Private practice – does it pay?

History resource – the John Snow archive

Safer connectors – data collection announcement
2011 ULTRASOUND TRAINING COURSES

Introduction to Ultrasound Guided Regional Anaesthesia

2011 Course Dates:
- Introductory Ultrasound Guided Regional Anaesthesia
  - 4–5 July
  - 3–4 October
  - 21–22 November

Ultrasound Guided Venous Access
- 9 June
- 13 October
- 10 November

Ultrasound Guided Chronic Pain Management
- 21 September
- 28 November

Venue: SonoSite Education Centre – Hitchin

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

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

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

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

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

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

WORLD LEADER AND SPECIALIST IN HAND-CARRIED ULTRASOUND

For further information and to register logon to
www.sonositeeducation.co.uk
Editorial

In praise of protocols

A few weeks ago I organised a core topics meeting in Newcastle, and an interesting common theme emerged from a number of apparently unrelated talks. In essence, the message was ‘protocols work’. It does not even seem to matter whether the individual elements of care in a protocol work – leading to much confusion when trying to interpret the results of clinical trials. I guess we are entering the twilight zone for ‘clinical freedom’ – about which there was much rhetoric and bluster in the not-so-distant past, but I can’t recall hearing it mentioned lately.

It is no coincidence then that I am busy revising parts of our delivery suite guidelines. This is another change in the firmament – ‘guidelines’ used to be something you could follow if you felt it was appropriate, but if you were an experienced clinician you could feel free to do what you felt was best. On the other hand, protocols were things you did have to stick to. Nowadays, all this has changed. Our delivery suite guidelines are written on a tablet of stone, and adherence to the letter is rigorously audited. Any semantic difference between a guideline, a standard and protocol seems to have blurred in practice. This is not universal of course – the Scottish Guideline Network has produced some very useful guidelines, which it explicitly states are not standards. We in the AAGBI produce many guidelines. These are often referred to as National standards for the purpose of local guideline development and audit.

I have spent some time recently reading the NAP4 report, to which I made a small and ignominious personal contribution. I anaesthetised one of the cases reported therein. Many of the elements of disaster which are eloquently dissected in the report were present in my case. I was working with a surgeon I don’t know. I knew that my patient (who had had radiotherapy to the neck in infancy – about seventy years ago, leaving him with a hypoplastic jaw and neck, and ‘woody’ tissues in the neck, jaw and pharynx) was impossible to intubate conventionally, and that he had previously (relatively recently) been intubated fibreoptically with enormous difficulty, due to a combination of the lack of space in the posterior pharynx, the abnormal position of the larynx, and the general lack of mobility of any of these structures. On that occasion, anaesthesia had been induced prior to intubation, and his airway had been described as easy. Anaesthesia and oxygenation had been easily maintained during the 90 minutes or so it had taken to achieve intubation. The proposed plastic surgery was fairly minor – extension of an excision of a skin cancer on the scalp and then creation of a small flap to cover this. The surgeon estimated the operative time at 20 minutes. I couldn’t think of a local anesthetic block which would cover the area required adequately (in retrospect, thinking harder about that, and phoning a regional friend, would have been a good idea). My plan, such as it was, was to ‘keep things simple’. I was not entirely happy with this plan, and discussed it with a colleague who is a regular ‘head
and neck’ anaesthetist. I didn’t plan to intubate the patient at all. I thought I would use a supraglottic airway as plan A, and a simple face-mask as plan B. That was as far as my planning went, though I did have the difficult airway equipment (we keep ours on a trolley), fibreoptic scope, etc available and checked. We don’t have a videolaryngoscope. I enlisted the help of a very senior trainee, with better fibreoptic intubation skills than me.

