Clinical excellence awards: Helpful Tips

A 'subconsultant' Grade? - A debate

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Hilary Aitken is taking a well earned break from editing *Anaesthesia News* this month, and (at the time of writing) I am taking a break from anaesthesia – I am crossing the USA (from San Francisco to Washington DC) on a motorbike. I am in good company: five members of the AAGBI council or executive, one other anaesthetist (my husband and chauffeur) and Dr Johnston’s son, who brings down our average age and weight, and gamely puts up with what must be very tedious conversation at dinner. Last night we debated the question of why we are doing this. An initial proposition was that it was odd for six normally right-thinking, risk-averse anaesthetists to embark on such a hazardous journey. Perhaps we were doing this in order to break free from our normally very highly-controlled, planned and organised working lives? We eventually came to a rather different conclusion, which is why I am recounting this story. We decided that a quality best described as bravery underpins both our professional lives and our current endeavour.

We (rightly) focus a great deal of our attention on the safety aspects of our work, constantly attending to the details and rituals that will keep our patients safe, to the point that we may forget this other fundamental aspect. In order to be a good anaesthetist, it is necessary to be brave. Excessive bravery (or recklessness) and insufficient bravery (over-cautiousness) are, of course, both problematic traits in an anaesthetist (and also, arguably, in a motorcyclist). You will all be able to think of examples of both. In my experience, recklessness is something occasionally demonstrated by the young, inexperienced anaesthetist, and the latter is occasionally an issue for trainees but is also one that many of us experience as we get older.

My point is that we should occasionally celebrate (or at least acknowledge) the fact that our work calls for a certain amount of bravery. I note (as Aileen Adams reports on page 25) that Joseph Clover’s new memorial will describe him as “an extremely brave but safe and gentle practitioner”. To achieve this would be a fitting goal for all of us.
Bravery is not limited to the clinical arena. A clinical anaesthetist has written an article proposing that a sub-consultant grade in anaesthesia would be a good thing (though he or she did not feel quite brave enough to put their name to the article – that would probably have been reckless). This article appears together with an opposing viewpoint in this issue (pages 26–28). I am sure that many of you will have strong views about this and we look forward to hearing from you in response to this. This is an issue on which it would be appropriate for the AAGBI to demonstrate some leadership, but your views are necessary to ensure that you are properly represented.

On the subject of safety, I applaud the introduction of the WHO checklist and safe surgery initiatives. We have been running a pilot WHO checklist in our Trust for the last few months. It really doesn’t take much time and is quickly embedded into practice. I hope it will reduce the incidence of wrong-site blocks and surgery (which previously occurred occasionally despite the introduction of correct site checklists a couple of years ago) as well as reducing the incidence of other types of adverse outcome. Nevertheless, I am a bit fed up (already) of being asked whether a pulse oximeter is applied and intravenous access secured prior to the start of surgery – often half an hour or so after the start of the anaesthetic. Do people actually forget to do either of these? I’d rather be asked about something which is more conceivably the subject of error, such as ‘What is the MAC?’ or ‘Have you turned the warming blanket on?’. ‘Scoop’ (page 31) presumably shares some of my frustration.

Elsewhere in this issue Chris Meadows announces that he will be handing over the chair of the GAT committee to Felicity Howard at the GAT Annual Scientific Meeting in Cambridge at the beginning of this month. Chris has worked tirelessly to ensure that the voice of trainee anaesthetists has been heard in the corridors of power during difficult times, particularly following the introduction of MMC, and is to be congratulated for his efforts and achievements. Felicity has already proved her worth in the GAT committee, and will, I am sure, prove to be a worthy successor.

I wish Chris all the best for the future and congratulate Felicity.

Our president has had some very constructive meetings with Professors Jonathan Montgomery and Hamid Ghoose regarding the relative under-recognition of anaesthesia (compared with other specialties) with respect to higher awards. The outcome of this exchange appears in this issue (page 6) and is a ‘must read’ for all those eligible to apply for higher awards as it contains information about what information would be regarded as appropriate for an anaesthetist to cite in the various domains of the application form.

The election process for the next President of the AAGBI is still in process at the time of writing. The successful candidate will have been chosen by the time you read this, and I offer my congratulations to him. All three candidates are extremely able and will, I am sure, continue to serve our specialty and our patients well.

Val Bythell,
Deputy Editor

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The Association of Anaesthetists
of Great Britain & Ireland

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 (Pontypridd) 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 and Dr Neville Robinson (London) in 2008.

Nominations are now invited for the award to be presented at WSM London in January 2010 and may be made by any member of the Association to any practising anaesthetist 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 Dr Les Gemmell at honsecretary@aagbi.org by Friday 2 October 2009.
COURSE TOPICS
- The physics of radiofrequency: the story so far: Dr. E. Cosman (USA)
- The biological mechanisms and clinical effects of radiofrequency procedures: Prof. A. Cehana (USA)
- The role of radiofrequency in the management of facial pain: Prof. S. Erdine (Turkey)
- The role of radiofrequency in the management of cervical pain: Dr. L. Lou (USA)
- The role of pulsed radiofrequency in the management of radiologic pain: Dr. G. Rohn (The Netherlands)
- The role of radiofrequency in the management of thoracic spinal pain: Dr. I. Fox (USA)
- The role of radiofrequency in the management of lumbar pain: Dr. R. Benjamin (USA)
- The role of radiofrequency in the management of sacroiliac joint pain: Dr. M. Ather (UK)
- Lumbar Discogenic pain: Dr. A. Trescot (USA)
- The role of radiofrequency in Symptomatic maintained pain: Dr. M. Puyha (Belgium)
- Pulsed radiofrequency procedures on peripheral nerves and joints: Dr. C.A. Gauci (UK)

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This symposium has been awarded 8 CME points by the Royal College of Anaesthetists
Many will be aware that for some time now there has been concern about the relatively poor performance of anaesthesia as a specialty in both Employer-based Awards (EBA) and in the national Clinical Excellence Awards. We have been in consultation with ACCEA representatives for several years to try to address these issues and have had some very useful and hopefully fruitful meetings with them. This article reports some of the issues brought up in these meetings and over a period of years we hope to see the performance of our specialty improve and match other specialties.

Firstly the principles of form filling are the same for both EBAs and national awards. The assessors are essentially looking for evidence of contribution over and above that regarded as ‘normal’ contractual work for the NHS. More statistical evidence concerning awards is coming on-stream year after year. For anaesthesia we have more of a feel for what is happening in national awards than EBAs, and more evidence is being gathered year on year. Our impression is that anaesthetists underperform equally at both local and national levels.

Previously there have been suggestions that the ‘bed-holding’ specialties do better because it is easier to demonstrate the impact of a change in therapy or surgical technique and convey this as clinical excellence. It has also been suggested that the forms are clearly more relevant to the major specialties of medicine and surgery and bear little relevance to anaesthetic practice. This is the reason for the common criticism that anaesthetists are perceived not to fill the form in correctly. There are other specialties that could also argue along these lines but still do better than anaesthesia. So even though ‘bed-holding’ may have some influence it is clearly not the whole story. We are told that the domains in which anaesthetists do particularly badly are domains 1 (delivering a high quality service), 2 (developing a high quality service) and 3 (leadership and managing a high quality service).

We have had two meetings this year with Professor Jonathan Montgomery and Professor Hamid Ghodse, respectively chairman and medical director of ACCEA. Of course, all four home countries are now different and the ACCEA essentially looks after England and Wales, although Wales has no EBAs, rather a system of commitment awards. Scotland and Northern Ireland have different arrangements but certain similar principles apply. The ACCEA tell us that the number of anaesthetic applications is increasing year on year. It was hoped that increased numbers of applications would increase the number of conversions into actual awards but this did not initially happen. There are signs that the conversion rate may now be increasing but there is clearly a long way to go for the specialty.

We were challenged at these meetings to look through the guidelines the ACCEA publish on their website and make comment on them with reference to the specialty. This was a valuable exercise, well received by the ACCEA, and may be used for other specialties in an effort to provide additional information to assessors. We were also asked to come up with examples of achievement which would score 10 (excellent) or 6 (above and beyond) in domains 1 to 3. Some of these may be used by the ACCEA in future guidance.

