the new objects into the museum. We had been donated a collection of objects and among them were three medals awarded to Dr Russell Davies for his work in Yugoslavia. When recording the descriptions of the medals I was intrigued as to what Dr Davies had achieved and why this was relevant to the Anaesthesia Heritage Centre.

As Dr Davies was not a well-known name in the museum I decided to undertake some research and discovered a 1974 copy of Anaesthesia where the presentation of one of the medals was recorded – the ‘Dr Russell Davies Medal’. The Anaesthesia copy also included a piece on Dr Ivo Bettini and his work as an Anaesthetist in Zadar, Yugoslavia 1947 with his anaesthesia tests on animals and humans. I went on to discover a 2008 copy of Anaesthesia News which contained a piece on Dr Russell Davies and included a picture of him holding one of the medals I had before me. Further research and contacting the donor of the medals, told me that Dr Davies had gone to Yugoslavia in 1947 to help and to teach Doctors anaesthetic practices so they could provide plastic surgery to Yugoslavians injured in World War II, and one of these medals of his remains in the museum today.

As a history student this task was what I most enjoyed and I was fascinated that these medals which were just museum objects had so much history behind them. Researching the history behind an object that at first sight looked like a simple medal was fascinating. Behind the object you discover the micro history of individuals such as Dr Russell Davies and his work as an anaesthetist.

Working as an intern at the Anaesthesia Heritage Centre has allowed me to gain a more profound understanding of the history of anaesthesia and the work of anaesthetists. I have been able to view the importance of the role the Heritage Centre undertakes for visitors, researchers, students and the public. I helped an anaesthetist who was writing a book browse the images we have saved so that he might use some of them for his book. I have also supervised a researcher who is an aspiring anaesthetist in our archives as well as shown visitors around the museum. These roles emphasised to me the importance of the heritage centre as a resource for visitors and anaesthetists.

Overall, I thoroughly enjoyed myself as an intern at the Anaesthesia Heritage Centre and felt that I learned valuable skills as well as more about the role and operation of the museum. My interest in public history and museums has been furthered and assisted my aspirations of pursuing a career in this area.

Alice Elliott

Photographing discs of Cocaine was the last thing I was expecting as I found my way to Portland Place on a grey Monday morning. It was straight down to business - or rather - the basement, where Henrietta and I were to photograph a syringe of Morphine, bottles of Sublimare and other so-called ‘poisons’ for Congress. It was, for the beginner, a fascinating experience and the test of the Pain Relief: its uses, and more, often, than not, abuses. I learnt something of the sordid past of Anaesthesia.

As Congress loomed closer and closer, the frames refused to play the photographs in the set order, and so what should have been a simple task reduced both Henrietta and I, and even Trish, to tears. The frames started behaving only a couple of days before Congress, much to our relief, where I was lucky enough to spend a day helping set up the Heritage stand.

One day I was working in the Museum when I stumbled across the work of Edgar Alexander Pask. At first, I simply could not understand what photographs of a man drowning, or so it looked, were doing there. Thankfully, a builder working nearby helped me out. Pask, together with Robert Macintosh, sought to devise flotation jackets for pilots during the Second World War, who were dropped from altitudes of up to 35,000 feet into icy cold waters. So, in retrospect, I must have been looking at the least successful experiments! Having always held a secret interest in military history - a result, I think, of being dragged to the RAF museum at least monthly when I was little - Pask’s work caught my eye. The prints themselves are transtig. They show Pask unconscious, in an assortment of life jackets, suspended at various angles in a swimming pool. Some are attached to typed notes recording the outcome of the experiment, such as ‘Ministry of War Transport ‘Victory’ Lifebelt (self-righting complete, although head can fall over sideways)’. I felt privileged to have handled original prints of what had proved to be vital to the war effort. That was, I think, one of the best things about working in the Heritage Centre - you are trusted, even as a lowly intern to handle objects and records of worth, something I doubt I would have been allowed to do in other museums.