I am very grateful to those who provided us with their successful CVs which were of considerable help in this exercise. Some of these examples are shown in box 1. After this exercise and after further discussion with ACCEA representatives a series of points which tend to let us down as a specialty were highlighted. Some of these will have been heard before; some are a result of increasing experience in assessing applications:

- Use plain language
- Anaesthetists tend to be dismissive about routine areas of their practice. For example it may be appropriate to comment on post operative pain or nausea and vomiting rates in your
Box 1 shows some good, illustrative examples for each of the first 3 domains. NB The examples do not represent the whole submission for each domain.

**Domain 1  DELIVERING A HIGH QUALITY SERVICE**
..As the Anaesthetic Clinical Lead for the Day Surgery Unit since 2004, I have designed patient flows and processes that have allowed an increase in throughput of >20% and a decrease in the incidence of unplanned overnight admissions. This has been achieved by the targeting and optimisation of antiemetic therapy and with the use of local anaesthesia and regional anaesthesia.

**Domain 2  DEVELOPING A HIGH QUALITY SERVICE**
..I represent the Department of Anaesthesia on the Trust’s Drugs and Therapeutics Committee. Not only have I driven a decrease in the cost of anaesthetic drugs of >3% in the last year, but I introduced audit and review processes in drug usage in other clinical areas of the Trust that have led to decreases in drug expenditure throughout the Trust.

**Domain 3  LEADERSHIP AND MANAGING A HIGH QUALITY SERVICE**
..As the Clinical Director of a department of over 100 consultants, I am responsible not only for the Clinical Governance, budget, efficiency and safety of the Operating Theatres, but I also work with the College Tutor to manage the training of the largest number of specialty trainees in the Trust. I have recently ensured that trainee rotas are not only European Working Time Directive compliant, but they really are European Working Time Directive compliant. I have done this by making substantial changes to consultant work patterns- a job that was time consuming and complex but ultimately beneficial to patient safety.

Comments are heard around Trusts such as, “I’ll never get an award”, “I cannot be bothered to fill in that long and complicated form”, “let’s move to the Welsh system”, and some would have sympathy with those comments. The reality is, however, at the moment the EBAs and national awards are increasingly recognised as part of the overall remuneration package of consultants. Only by increasing numbers filling the forms in and learning how to fill them in effectively will we increase the number of anaesthetists benefiting from this process.

Dr Richard Birks, President
As you, gentle reader, peruse this month’s Executive column, the light is starting to show at the end of a very long tunnel. In three months’ time – the second week of October, to be precise – I will come to the end of my term of office as Editor-in-Chief of Anaesthesia and will hand over the reins (indeed, the entire horse and stable) to that towering intellectual, all-round good guy and serial tie-avoider, Steve Yentis. I hope that you will therefore indulge this aging pen-pusher as he reminisces about how it was in his day.

Before taking over as Editor-in-Chief from the redoubtable Mike Harmer in 2003, I had already served nine years on the Editorial Board, initially under the wise leadership of Maldwyn Morgan. Back in ’94, e-mail and electronic communication was rather in its infancy, at least as far as the journal publishing business was concerned. Consequently, papers would arrive in the form of a large brown envelope with a big yellow sticker on the front, usually on a Friday morning. The average workload was 2-3 papers per week but, if Mal had been away and there was a backlog, this could easily double or even treble. I remember nine manuscripts arriving on the second day of a Test Match against the Aussies; I scooped the whole lot up, took them off to Trent Bridge with a red pen and a plentiful supply of pinot noir, and worked my way through them during a particularly slow England opening partnership.

The process was simple but, with the luxury of hindsight and new technology, now looks positively stone-age and cumbersome. I would read the paper, decide whether to provisionally accept or reject, and then compare my view with that of the boss. If we agreed, well and good: if not, it was posted to another Editor for a casting vote. If it was something outside the field of expertise of any of the Editors – and we had a wide range of interests – an external expert opinion would be sought. Rejection meant the Editor wrote a draft rejection letter and sent it to the editorial office, where Mal would sign it himself to ensure any brickbats came his way rather than ours. Provisional acceptance meant the start of a long postal correspondence with the authors to knock the paper into shape. Once the science was right, the Editor would then take up the red pen again, mark up two copies of the manuscript with grammatical changes and ‘house-style’ corrections, send one to the office (another brown envelope, another yellow label) and retain the other. The Editorial Assistant would type up the changes, and send the manuscript for proofing. Finally, the paper proofs would circulate to authors, Editor and Editor-in-Chief, each making their own scribbled changes, before appearing in print. All this by post and each exchange denuding the rainforests further.

Much has changed and, over the last few years, we have finally achieved the dream of the paperless office. All business is conducted by email and, apart from the occasional luddite Editor who likes to print out the copy, editing is entirely done on screen. Communication between Editors, the editorial office, reviewers, authors and publisher from the moment of submission until the final copy appears in the on-line journal is now totally electronic with the final two hurdles, proof-handling and the authors’ declaration, falling in the last three years. Authors and Editors now have access to a tracking system to follow the progress of a manuscript, and turn-around times – always a point of honour for Anaesthesia – are shorter than they have ever been.

It has been both a privilege and a pleasure to manage Anaesthesia, a journal which I had admired from my early days as an SHO when John Lunn was still the man in charge. But it has certainly been hard work. In the last 5½ years, I have assessed over 3500
papers and 2200 items of correspondence. Every paper, however
dire, gets the benefit of at least one further expert opinion and
around 22% make it into print. At the same time, querulous authors
have to be placated, ethical issues must be considered, marketing
matters dealt with, supplements produced, overseas editions
developed and all to a relentless series of ever-repeating deadlines.
Do you, gentle reader, picture a large office suite, buzzing with
frenetic but productive activity? A phalanx of editorial assistants
overseen by a manager in a glass-walled office? An army of busy
copy typists? Wipe that vision and instead picture two chairs, a
shared desk, and a part-time Editorial Manager. And, frankly, that’s
it. In the great tradition of the British medical academic journal –
and in stark contrast to our friends from Anesthesiology and
Anesthesia & Analgesia over the water – we have an endearingly
amateur approach to both staffing and facilities. A plume of pipe-
smoke, a tweed jacket slung casually across a chair-back and a
map on the wall, and you could be back in Bletchley Park with the
Enigma code-breakers.

Of course, there are many others behind and in front of the scenes
without whom I would be floundering and you would not have a
regular journal to read. The Editors, whom I am proud to count
as friends as well as colleagues, the team at Wiley-Blackwell, our
publishers, the staff at the Association and the wise heads of the
members of the Editorial Board. I am hugely indebted to all, both
past and present, and will thank them in my piece in the Association’s
forthcoming Annual Report. But this article should be viewed as a
tribute to Sue Jarvis, the aforementioned Editorial Manager. Sue was
initially introduced to me by my colleague, Professor Jim Thornton,
who was relinquishing his editorial role at the European Journal of
Obstetric and Gynaecology and who therefore had a spare editorial
assistant, and we hit it off immediately. She is the epitome of
efficiency, and has been instrumental in developing the databases
which allow us to keep track of our workload. She controls me
in a quiet but wholly effective manner, charms authors, imposes
the iron fist in the velvet glove upon the occasional intemperate
correspondent, and generally soothes the savage beast, all while
maintaining a sense of humour, a dignified and elegant demeanour,
and a constant update on her degree studies in ancient languages
and music. It may all have been hard work but, catch me in my
cups, and I will admit that I am going to miss the journal: but I will
miss Sue more.

The good news for the journal is that it is going to be in the best
possible hands over the next six years. Steve will bring a thoughtful,
innovative and far more intellectually rigorous mind to bear on
the best anaesthetic journal in the world, and he is, very sensibly,
keeping Sue on. One of the many benefits of the electronic office
is that Steve can be in London, Sue in Nottingham and they can still
work together happily. I don’t know who’s going to make his tea
though.

David Bogod, Editor in Chief of Anaesthesia
Once again the ICS will be bringing together leading figures and international speakers within the field of intensive care to speak at our most prestigious and important meeting of the year. Day one of the meeting will provide a choice of parallel sessions with the clinical practice and research forums. Day two will be dedicated to state of the art topics of relevance to intensive care medicine.

Submissions of free paper abstracts will be accepted for presentation in the research and clinical practice sessions. Applications for the Research Gold Medal Award are also invited.

CPD accreditation: TBC

Further details including a full meeting programme, registration details and guidelines for free paper submission may be obtained from the ICS website www.ics.ac.uk/meetings.

To register for any ICS meetings and view full programme details please visit www.ics.ac.uk/meetings. All seminars will take place at Churchill House, 35 Red Lion Square, London WC1R 4SG.