I came to the Association in want of something to do, and a broad interest in history. I left with invaluable experience - not only of working in museum, but also of public communications, as I spent a couple of my most enjoyable days on reception. John and Guto were lovely to work alongside and so helpful teaching me skills that will give me a helping hand once I graduate from university. I have felt lucky to have had the chance to be part of such a close-knit association, and I hope I have been able to give back at least some of the time and effort they have invested in me.

Katherine Richardson

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Katherine Richardson
The Group of Anaesthetists in Training (GAT) Committee comprises elected trainees of all grades. It is the only democratically elected and independent body representing anaesthetic trainees at AAGBI committees, Royal College of Anaesthetists Trainee Committee and other national medical bodies. The GAT Committee also works on publications, seminars and the ever-popular Annual Scientific Meeting.

Nominations are now invited from trainee members of the Association wishing to stand for election. In 2013, there will be at least one seat available on the committee. Those standing for election will be expected to serve for a minimum of two years and be resident in the United Kingdom or Ireland. If elected, nominees agree to fulfill the duties and responsibilities required of them.

Further information and nomination forms are available from the AAGBI Secretariat on 020 7631 8812, gat@aagbi.org or can be downloaded from the AAGBI website www.aagbi.org

All forms should be submitted with the signatures of a proposer and seconder (who must both be trainee members of the Association) to: Dr Richard Paul, Honorary Secretary, GAT Committee
By post: 21 Portland Place, London, W1B 1PY
Email: gat@aagbi.org
or faxed to 020 7631 4302
Closing date - 17.00, Friday 11th January 2013

The Committee has 12 elected members, with an executive comprising Chair, Vice Chair and Honorary Secretary. We meet three times a year at the Association headquarters in Portland Place and also at the GAT Annual Scientific Meeting. The Chair and Honorary Secretary are full members of AAGBI Council; the Vice-Chair is co-opted. The GAT Committee members represent trainees on all AAGBI committees and working parties; they are also co-opted onto several external committees, including The Royal College of Anaesthetists Trainee Committee. As well as committee and working party roles, the GAT Committee has editorial control of a monthly section in Anaesthesia News and also organises seminars specifically for trainees. GAT maintains an international presence by representing UK and Ireland trainees at international meetings. As advocates for our specialty, we continue to work with all training organisations to ensure we retain the highest quality in both anaesthetic practice and training.

Unfortunately the GAT Committee does not currently have any elected members from Ireland, something we’d like to rectify. The GAT Committee has 12 elected members from the AAGBI website (www.aagbi.org). All forms should be submitted with the signatures of a proposer and seconder (who must both be trainee members of the AAGBI) to: Dr Richard Paul, Honorary Secretary, GAT Committee, 21 Portland Place, London, W1B 1PY by 020 7631 4302. The closing date is Friday 11th January 2013 at 17.00.

We look forward to receiving your nomination form.

Nicholas Love,
Chair, Group of Anaesthetists in Training

What to do next
In 2013, there will be at least one seat for election to the committee. Those standing for election will be expected to serve for a minimum of two years, with a maximum of four years. You need to be resident in the UK or Ireland for your term of office. It is hard work but very interesting. In addition to attending meetings of the GAT Committee, you will also be required to represent GAT on both AAGBI and external committees. If elected, nominees agree to fulfill the duties and responsibilities required of them. The term of office on the committee commences at the GAT Annual Scientific Meeting in April 2013.

Further information and nomination forms are available from the AAGBI Secretariat on 020 7631 8812, gat@aagbi.org or can be downloaded from the AAGBI website www.aagbi.org. All forms should be submitted with the signatures of a proposer and seconder (who must both be trainee members of the AAGBI) to: Dr Richard Paul, Honorary Secretary, GAT Committee, 21 Portland Place, London, W1B 1PY by email to gat@aagbi.org or faxed to 020 7631 4302. The closing date is Friday 11th January 2013 at 17.00.

We invite trainees to stand for election to the Group of Anaesthetists in Training Committee.