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Further details including a full meeting programme, registration details and guidelines for free paper submission may be obtained from the ICS website www.ics.ac.uk/meetings.
Look into your darkest heart. What medical errors have you made over the years? What harm has resulted? What have you learned from these?

Let us assume you have been in active medical practice for a number of years, that you are a careful and conscientious practitioner and that you routinely reflect on your practice to determine how you might continue to improve. You will probably be able to recall numerous errors, some of which have resulted in harm to individual patients. Hopefully you and others have learned from these, as a result of critical incident reporting and analysis leading to changes that result in improved standards of safety for patients in the future. This is the paradigm for managing critical incidents which the medical profession and the Government endorsed in a joint statement in 2001 and which is explicit in the National Patient Safety Association’s (NPSA) guidance.

Mistake: Error in planning an action
Slip: Error in executing an action
Technical error: Failure to carry out a plan successfully
Violation: Deliberate deviation from safe practice

Unfortunately, for a few of us an error of some sort (Fig 1) has instead set in motion a train of events leading to a police investigation and potential or actual criminal prosecution. I recently became aware of an anaesthetist whose relatively minor (in my opinion) oversight has catapulted him into the latter scenario. Reflecting on the plight of that individual, I have been thinking about the wider problem of medical manslaughter.

It is understandable that the victims (or their relatives) of medical errors should seek justice, and this often seems to take the form of a wish to find an individual to blame and to punish. Indeed, there is arguably a wider trend in society in favour of seeking to apportion blame when things go wrong, rather than accepting the stoical view - ‘accidents happen’. That bastion of medical opinion, the BMJ, has advocated abolishing the very word ‘accident’ (or at least its inappropriate use) on the grounds that most injuries and their precipitating events are preventable. There is thus an alternative view as to how critical incidents should be managed.

These opposing views can be crudely summarised in a single question: When is a mistake a crime?

If all medical errors were to be criminalised, then large numbers of us (except for those of you who really have never made a mistake) would be locked up (or whatever punishment is to be meted out), leading to serious difficulty delivering healthcare. On the other hand, is it right that the most careless practitioner, serially committing gross errors despite appropriate training and systematic support, should escape censure? Surely balance must be achieved? The authors of a recent article on medical manslaughter conclude as follows: ‘The criminal prosecution of a doctor is appropriate when there is a clear violation of safety rules. However, human error is unavoidable’.

In recent years in our society the balance seems to be tipping in favour of criminalising medical errors (Fig 2), despite a joint declaration on behalf of the government and the medical profession ‘...recognising the fact that honest failure should not be responded to primarily by blame and retribution but by learning and a drive to reduce future risk to patients’.

Fig 2

Number of doctors charged with manslaughter as a result of the death of a patient, 1795 to 2005 (excluding abortion cases). From ref 5.
The numbers of doctors charged is still small compared with the numbers of deaths which are thought to be related to errors in healthcare, but the trend is surely a cause for concern for all of us practising at the sharp end.

In the case I mentioned earlier, the criminal investigation was instigated by the coroner. A staggering 46% of all deaths in England and Wales (229,600 in 2006) are reported to a coroner. Most coroners (90%) are not medically qualified, and this proportion is likely to rise further as reforms to the coronial service are enacted. It must be particularly difficult for coroners who aren’t medically qualified to grasp the intricacies of complex medical treatment preceding deaths occurring within a healthcare setting.

If the coroner is concerned that a criminal act may have been involved in a death then he/she can ask for the matter to be investigated by the police. For example, in 2004 the Royal Coroner decided to ask the metropolitan police to investigate the death of Diana, Princess of Wales. There is anecdotal, but worrying evidence that coroners may be increasingly likely to refer deaths occurring in more mundane circumstances in secondary care to the police for investigation. If this is the case, then we should be very concerned.

There are some changes in the wind, which might mitigate this disturbing trend. The Coroners and Justice Bill (published in draft in 2006) is currently before the House of Lords. The Bill legislates for some important changes to the current system. If it becomes law, a new leadership structure for coroners will be established in the form of a Chief Coroner and a Coronial Council, and a new system for providing medical advice to coroners will be set up. A new post, the chief medical adviser to the coronial service, will be established. This offers a potential route for sensible medical explanation and advice to be made available to coroners at an early stage in their investigations.

What can the AAGBI do about all this?
The AAGBI Council has discussed this. We believe that it is not in the public interest for doctors to be prosecuted for medical errors. We resolved to strengthen our pre-existing informal links with the coronial service, and to look for opportunities to interact with the police over such matters. We will follow the progress of the draft Coroner’s Bill with interest, and will continue to look for ways to influence the debate.

Through our Safety Committee we will continue to pursue appropriate critical incident management strategies. Through our welfare committee we will ensure that support is available to provide an empathic ear and advice to all members who are affected by serious critical incidents involving patients in their care.

We are interested in any other suggestions and contributions from our members on this subject.

Val Bythell
AAGBI Council Member

Refs
2. www.npsa.nhs.uk/patientsafety/reporting/incident-investigations/
4. BMJ 2001;332(7298):1320 (2nd June)
Come in number 24, your time is up. As my time on the GAT Committee draws to a close, it is tempting to look back on the last five years and recount stories of the turbulent times in anaesthesia training. However, retrospection is rarely constructive, change is an integral part of evolution, and we must look to the future.

With the turning of the clock at the Annual General Meeting, this year held in Cambridge at the GAT ASM (1-3rd July), I shall hand over the reins to Felicity Howard. Having served on the Committee since 2006 and performed the duties of Honorary Secretary admirably for the last two years, Felicity is most definitely a safe pair of hands.

The ASM itself promises to be a spectacular event, the academic department at Cambridge having produced a superb programme with ‘big name’ speakers, together with punting on the Cam and dinner in the banqueting hall at King’s College. Huge thanks are due to Professor David Menon and the Local Organising Committee.

The GAT Seminar programme continues to run successfully, with the ‘Consultant Interview’, ‘Management’, ‘Medico-Legal’ and ‘Ventilation’ seminars all once again scheduled this year.

Of course, GAT would not be GAT without the politics. Current debate includes the often thorny issue of who should perform rapid sequence inductions in the Emergency Department; the implications and full impact of the 48-hour European Working Time Regulations on duration of training and inevitable scrutiny of the RITA / ARCP processes; the rights and wrongs of study leave time as a Less-Than-Full-Time trainee; and the countdown toward national recruitment into the specialty using a more correct approach.

We continue to use the email database to survey trainees and thus inform debate. The next few months will see communications about methods of preparation for the Primary FRCA exam following reports of falling pass-rates and, a particularly sensitive issue at present, a Welfare Committee / GAT collaboration questionnaire examining morale and
wellbeing amongst trainees. All survey results are to be reported in *Anaesthesia News*, together with insightful comment and analysis.

As I write this, almost my last act as Chairman, I would like to take this opportunity to thank the Committee for all their hard work during my time in office and also to thank AAGBI Council and the in-house staff for their advice, support and friendship. Thank you too to the many anaesthetic trainees who have written, emailed and telephoned me with suggestions, worries and complaints. With their help, the GAT Committee will continue to be representative and enjoy the high regard in which it is held. I wish my successor well.

*Chris Meadows*
*Immediate Past-Chair, GAT*

So, how to follow that... first and foremost I must say thank you to Chris for all his hard work on behalf of GAT, particularly during his time as Chair over the last two years. He has worked tirelessly to raise the profile of GAT and fought for the trainee voice to be heard throughout his time in office, often under trying personal circumstances. Chris has a remarkable ability to distil the discussions and opinions of trainees and the GAT Committee into a short coherent summary and direct this towards the very people who should hear it and, more importantly, who have the power to act on it. For this he will be particularly missed, and I can only hope to emulate him.

For those of you whom I have not come across before on my travels, my name is Felicity Howard and I am a final year Specialist Registrar from the Welsh Deanery, which has a long tradition of providing GAT Chairs to the AAGBI. My specialty is Paediatric Anaesthesia, for which I undertook a year out-of-programme at Great Ormond Street Hospital in London. During this time I lived apart from my husband so I have a particular understanding of that situation in which many of you find yourselves, especially post-MMC. I feel very privileged to have been elected as the next GAT Chair, and will do my utmost to serve you all with dedication to the cause. I will have a particular challenge on my hands as, by the time you read this article, six new committee members (half of the total elected members) will have been elected to replace those standing down. Many thanks must be extended to Drs Paul Johnston, Mark Hearn, Manu Shankar Hari, Adam Paul and Mike Parris who have all worked extremely hard on your behalf during their time on the GAT Committee. They will be sadly missed, but I look forward to welcoming the six new members in their place. My job during my year as Chair will be to cement this new Committee together to continue the good work.

I also have some ideas for moving forward with the work of GAT during my time as Chair. In particular, I would like to try to extend the co-operation between GAT and the trainee representatives of specialist societies; if you are one of these people then please contact me via email at gat@aagbi.org so that we can explore the available options. Similarly, I would love to hear from you if you are a representative of a local anaesthetic trainee committee; I know a lot of hospitals/regions have these and that the people involved do a lot of very good work at a local level. It would be fantastic to know what is going on “out there” and if there are any ways that GAT can be of assistance. The AAGBI currently operates a very successful Linkman scheme; at present we do not have anything similar for trainees so we on the Committee have no formal way of knowing what else is going on around the country. GAT exists to represent the interests of our members and, as mentioned before, we cannot properly represent you if we do not know what you want or need from us. So please get in touch and let us know, either on the above e-mail address or through our web pages on the main AAGBI website. The website is shortly to be revamped, and the GAT pages will be similarly revised. For now, these are the best and most up-to-date way of finding out what the Committee has been up to on your behalf in recent times. They include reports of meetings attended by Committee members, and this year the GAT ASM has been chosen to pilot the new electronic booking system for AAGBI events.

The AAGBI is currently involved with international trainees in Uganda through the work of the International Relations Committee. At present this takes place without any GAT involvement, but I would be keen to explore ways in which we could interact with this scheme.

These are just some of my ideas for the future; I recognise that I cannot change the world during a year as Chair, but I hope to go some way towards continuing the work of my excellent predecessor and promoting trainees’ interests at every opportunity. Please let me know what else you think we, as a Committee, should be focusing on, so that we can do our best for you – the future of our specialty.

*Felicity Howard*
*GAT Committee Chair*
# The Mersey Autumn Menu

<table>
<thead>
<tr>
<th>Course</th>
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<tr>
<td><strong>The Final FRCA and FCARCSI MCQ Courses</strong></td>
<td>14.00 Sunday 9th – 12.00 Friday 14th August</td>
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<td><strong>The Final SAQ and E&amp;SAQ Weekend Courses</strong></td>
<td>14.00 Friday 14th – 13.00 Sunday 16th August</td>
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<td><strong>The Final Examinations (Booker) Crammer</strong></td>
<td>14.00 Sunday 16th – 16.00 Friday 21st August</td>
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<td><strong>The Final FCARCSI Viva Weekend Course</strong></td>
<td>14.00 Friday 9th - 16.00 Sunday 11th October</td>
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<td><strong>The Final FRCA Viva Weekend Course</strong></td>
<td>14.00 Friday 20th - 16.00 Sunday 22th November</td>
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<td><strong>The Primary FRCA MCQ Course</strong></td>
<td>14.00 Sunday 23rd – 16.00 Friday 28th August</td>
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<td><strong>The Primary FRCA Viva Weekend Course</strong></td>
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<td><strong>The Primary FRCA OSCE Weekend Course</strong></td>
<td>14.00 Friday 18th – 13.00 Sunday 20th September</td>
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<td><strong>The Primary FCARCSI MCQ Course</strong></td>
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<td><strong>The Primary FRCA OSCE/Orals Course</strong></td>
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<td><strong>The Primary FCARCSI OSCE/Orals Course</strong></td>
<td>14.00 Friday 6th – 16.00 Friday 13th November</td>
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All Details

[www.msoa.org.uk](http://www.msoa.org.uk)
Pheromones are the compounds we give off to attract the opposite sex. Bibliomones, hitherto undescribed, similarly are given off by second hand books, and have an equally devastating effect on susceptible individuals. Some thirty years ago, while passing a local shop that was selling off a great mixture of bankrupt stock very cheaply, I felt the irresistible pull, so in I went. There was a shelf of disparate volumes, of strictly academic interest. Two historical reprints caught my attention; of Joseph Priestley's autobiography, and of the first volume of John Dalton's 'A New System of Chemical Philosophy'. This was small, (about 160 pages) so it could be smuggled into the house easily; but I doubted whether I would ever read it. So I started to skim through it; the language wasn't too difficult, and it was priced at only 50 pence. Then, on page eleven I saw a table of ten columns, and the heading of the ninth almost literally made my eyes pop out. So the decision was made for me, and it is that ninth column that this article is about.

It has always amazed me that John Snow's very first publication on general anaesthesia was the table (table 2) that he presented to the Westminster Medical Society on Saturday 16 January 1847. It shows the ether uptake by air to a total of 100 cubic inches of mixture through a range of temperatures, but it can be read also as the partial percentages of the atmospheric pressure.

One week later Snow presented a vaporiser of his own design, made of metal, and pointed out that by immersing it in a water bath of known temperature he could both control the maximum concentration of ether vapour, and ensure that it remained reasonably constant. His first paper on the technique of general anaesthesia, published on 12 March 1847, started with the following sentence. 'It will be at once admitted that the medical practitioner ought to be acquainted with the strength of the various compounds which he applies as remedial agents, and that he ought, if possible, to be able to regulate their potency. The compound of ether vapour and of air is no exception to this rule …'. He also made an acknowledgement to Andrew Ure, whose original table he said he had adapted.

Now, what made my eyes pop out, column nine of the table on page 11 of Dalton's 1808 book, is, in effect, a table of the saturated vapour pressure of diethyl ether over a range of temperatures. Trying to find out what it was doing there, forty years before the use of ether as a general anaesthetic, took me on a long journey, of which this is a drastically shortened and simplified account. Crucial to its understanding was the contemporaneous belief that air acted as a solvent for water, and that the water in the atmosphere was somehow chemically combined with air.

John Dalton (1766-1846) is now remembered mainly for his atomic theory, and it is unfortunate that his earlier works have been studied only as stepping stones to this. As a result, certain of his other important contributions have been overlooked. His earliest scientific interest was in meteorology. His serious study of the weather began about 1788. Living in the Lake District, he made many observations around Kendal and Keswick, and in 1794 he

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Table 1: Dalton's Table showing SVP of ether
The atmosphere, or it always exists therein as vapour of water is ever chemically combined and at the beginning of his sixth essay he tackled this question. ‘Evaporation is that process of nature by which water and other liquids are absorbed into the atmosphere, or are converted into elastic fluids and diffused through the atmosphere; the liquid thus changed is termed vapour ... Whether the vapour of water is ever chemically combined with all or any of the elastic fluids constituting the atmosphere, or it always exists therein as a fluid sui generis, diffused amongst the rest, has not, I believe, been clearly ascertained.’

He continues that experiments with the air pump have demonstrated, ‘that the greatest heat water is susceptible of, or its boiling heat, depends upon the pressure of the air upon its surface; the less the pressure, the less is the boiling heat ...’ Since this variation of boiling point with ambient pressure was relevant to his subject, and since he had never seen a similar account, Dalton reproduced a table of boiling points at various air pressures, the result of a series of experiments. From these he argued that if water vapour were chemically combined with air, then rarified air should take up less, not more, water, and evaporation should be impossible in an absolute vacuum.

He then proceeded to the idea of saturated vapour pressure, which he observed by introducing a small quantity of liquid into the Torricellian vacuum at the top of a barometer and measuring the depression of the mercury. Here his language is more difficult, but he pointed out that when the atmosphere has been rarefied twenty nine times, (i.e. its pressure reduced from 30 to 1 inch of mercury), water at 80° ‘is at the point of ebullition; or, in other words, aqueous vapour of the temperature of 80°, can bear no more than 1.03 inches of mercury, without condensation; this, then, is the extreme density of the vapour of that temperature.’ He continued with a calculation, making implicit use of the Law of Partial Pressures, to demonstrate that at any given temperature water will vaporise until, relative to the total pressure, the appropriate proportion of the bulk of the compound mass is vapour, and then it will be saturated, or imbibe no more; because if it did, the density of the vapour must be increased, which it cannot be in that temperature, without ... becoming water.’ So here, in virtually his first scientific publication, Dalton was setting out his ideas on saturated vapour pressure, and on the independence, or additive nature, of partial pressures in a mixture.

In 1808 Dalton published his A New System of Chemical Philosophy. This contains his work on atomic theory, but the first hundred pages are devoted to heat, or caloric, and to his erroneous idea that the linear calibration of conventional thermometers was wrong.