Through its mandate, the GAT Committee seeks to represent the interests of trainees in the UK and Ireland. It is the only democratically elected representative body for trainee anaesthetists of the AAGBI and has existed in some form for almost 50 years.

With more than 3000 members we represent 80% of trainee anaesthetists, who together form the largest single group of acute hospital specialty trainees within the NHS.

Educational Events Manager
Nicola Heard
Direct Line: +44 (0) 20 7631 1650
Flying the nest

For some time I’ve been thinking about perhaps dipping my toe in a career outside mainstream medicine, and I’m about to take the plunge. Truth be told, I’ve managed a limited amount of toe dipping along the way, so the intention is to fully immerse myself now I suppose, or at least try to get my hair wet. Yes, I'm going to be an actor - mwah mwah (air-kiss, air-kiss). Actually that's an overly bold statement given the limited control most actors have over their career, and it doesn’t accurately reflect my confidence or chances of success – perhaps drowning is the correct analogy?

I’m going to be an actor. It is, after all, the anaesthetic way to want a life outside medicine, or as cynics might see it, not to want to come to work very much. Physiotherapists have been less encouraging. One warned me that a year away was the absolute maximum, and might even be too much. I tried to explain my plans to one of the registrar whom friends keep meeting at weddings. He’s doing well (as a GP) – I would’ve told him my deepest secrets. In fact I’ve been very careful about whom I confide in, probably more chance you’ll see me back in the fold, a grumpy anaesthetist, than see dogs with navels”.

My reasons for embarking on a year in Malawi included the desire to experience a developing world healthcare system, and to improve my clinical experience prior to pursuing registrar training. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. My clinical experience prior to pursuing registrar training. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation. We arrived in Malawi to a tropical climate and the compact city of Blantyre. However, within hours of landing we discovered that the company my fiancé, a civil engineer, was to work for had gone into liquidation.
THE WYLIE MEDAL
UNDERGRADUATE ESSAY PRIZE 2013

The Wylie Medal is awarded to the most meritorious essay on an annually changing topic relating to anaesthesia or associated clinical practice written by an undergraduate medical student at a university in Great Britain or Ireland.

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

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

For further information on the 2013 round and to download the winning essays from 2011 and 2012 and an application form please visit our website:
www.aagbi.org/undergraduate-awards
or email secretariat@aagbi.org
or telephone 020 7631 8807
Closing date: 7 January 2013

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or email secretariat@aagbi.org
or telephone 020 7631 8807
Closing date: 7 January 2013

The 2012 topic was ‘anaesthesia and patient safety’ and the prize was awarded to Christopher Smith for his essay entitled, Patient safety in the peri-operative period: Is the implementation of an evidenced based checklist a sustainable method of improving patient-safety?

The topic for 2013 is ‘an elderly person who changed my views of anaesthesia’.

Chris was presented with £500 and the Wylie Medal at a lunch with AAGBI Council members at 21 Portland Place on 6 July. Chris’ winning essay can be viewed here www.aagbi.org/undergraduate-awards

Safer Surgery Week Webinars

If you missed any of the webinars from Safer Surgery Week on 24-30 September, (including Safer Practice in Surgery – a professional responsibility with AAGBI’s Immediate Past Honorary Secretary, Dr Andrew Hartle) you can watch them online.

View the webinars on the Patient Safety First website:
http://bit.ly/PuVwfc

Latest safety updates

View the latest safety updates and Medical Device Alerts on the AAGBI website
www.aagbi.org/safety/incidents-and-alerts

For breaking news and event information follow @AAGBI on Twitter

Lectures from Annual Congress on Video Platform - top tips on Revalidation!

Don’t forget to view lectures on the Video Platform from our recent Annual Congress in Bournemouth. Lectures include:
• Dr Paul Philip – Revalidation: The GMC’s View
• Dr Nancy Redfern – Revalidation made easy – the basics
• Dr Ian Wilson – BMA Job Planning/SPAs

www.aagbi.org/education

WSM London – Early bird closes on 17 December!

If you want to take advantage of the early booking rate for WSM London on 16-18 January 2013, you must book before the 17 December. Trainees will save 17% and ordinary members 10% on the normal subscription costs.

www.wsmlondon.org
1. Sir Robert Reynolds Macintosh (1897-1989) - Sir Robert Macintosh was born in New Zealand. His priorities for anaesthesia were incorporating basic sciences, formal clinical training and the encouragement of research. He was appointed Nuffield Professor of Anaesthetics in Oxford in 1937 at Lord Nuffield's insistence but against the University's wishes, for at that time anaesthetics lacked academic credentials. During the Second World War, Macintosh was adviser in anaesthetics to both the Royal Air Force and the Royal Navy. In the post-war period he was particularly interested in anaesthesia in developing countries and travelled extensively, demonstrating the principles of modern anaesthesia.

2. Bird Ventilator (Mark 8) Forrest Bird - Forrest Bird invented the first practical mass-produced medical ventilator. He was a pilot during the Second World War and his experience with the gear that allowed pilots to breathe at high altitude stimulated his interest in the research into ventilators and initiated his decision to train as a doctor. In 1954 he founded the Bird Products Corporation to market and develop his ventilators.

3. Oxford Endotracheal Tube - This tube's 'L' shape prevents obstruction by kinking even when the head is fully flexed.

4. Bellamy Gardner Dropper Bottle - H. Bellamy Gardner exerted a powerful influence in establishing open ether in England. The ether dropper fitted an ordinary medicine bottle. It had a rubber stopper. The longer metal tube dipped into the ether and the short one allowed air to enter the bottle to replace the ether that had been used. The flow was controlled by blocking one tube and pouring from the other or by rotating the bottle until the bent inner tube was above or below the ether level. It could also be used to drop chloroform or with a mixture.

5. Foregger Laryngoscope - Richard von Foregger was born in Austria in 1872. He came to America in 1898, and was employed by the General Electric Co. In 1914 he set up his own manufacturing firm. The Foregger Company specialized in the manufacture of equipment for the administration of anesthesia gases to human beings. Foregger was very much involved in the design and development of laryngoscopes, working with Guedel, Waters, Prof. Robert Macintosh of the Nuffield Department of Anesthetics, Oxford University, England, (1897-1989), Dr. Robert A. Miller (1906-1976) of San Antonio, TX, and many others. All together the 1959 catalog shows some 20 different shaped laryngoscope blades, in several sizes.


7. Rendell Baker Facepiece - The first masks to be designed to follow the contours of children's faces.

8. Airmed 'Marrett' Anaesthetic Machine - This was designed for dental anaesthesia in a chair and out-patient anaesthesia with nitrous oxide, oxygen and halothane. The patient was anaesthetised using halothane and oxygen with nitrous oxide. The vaporizer was fitted with a multi-use bracket so that it could be fitted onto a Medlite cylinder stand or the vaporizer bar of a Boyle's table. Pre-medication was unnecessary.

9. Boulitte Sphygmomanometer - The Boulitte Universal Oscillotonometer used the Gallavardin cuff, a double cuffed armlet described c1909 which produced a more reliable systolic pressure estimate. Movement of the oscillotonometer needle always started from the same point, so that readings were taken more easily.

10. Huffman Prism - Used to improve view of the vocal cords during nasal and difficult oral intubation and for post-operative examination of the larynx. It provided a refraction of 30°.


12. Forrester Anaesthetic Spray - Used to administer a small amount of local anaesthetic directly to the vocal cords before intubation.
Anaemia and brain oxygen after severe traumatic brain injury


Introduction

Impaired cerebral oxygen delivery is a cause of secondary brain insult in traumatic brain injury (TBI). Anaemia is a contributory factor to impaired oxygen delivery and results in reduced brain tissue oxygen tension (PbtO2). Episodic decreases in PbtO2 are associated with poor outcome in TBI. Current guidelines in the management of TBI do not contain an established, measurable physiological parameter in order to assess the effect of anaemia on brain function and guide the clinician in blood transfusion therapy.