The table of the ‘force of vapor of ether’ (its saturated vapour pressure) in column nine, arose from his need to establish the behaviour of a mixture of gases and relate it to his theory that water vapour has a separate existence in the atmosphere. Hence, accepting that ‘when a vessel contains a mixture of two such elastic fluids, each acts independently upon the vessel, with its proper elasticity, just as if the other were absent ... the only thing now wanting to completely establish the independent existence of aqueous vapor in the atmosphere, was the conformity of other liquids to water, in regard to the diffusion and condensation of their vapor. This was found to take place in several liquids, and particularly in sulphuric ether, one which was most likely to show any anomaly if it existed, on account of the great change of expansibility in its vapor at ordinary temperatures.’ He had already concluded that ‘Ether as manufactured ... appears to be a very homogeneous liquid. I have purchased it in London, Edinburgh, Glasgow and Manchester, at very different times, (i.e. its pressure reduced from 30 to 1 inch of mercury), water at 80° ‘is at the point of ebullition; or, in other words, aqueous vapour of the temperature of 80°, can bear no more than 1.03 inches of mercury, without condensation; this, then, is the extreme density of the vapour of that temperature.’

Because Dalton’s apparatus, a barometer, could not be kept at a uniform temperature throughout its length, some ten years later Andrew Ure designed his own, and it was his table and ratio for calculating intermediate values by extrapolation from experimentally established ones that John Snow referred to when constructing his own table. How Snow, an ‘ordinary’ general practitioner, was aware of this research, is a question that remains unanswered.

David Zuck, Retired Anaesthetist
British Association of Indian Anaesthetists

8th Annual Meeting
Saturday 10th October 2009
The Cedar Court Hotel,
Denby Dale Road, Wakefield WF4 3QZ. (J39 M1)

The scientific programme will include lectures and discussions from Dr. Richard Birks, President of the AAGBI, Prof. Jonathan Montgomery, Chairman ACCEA, Prof. Narinder Rawal from Sweden, Dr. R. Sashidharan, Bernard-Johnson Advisor (RCoA), Drs. Keith Judkins, C. Subudhi, S.Karthikeyan, Iain Moppett, Roop Kishen, and Professors Rajinder Mirakhur, Chandra Kumar, Ravi Mahajan, and other eminent speakers.

The meeting is open to all anaesthetists.
Anaesthetists in training presenting papers are eligible for prizes.
The deadline for abstract submission is 2nd October 2009.

CME 5 Points

Chief Guest: Prof. P.F.Kotur, Belgaum, Karnataka, India

For further details, contact the Organising Secretary
Dr S.Balaji, Consultant Anaesthetist
Leeds General Infirmary
Tel: 07769686507 (Mob.)
e-mail: balajis@hotmail.co.uk
Website: www.baoia.org
The inspiration for this article was provided by Dr W Allister Dow; Overseas Fellowship – cultural experience or culture shock? The author posed the question ‘Do foreign trainees arriving in the UK experience a similar ‘culture shock’?’

Disclaimer
This is entirely my own experience. Any resemblance to any person (living or dead) whilst not regretted is somewhat inevitable.

Burton on Trent – July 2003
I came to the UK on an out of programme experience (OOPE) placement from my training in Lagos University Teaching Hospital, Nigeria (LUTH). I arrived to take up the position of SHO in anaesthetics in Burton-on-Trent, Staffordshire. To my grandmother who had absolutely no formal education, anyone in the UK was in London (pronounced with a distinct eastern Nigerian accent). So in a telephone call to my grandmother on arrival, I confirm…‘Yes, I am now in London’.

I was expected in Burton and felt truly welcome. I started a clinical attachment which lasted three weeks followed by a day of formal induction. That was one of my early shocks – the concept of a whole day dedicated to orientation. In my home institution formal induction at the postgraduate medical level did not exist. Induction was entirely informal. Like the combination of Oliver Twist and Artful Dodger you learnt by aligning yourself with older trainees. Unfortunately because the formal induction all happened in one day it was a bit too much information for my poor brain. The only thing that clearly stands out in my memory now is receiving my bleep and being shown how to use it.

There was also informal orientation in Burton – now, this was familiar ground. I soon learn from the trainee grapevine which consultants would rather use isoflurane than sevoflurane (so keep your hands off the sevoflurane vaporiser while working with them!); the academic-orientated consultants who turned every theatre session into a meaningful learning experience and more importantly the consultants who would look for the slightest excuse to run over you like a tractor whose brakes had failed.

To be forewarned…

Shock!!!
Culture shock…these are my favourite recollections.

Being asked whether I was going to stop the trauma list for dinner. Initially my answer was always “no”. I could not consider having dinner at noon. It soon became apparent that my use of the word “dinner” was different. Had I missed an important step in the evolution of the English language? My English teachers taught me that dinner was a meal you ate in the evening while lunch you ate around mid-day. So why was lunch being referred to as dinner? It was the kind of question that ceaselessly niggled but which you felt too stupid to ask. After several consultations with notable dictionaries including Oxford and Collins I had still not gained clarity. Eventually I confided in a Nigerian colleague and I was relieved to hear that on arrival she had also found it confusing. However she had done one thing differently. She had asked the college tutor about it.

Theatre temperatures were another shock. I am one of those ‘unfortunate’ people who represent the missing link between warm and cold blooded creatures. At 23.9 degrees Celsius my ears begin to twitch and my
capacity to function rationally declines in an exponential fashion. This was not a problem in LUTH as theatre temperatures on a good day were between 24 and 26 degrees Celsius. So imagine my first day in theatre with temperatures as low as 18 degrees – Wow! I barely survived the day and embarked on a quest for thermal underwear (in summer!) Mission accomplished, I returned fully clad in a multitude of jumpers under my theatre outfit. This multi-layered look became my signature ‘theatre fashion statement’.

Medical staffing is a shock! I am shocked by how helpful they are. In LUTH everyone who worked in medical staffing was perceived as ‘the enemy’. Here I can sort out so much with just a phone call. That first impression of medical staffing departments in the UK will probably stay with me for life.

First names at first sight
Yes, we all know that this side of the Sahara desert people often elect to be on first name basis from first contact but it still takes getting used to. Just as we know that in the UK people drive on the left side of the road, which didn’t prevent the many times I was nearly knocked down within the first three months of being here.

In Nigeria first names signalled familiarity. You knew where the person lived, you had met their spouse, children or parents, and you had most likely exchanged visits. Surnames are also a vital part of your identity. Your name is Peter but which of the numerous Peters are you? I still find myself instinctively peering at badges to memorise surnames and cannot stop calling the consultants Doctor … - it just seems their due. I am asked by my supervisor to call him by his first name and I know that I am not doing very well when two sentences down the line I again default to my comfort zone.

End of phase one
At the end of my OOPE in 2004 I returned to LUTH, Nigeria to honour the terms of my contract and more importantly I am reunited with my family.

Swansea – August 2006
If this was a film then this is the part where the screen goes blank and a subtitle appears which reads … Two and a half years later.

In 2006 I decided to return to the UK. I am hoping to pick up the threads of my training and take them to completion. I had worked in the UK before and so was returning to familiar territory. Did I hear someone say “illusion”? Delusion would actually be more correct. I return to completely different nomenclature – FP1, hospital at night, run-through training and MMC. Just when you think you’ve got the hang of it...

Janet Adanma Ezibe-Ejiofor
LAT SpR (CT2), anaesthetics
University Hospital of Wales, Cardiff

Hello mama...
Yes, I am now in London

1 Dow WA. Overseas Fellowship – cultural experience or culture shock? Anaesthesia News 2007; 234: 3-4.
Cambridge Anaesthesia Courses 2009
Cambridge University Hospitals NHS Trust, Cambridge

Final FRCA VIVA DAY
12 June & 27 November 2009

Consultant-led, intensive VIVA preparation course giving trainees
Extensive VIVA practice for the exam

The aim of the day is to provide candidates with at least 8 hours VIVA practice to give the required preparation and confidence to pass the exams.

“A very good course with lots of exposure to all aspects of finals exam”

Registration Fee: £200.00

For further information, please contact: Miss Lucy Bailey,
Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP;
Tel: 01223 217059; Email: lkb39@medschl.cam.ac.uk

Addenbrooke’s Simulation Centre

Cambridge Airways Course
24th June / 6th October 2009

A full-day course for Anaesthetists to refresh and update skills in managing patients with difficult airway
Registration fee: £125.00

Anaesthetic Emergencies for ST1s/SHOs
8th May / 22nd July / 6th November 2009

A simulation-based teaching course using scenarios and video debriefing by experienced anaesthetic faculty in a non-judgmental, friendly environment
Registration fee: £150.00

Obstetric Crisis Resource Management
9th March / 13th May / 17th November 2009

Learn how to manage obstetric emergencies using a high-fidelity computerised medical simulator
The course is suitable for all grades of Obstetrician, Anaesthetist and Midwife
Registration fee: £150.00

For further information on Simulation Centre courses, please contact: Miss Debbie Clapham,
Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP;
Tel: 01223 348100; Email: dlh48@medschl.cam.ac.uk
The AAGBI recognises that a proportion of members will at some point in their career experience difficulties, either personal or professional, of sufficient severity to require external help. The AAGBI Welfare Committee was convened in June 2006 to provide support and help to anaesthetists in difficulties and this replaced the AAGBI Sick Doctors’ Scheme. Our aim is to provide a framework from which members feel able to access appropriate support and guidance, and to provide, oversee and monitor a system to support anaesthetists with difficulties. The ideal outcome is the provision of timely advice to minimise further consequences and helping the anaesthetist to resume a normal life and career.

I took over as chair of the Welfare Committee in October 2008 from Diana Dickson who is known for her work in Stress Management and other welfare areas. Three members of the committee work as voluntary advisors for the BMA Doctors for Doctors Scheme which is available to AAGBI members: contact details are published every month in *Anaesthesia News* as well as on the back of the AAGBI membership card. Further details can be obtained from the Members’ Wellbeing webpage http://www.aagbi.org/aboutaagbi/committees/welfare.htm.

A recent audit of the Doctors for Doctors Advisory Service revealed that the top 10 issues (in order of frequency) which affect doctors from all specialties are career, disciplinary matters, stress, anxiety, depression, bullying, clinical competence, physical illness, alcohol abuse and relationship issues (see chart). Our own pilot survey of 5.6% (n = 476) members in 2008 showed very similar results with 23% of anaesthetists having experienced ‘burnout’. The top three stressors are a stressful working environment, lack of support and perceived bullying. The most helpful interventions are supportive colleagues and family, an understanding general practitioner and counselling.

One of the first tasks of the Welfare Committee was to produce a Resource Pack. This was completed in October 2008. The AAGBI Welfare Resource Pack is designed to provide members with a wide range of information. The first section aims to help members cope with the challenges of work and life – with subjects such as warning signs, bullying and harassment, how to cope with stressful situations and rights and responsibilities. The second section provides advice on how to access support, including up-to-date contact information on the AAGBI website. A press release in November 2008 to publicise the Resource Pack received widespread coverage amongst the national and international lay and medical press. This provided excellent publicity for the AAGBI, recognising the efforts made to highlight the problem and to help members in difficulties. Copies of the Resource Pack were also sent to the Royal Colleges and politicians associated with the health service, generating a positive response.

Other areas of work for the committee include improving the Members’ Wellbeing webpage, with links to other welfare organisations nationally and internationally. The Welfare Committee is also keeping an anonymous database of cases referred to the committee or to Doctors for Doctors so that lessons can be learned and shared, and this will be complemented with a series of heavily disguised and anonymised case histories in *Anaesthesia News*. Since members deem local support for anaesthetists in difficulty extremely helpful, the committee is exploring ways to set up a viable and effective mentoring or ‘buddy’ system, which can be replicated nationwide.

Individuals respond to pressure in various ways – some constructively using coping strategies and others resorting to more destructive means such as increased alcohol or drug intake, aggression or other behavioural changes such as social withdrawal and altered mood. The Welfare Committee is currently collaborating with the AAGBI working party in the revision of the *Drug and Alcohol Abuse in Anaesthetists* guidelines. This publication will provide guidance to departments and anaesthetists regarding drug and alcohol abuse - recent evidence from the wider health community seems to suggest an increasing prevalence.

The DoH recognises that stress and pressures within the NHS have implications in terms
Help for Doctors with difficulties

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help (www.bma.org.uk/doctorsfordoctors). To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor*. A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

If for any reason this does not address your problem, call the AAGBI during office hours on 0207 631 1650 or email secretariat@aagbi.org and you will be put in contact with an appropriate advisor.

*The doctor advisor scheme is not a 24 hour service

A prototype Practitioner Health Programme (PHP) has been set up as a free, confidential service, provided for registered medical and dental practitioners living or working within the London Strategic Health Authority area. Concerns may relate to physical or mental health or addiction, in particular where these may affect ability to work. The model draws on good practice in the UK and physician health programmes in North America. It is envisaged that success with this prototype might allow it to be rolled out more widely in the UK (funding permitting!).

Life skills that can help you and your colleagues to cope include communication skills, assertiveness, conflict management, time management and constant reflection on your work - life balance. The Welfare Committee has set up small working group to suggest seminars and workshops to assist members with some of these skills.

Finally, a few words of advice from the Welfare Committee. Sometimes career aspirations get in the way of domestic and social life with less than desirable consequences. Get a life outside work. Have a ‘buddy’ or better, ‘buddies’ whom you can talk to regularly - they do not have to be someone from your own department or indeed your own Trust. They can give you a frank reality check. It is important to judge success in your career by your own standards and not those of others. If you enjoy your work, keep up to date and give safe anaesthetics coupled with a good social and domestic life; you are having a successful career and life.

But there will be times when we ALL need a sympathetic ear and good counsel at some point of our busy and sometimes stressful lives so seek help to get you over a rough patch or low point. In times of distress call the BMA Counseling and/or the Doctors for Doctors Advisory Service: 08459 200 169 where you will be given help. Alternatively, contact the AAGBI secretariat who will contact a member of the Welfare Committee who may be able to help you or point you to somebody who might be able to.

Michael Wee
Chairman, Welfare Committee
Consultants first on call

I read with great interest the arguments put forward for and against Consultants doing first on call as a solution for the EWTD. (Anaesthesia News, May 2009)

Medicine is one of the few professions where the apprenticeship period drags on for more than a decade. I view the EWTD as a mature piece of legislation aimed at improving trainees’ lives.

The Consultant post is the pinnacle in our profession. It’s obtained by crossing multiple objective and subjective ratification hurdles while undergoing a competency-based training. Hence I feel that Consultants doing first on call devalues the responsibilities of the Consultant post. One does not expect the Chief Constable of Scotland Yard to do the night beat on Elm Street.

One of the arguments given for the Consultant to be resident first on call is that allowing the trainee to go home at 22.00 hours increases the logbook numbers. I would like to state that if the SHO does not sweat at night, he/she will bleed as a Consultant for the simple reason that we all know that it’s at night that the trainee is challenged and asked to dig into his/her reserves when faced with clinical situations. Help is at hand but it is the exposure of our inadequacies which provoke us to reflect and think about the problems encountered and through this process, and by watching the seniors, we learn. Increasing logbook case numbers may be comforting to educational supervisors but it may not reflect a real growth in the learning curve.

The EWTD has to be handled creatively. This is not the time to splinter the Consultant group into Junior and Senior. A Consultant should remain a Consultant. Period. If the trainee feels that at the end of the prescribed period of training, he/she is not ready for CCT, then the trainee should get/look at the option of undergoing targeted training to buff up weaker areas. The onus of becoming a safe Consultant should rest with the junior doctors who, given their relative age and maturity, should be able to take these decisions.

Devjit Srivastava
Specialist Registrar in Anaesthesia
Belfast

Consultants first on call (2)

Medical careers and training have been changing for even longer than the proposer in the debate suggests; the consultant’s job and role has done so over more than 60 years, and now there are too many chiefs and not enough indians. We have become hung-up on the idea that there should be only one senior grade of staff suitable for appointment after completing specialist training; now we are facing entirely predictable problems. Of course the public would, and should, expect an experienced doctor who has finished training to anaesthetise them for their emergency operation - we do for ourselves and colleagues - and it does, indeed, make perfect sense to have fully trained doctors dealing with the workload outside normal working hours. In other countries it is, of course, not consultants but specialists who are resident and, as noted in the debate, a natural progression from the resident specialist (in all acute specialties, not just anaesthesia) to non-resident consultant is what we need (1). I note the hope for resolution in 5 years but he shouldn’t hold his breath: I’ve been waiting 26 (2)!