Aim

The aim of this study was to investigate the relationship between anaemia, PbtO2 and clinical outcome in patients with TBI.

Methods

Patients with TBI in whom PbtO2 was monitored were enrolled in this prospective, single-centre, observational study.

Management of TBI was in accordance with accepted UK practice. If patient PbtO2<20 mmHg, ICP was reduced to <20 mmHg, cerebral perfusion pressure of ≥60 mmHg was maintained and ICP was optimized, surgeons and neurosurgeons were consulted, and Hb levels were maintained at ≥10 g/dL by blood transfusion transfusion of patients received transfusion if Hb was <7 g/dL, and

Primary endpoint was a dichotomized adaptation of the Glasgow outcome score (favourable: 4-5, unfavourable: 1-3) at 30 days. A mixed effect multi-level regression model was used to compare simultaneous Hb and PbtO2 levels, and logistic regression to assess risk factors for an unfavourable outcome.

Results

Eighty patients were studied over a 4-year period. Hb ≤10 g/dL was significantly associated with lower mean PbtO2 levels (p=0.001). A positive linear relationship was found between PbtO2 and CPP (coefficient 0.12: 95% CI 0.04-0.20: p<0.001). Thirty patients (38%) experienced episodes of simultaneous anaemia (Hb ≤10 g/dL) and a PbtO2 of ≤20 mmHg. Such episodes were independently associated with an increased risk of unfavourable outcome (adjusted odd ratio 2.41: 95% CI 1.61-24.22: p=0.008).

Anaemia alone did not confer an increased risk of an unfavourable outcome.

Discussion

This observational study demonstrates an association between episodes of simultaneous anaemia, compromised PbtO2 and poor outcome. This was not observed with anaemia alone.

In the future, a randomized, prospective study designed to investigate a causative relationship may demonstrate the usefulness of monitoring PbtO2 by giving the clinician a physiological parameter with which to guide transfusion therapy. This may, as a result, alter the risk axis with excessive blood transfusion in TBI patients.

References


Dr Richard Stewart

Specialist Registrar in Anaesthesia and Intensive Care Medicine, Oxford Deanery

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Dear Editor,

Don’t pour cold water on innovations

While anaesthetising for a general surgical list we noticed that an unusual clamp was in use on the drip stand. The senior ODP in the department had no idea how long it had been in use or where it had come from. We could find no sink in the theatre complex missing this device. With our investigations drawing a blank, it seems we have reached a complete tap top.

What luck - Anaesthetist has spent many hours observing laparoscopic surgery. (Toddler provides suck).

Fiona Martin

Consultant Anaesthetist, Royal Devon and Exeter Hospital

Dear Editor,

Unexpected fringe benefit of laparoscopic surgery

Sends your LETTERS TO:
The Editor, Anaesthesia News at anaenews.editor@aagbi.org

Please see instructions for authors on the AAGBI website

SEND YOUR LETTERS TO:

Dr Tom Green
ST5 Anaesthesia, Salisbury District Hospital, Wiltshire
Dr Sas Wijesingha
CT2 Anaesthesia, Salisbury District Hospital, Wiltshire

Ta da!

Toddler puts plastic ‘kiss in the bucket’ into plastic trapezoid. Anaesthetist finds kiss in bucket to be unattractively as it slightly bigger than the bucket hole.

Fiona Martin

Consultant Anaesthetist, Royal Devon and Exeter Hospital
The 2013 Winter Scientific Meeting promises to be the biggest yet!

POSTER COMPETITION

CORE TOPICS SESSIONS

SCIENTIFIC SESSIONS

INDUSTRY EXHIBITION

ESSENTIAL CPD

HANDS-ON WORKSHOPS

FUTURE WSM DATES:

2014
15-17 January 2014

2015
14-16 January 2015

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