The opposer has nothing really new to offer. Perhaps the time she recognises as needed in the first few years ‘to consolidate clinical skills and establish credibility in practice’ would be better formalised as the necessary specialist grade. Recruitment would only be adversely affected if all acute specialties did not go down this route. The explosion in consultant numbers is what has led to the bemoaned loss of power. We must look to better prepare such individuals (who would be fewer in number in the future) for ‘the complex and complicated environment that is the consultant post’ by a formal progression to it through a specialist grade.

Dr A P J Lake
Consultant in Anaesthesia and Pain Medicine
Glan Clwyd Hospital
North Wales.


Anaesthetic gases and the greenhouse effect

I thought the editorial on saving the planet (Anaesthesia News, May 2009) was excellent. There are some real differences that anaesthetists can make that I would like to suggest.

Firstly, avoiding nitrous oxide, a potent greenhouse gas, where possible is useful. Secondly, if using volatile anaesthetics, keeping the flows to a minimum is vital. Isoflurane, sevoflurane and desflurane are all fluorocarbons that contribute to global warming via the greenhouse effect. Thirdly, and perhaps the most effective measure, using TIVA so that no greenhouse gases are used.

Perhaps the green argument could be a good way of trying to ask for some more TIVA pumps!

Jeremy Stone, SpR in Anaesthetics
Leicester
Consultants first on call (3)

I thoroughly enjoyed reading the recent debate in Anaesthesia News about whether consultants should be first on call and I thought it might be interesting to hear an opinion from a trainee’s perspective. I write this from the perspective of a post-fellowship registrar.

Even though I think it is one solution to EWTD and is almost certain to be introduced, I am not in favour of consultants being first on call out of hours.

The problem with being opposed to consultants being first on call is that there is not a satisfactory alternative solution. I think if we are really honest with ourselves working 50 hours a week on average was not such a chore. It provided good experience and we did not have the current problem of trying to cover on calls. Consultants were around during the day and at the end of the phone out of hours if they were needed. So even though there are few options available and Dr Griffiths’ ideas would be a solution to the problem I think that consultants being first on call, with the negative implications for training is too great a price to pay.

Iain Dunn
SpR, North West rotation

Joseph Clover added to RSM Wall of Honour

Mr Anthony Clover, great grandson of Joseph Clover, has added JT Clover’s name to the Wall of Honour at The Royal Society of Medicine (RSM). Mr Clover is not medical, but he is very interested in his grandfather and is in the midst of researching for a full-length biography.

The Wall of Honour is one of the fund-raising initiatives of the RSM, and inclusion requires a donation. The inscription for JT Clover will read:

"J.T. Clover succeeded John Snow as the leading pioneer in anaesthetics in England and despite ill health dominated the London surgical and dental world for thirty years until 1880. An extremely brave but safe and gentle practitioner, as well as the ingenious originator of anaesthetic and surgical apparatus, his modesty and reticence has led to his being very much less well known than he deserved."

Aileen Adams

A useful tip, or taking the ****

Reading Dr Carey’s reflections in Anaesthesia News reminded me of preparation for a planned cycling holiday in Zanzibar. Fresh out of medical school, with substantial study loans, we could barely afford the flights. Reassured that we would be able to keep our expenses there to a minimum, we only needed cycling touring gear.

Hydration systems such as “Camelback” had just arrived on the market and were still very expensive. Seeing a urine collection bag I realized that one could turn the principle and a few tubes around and end up with a budget, homemade hydration system. With this in mind I set off to the hospital’s stores to see what varieties were available and had expired.

Urine collection bags came in different volumes and are designed not to leak, a definite advantage if you want to carry it in your backpack. The outlet tubing usually contains a tap. I extended the outlet tubing with the inlet tubing and used the tap as a mouth piece. The inlet was sealed with a clamp or another tap.

It certainly was not ideal. Getting your drink in through the small inlet was difficult and the connections were not as secure as one would have liked. Recently one of my colleagues asked what about the substances they used to sterilize it. All I can say is that I am still alive and now own a real hydration system!

Dr Abrie Theron
ST4 Anaesthetics, Morriston Hospital

Reference:

Editor’s note – anaesthetists often adapt pieces of kit for non-medical purposes. Send your handy hints to Anaesthesia News and we will print the best.
An anonymous consultant anaesthetist

It is far from easy to find someone who supports the introduction of some form of sub-consultant grade. The BMA is staunchly opposed to it and although I can find no formal pronouncements from the RCoA and the AAGBI, I know that these two bodies are also against it in principle. Most consultants I have talked to are vigorously opposed to it and I have yet to find a trainee who can say anything positive about it. It may therefore seem a little odd that I am prepared to stick my head (albeit anonymously) above the political parapet in this way! The answer lies in the current anaesthetic workforce situation.

Some years ago, David Saunders, former vice-President of both the AAGBI and RCoA, famously performed workforce calculations, allegedly on the back of a cigarette packet during a particularly long neurosurgical list. He calculated that by 2009, we were going to be short of several thousand anaesthetists. Those in charge of our specialty at the time endorsed these calculations and, in part because of the anticipated deficit of trained anaesthetists, the Anaesthesia Practitioner project was launched, later to become Physician’s Assistants (Anaesthesia) – PA(A). However, that was then, and we now know that as a result of developments that could not have been foreseen at the time, these calculations proved incorrect. The predicted undersupply of anaesthetists has not materialised and has in fact become an oversupply. This is part of the reason that the PA(A) project has stalled (in England at least), perhaps on a permanent basis: without a workforce gap to fill, there is arguably no need for non-medical anaesthetists. The recent significant expansion of the consultant grade that took place to compensate for the decrease in trainee hours caused by the Working Time Regulations (WTR) has now dwindled, and the anaesthesia section of BMJ Careers now contains lean pickings for those seeking substantive consultant posts in anaesthesia. It seems likely that we will soon be overproducing CCT holders by up to some 200 per year. What will happen to these anaesthetists? They will be well-trained, capable and in need of jobs. The consequences are slowly becoming apparent. The current medicopolitical situation allows the creation of jobs for trained anaesthetists that are not traditional consultant posts. Foundation Trusts are at liberty to create posts with terms and conditions that are not in line with national NHS agreements. Similarly, Independent Sector Treatment Centres (ISTCs) and private hospitals can employ doctors on their own terms.

In the NHS, a consultant anaesthetist earns >£80,000 and, if he or she is on a 10 PA contract, often does no more than six half-day lists per week or the equivalent period in other forms of direct clinical care. That’s three days a week of clinical work for £80,000. This relatively high salary is a result of the new contract introduced in 2003, which included an upward readjustment in part to maintain differentials over trainees whose income had risen because of punitively high rewards for long hours during the drive towards achieving WTR compliance. Now that trainees’ salaries have decreased, this differential, although welcome, is looking a bit expensive. A Foundation Trust could easily offer a hospital
specialist post for £60,000 pa that included, for instance, eight half-day lists a week. Two years ago, no recent CCT awardee in their right mind would accept such a job. In the coming months, if the choice becomes this sort of position or unemployment, it would be eminently reasonable for someone very much in their right mind to take up such a post. Political and workforce changes have therefore created a situation in which the introduction of a sub-consultant grade is very likely or perhaps even inevitable. If this happens without the involvement of the AAGBI and the RCoA, such posts will be created piecemeal by healthcare providers, whether Foundation Trusts, ISTCs or private hospitals. Some of them will be awarded to properly trained individuals and will provide good terms and conditions, with ample opportunities for the post-holders to acquire sufficient continuing medical education to provide effective and safe care for their patients. Others will not. This is exactly why the AAGBI and the RCoA should act now to make sure that the position of Hospital Specialist in Anaesthesia (let’s abbreviate this to HSA) is a job worth having, a job with prospects and a job with reasonable pay, a good pension and good terms and conditions.

Surely such posts will be undesirable and very much a second choice taken only by doctors whose qualifications or experience are not quite up to scratch? This is not necessarily so. If the posts were structured so that people could work as many or as few sessions as they chose, and if the jobs were not seen as a dead-end in career terms, they might prove to be very appealing indeed. Let us say that consultants devote 2.5 or more SPAs per week to teaching, research, management and continuing professional development (CPD), whereas HSAs are allocated 1.0 SPA per week solely for CPD. The burden of performing such roles as College Tutor, Programme Director and Clinical Director would be shouldered by consultants, leaving the HSAs to focus primarily on clinical work, working anything from two sessions per week to a full-time eight sessions. This would allow tremendous flexibility to anaesthetists who wish to use a proportion of their working week doing things other than NHS work. Although this sort of job plan may well suit women with children, it would also suit men with children and anyone who has other activities in their lives that require weekday time.

Another group who may well benefit from such posts would be those who wish to indulge in the private sector while maintaining a link with the NHS. We all know consultants, mainly working in the major conurbations and certainly a small minority on a national basis, who do their six lists per week but contribute little to the department in terms of teaching and management, preferring to spend their “non-clinical” weekday sessions in the private sector. Why not offer these anaesthetists the opportunity to work in this way without guilt and without accusations that they are not pulling their weight? If the post of HSA carried with it the right to conduct independent practice, it may well suit this group of anaesthetists.

The HSA post could also be developed into one that is a logical staging post on the road to full consultancy, occupied by trained anaesthetists who wish to develop their clinical skills further in subspecialties that need time and expertise to practise fully independently. Should someone who has fulfilled basic training to CCT be allowed to practise paediatric cardiac anaesthesia immediately on appointment to a consultant post, or should a period as an HSA in a specialist unit be a routine precursor to application for such a post? As the role of consultant becomes more specialised and the nature of specialist training is perhaps downgraded by time constraints, the need to prepare people for consultancy with periods of training beyond CCT will increase. In the past, this need was fulfilled by the Senior Registrar grade. For many people at present, such additional training is acquired in Locum Consultant or Fellowship posts. Would it not be better acquired in substantive posts with some sort of job security that can be paid a reasonable wage?

Another question that drives my argument in favour of HSAs is: what is a consultant for? The increase in consultant numbers to provide the service left uncovered by the decrease in trainee hours and the overall expansion of surgical services means that some consultants are doing six clinically undemanding theatre lists per week. Is this really the work of a consultant? Surely consultants should be involved in complex clinical work, supervision, teaching and management. They should plan and develop service provision, set the conditions under which anaesthetic care is delivered and drive clinical governance and audit. They should not devote their time mostly or solely to straightforward clinical tasks; this is arguably a waste of money and of their skills. These simpler tasks could readily be performed by clinicians who are supervised by the consultants. HSAs could work within boundaries laid down by consultants while taking individual responsibility for those cases treated within those boundaries. They could thus retain the role of independent practitioner while working within a structured environment. The situation with regard to on-call work would have to be considered, and it is likely that an on-call HSA would have to have immediate access to the advice of a consultant out-of-hours.

Many Departments of Anaesthesia are finding that their SPA allocation is coming under considerable pressure from management. I know of many who have been obliged to decrease SPAs for all consultants from 2.5 per week down to 2.0 or even less. The global and national financial situation means that there will be less money for the NHS in the next few years and the Government will demand greater efficiency from the resources already committed – this can only mean a relative freeze on pay increases and even greater pressure on SPA time for consultants. If we do not create the HSA grade, we may be taking the risk that the pay and work patterns of all consultants will be downgraded. Put simply, if we do not support the creation of HSAs, we may all become HSAs. Departments certainly need people wholly committed to clinical work, but patients will suffer if a large proportion of consultants do not continue to make significant contributions to the hugely important non-clinical work that underpins safe patient care.

Although I hope that I am being pragmatic, I accept that some of the above may represent a utopian view of what HSA posts could become, and that the reality may be different. Perhaps the department of the future will comprise a small number of highly trained and well-rewarded consultant anaesthetists who supervise and manage a larger number of HSAs who do the bulk of the clinical work? This is a form of the
“European Model” that many dislike, but there may be sense in it not only from the employers’ point of view but also from the profession’s point of view. I must stress that it is important that anaesthesia is not alone in developing some form of sub-consultant grade. If hospital specialists are to be developed as a separate grade, this should be done with the support of the Academy of Medical Royal Colleges, and I could not foresee its development without similar, simultaneous moves in surgery, medicine and other medical disciplines.

Change is inevitable; the status quo is no longer an option. The introduction by Foundation Trusts of a sub-consultant grade is arguably inevitable. If our specialty leaders hide their heads in the sand, they lose the opportunity to influence the creation of these posts and to make these jobs worth having. Although they risk opprobrium from members of our specialty by becoming involved in the development of the qualifications, terms and conditions in order to make sure that these jobs are good jobs, I think that they will be doing the right thing for the specialty of anaesthesia in the long run. The AAGBI took a risk by supporting Anaesthesia Practitioners when few of its members agreed with this approach. I think that time has proved that this decision was correct. I think that the AAGBI should consider taking the same bold view of HSAs in the long-term interest of the specialty.

The author is a working Consultant Anaesthetist who has asked to remain anonymous.

Iain Wilson
Consultant anaesthetist, Exeter

When the NHS was formed in 1948 senior anaesthetists worked hard to ensure that anaesthesia specialists would take their rightful place alongside other consultant medical staff. This was not a foregone conclusion – in many countries anaesthesia was developing using nurse anaesthetists and the role of doctors in anaesthesia, and their seniority within hospitals, was under debate. This has still not been resolved satisfactorily in some countries.

There are currently three grades of senior doctor in the NHS: Consultants, Staff and Associate Specialists, and more recently post CCT Fellows undertaking 6-12 months of advanced training in a specialised area before applying for a consultant post.

Why do we need a new grade – the permanent sub-consultant? The perceived reason is that anaesthetic departments are top heavy with consultants (too many chiefs), many of the jobs can be done by trainees (why do we need consultants), out-of-hours work needs covering by trained staff (but not necessarily consultants) and the trainees are not ready to take on consultant responsibility when they finish training.

Of course these arguments can be made for most specialties, but anaesthesia is particularly vulnerable because of our numbers and the amount of work performed by trainees, especially out-of-hours.

The NHS, as with any other public service, has to employ a balanced and appropriate workforce ensuring safe and good quality care for patients and value for public money. Given the state of public finances, the next few years could prove tough. Any new grade is likely to be introduced without a national contract in the fast-developing spread of Foundation Trusts, and would need to deliver a series of benefits to Trusts to be of use. From the Trusts’ point of view, the grade should be cheaper to employ, easier to utilise out-of-hours on antisocial rotas and provide an opportunity to limit career options for the future by drastically limiting the number of consultant positions. No national terms and conditions to fight over. Why would the post need SPAs? Would existing consultants support this development? Some would - fewer consultants, more exclusivity, a greater share of private practice, fewer night calls with highly skilled staff in the hospital – lots of plus points.

However, would trainees still be attracted to a specialty with little chance of a consultant position? No, our reputation would fall precipitously, precisely into the abyss that our seniors worked us away from 61 years ago. We need to be very careful – the fact that the debate is even happening reflects that Trusts are considering this option. The long-term consequences for anaesthesia as a profession could be very significant.

Consultants are the appropriate senior grade. Most trainees aspire to the position and deserve it when they get there – autonomous clinical practice in well-run NHS departments. The existing alternative, the SAS grade, already contains many well-regarded and expert colleagues who either do not wish a consultant career or have taken a different direction. If there are issues with training and the EWTD, then post CCT fellowships are the way forward – time-limited focussed training posts with a service commitment, but not a permanent grade.

Whenever I have observed colleagues needing to undergo medical investigation or treatment, not only do they go straight to a consultant (or senior SAS doctor), they are often very selective about which one to consult. This is because we all expect to be managed by a senior doctor, trained and assessed to provide specialist care, leading a multidisciplinary team. This is the consultant grade. If this is what we expect, then so should our patients.

Sub-consultant grade – no thanks. It is illogical and will not serve the NHS.

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Members of the Anaesthesia Detail Club (ADC) have recently submitted their new checklist that they say should replace the Sign In section of the WHO checklist. This is reproduced below and their President Dr OCD Twitching is keen for any feedback before he approaches WHO on behalf of his detailed colleagues. “The WHO Sign In is wholly inadequate. No detail and no signatures! We need to get it right, even if it slows the theatres down. Safety should be our first and last concern!!”

Informally the National Patient Safety Executive have welcomed these suggestions and are looking into training requirements to develop this new work. “Just fab!” was the reaction of Ms Joy Fulbutifik, the national checklist champion.

Dr Isle Killim the Clinical Director of the Trust where Dr Twitching carried out his first trials was less certain of the advantages and after careful consideration by the Editor of Anaesthesia News her comments have not been included.
Current Controversies in Anaesthesia and Peri-Operative Medicine

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