I induced anaesthesia with sevoflurane, and the airway was indeed excellent. I then spent a happy half an hour trying to get a decent airway with the variety of SADs we have on offer. I couldn’t (predictably enough, in retrospect) get any of them to sit properly – most wouldn’t fit behind the tongue at all. In fact, a small conventional LMA provided the best fit. It leaked like a drain with positive pressure, but he breathed through it pretty well. I decided that I had spent enough time fiddling and that this was acceptable, if not ideal. The surgery proceeded. All seemed well for 20 minutes or so, except that (surprise, surprise) the surgery was more tedious than anticipated.

Then, suddenly, I was off my seat before my brain had time to catch up. The patient had made a small movement, and the reservoir bag stopped moving, though he was still making respiratory movements. I could not ventilate the patient at all. On unpeeling the drapes, I had a nanosecond of incomprehension prior to the horrible realization that the stuff that looked like dog food filling the circuit up to the humidifier was in fact vomit. I removed the LMA, (following which the patient immediately carried on breathing with a patent airway) cleaned up the pharynx (a Yankauer suction was not quite up to the job), applied the face mask and informed the surgeon (who was looking pretty impressed as you can imagine) that the surgery was finished for today. We turned the patient into the lateral position, and he recovered unscathed.

So, I made some of the common errors which are described in NAP4 – inadequate assessment (no imaging) and inadequate planning/preparation primarily I think. The authors make a large number of recommendations, but the use of what Martin Bromily refers to in his introduction as ‘standardised processes’ features quite prominently in these; so I guess it doesn’t matter what you call them – guidelines, protocols, standards – they are here for good.
Photography Competition

We are delighted to congratulate Dr Peter Isherwood, whose winning entry in our photo competition graces this month’s front cover. It was a difficult job deciding which entry should win, and we commiserate with and thank all those others who have submitted entries. The current drought (at the time of writing - in early May - fires are raging on heathland in Scotland and Northern Ireland) may have subtly influenced the judges’ choice...

Dr Isherwood currently works for Brighton and Sussex University Hospitals NHS Trust and is an SpR/ST7 Dual CCT Trainee in Anaesthesia and Intensive Care Medicine. He is also the lucky recipient of the prize for a front cover winner: £100 in Amazon vouchers.

Keep sending us the photo competition entries!

Val Bythell

Description: Water droplet falling into small pool. The image was taken in the kitchen with a Canon EOS 30D, 100mm macro lens. Setting f18 at 1/200, side flash with a real reflector.

Anaesthesia News has received some excellent photographs in response to our call for images for the front cover; so much so that we have decided to run a competition for six months from June to November 2011. A prize of £100 worth of Amazon™ vouchers will be awarded each month (from June to November 2011) to the winning entry.

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

Compression Rules:
1) All submissions must be in a digital format and entrants own work.
2) A maximum of 1 image is allowed per entrant throughout the entire competition.
3) Entries from all countries are allowed.
4) Digital images to be submitted in JPEG format, high resolution - good enough to be printed in A4 size.
5) All emails to be labelled with TITLE/DATE TAKEN/PHOTOGRAPHER NAME/SHORT DESCRIPTION.
6) All submitted images must be emailed to anaenews.editor@aagbi.org and titled PHOTO COMP ENTRY.
7) Image refining via the usual adjustment, levels, lighting etc is acceptable. However major manipulation is NOT allowed.
8) Winners will be notified by email.
9) All images retain author copyright and will not be passed on to third parties without prior agreement with author.
10) All queries to be made via email at anaenews.editor@aagbi.org and titled PHOTO COMP QUERY.
11) MODEL RELEASE - Any photographic competition entries that contain identifiable people/faces/features must have a signed letter (by the model) or model release agreeing to be featured on the front cover of Anaesthesia News magazine - should the photo be a competition winner.
12) The editors decision is final.
The BMA holds a one-day Private Practice Conference every year at its headquarters in London. The meeting starts with a morning of plenary lectures after which the delegates are split into two streams in the afternoon to accommodate the differing interests of hospital doctors and general practitioners. The topics covered were varied but had one main theme: money - how to earn it, keep it and save it. Having said that, the conference does not have a purely mercenary feel – most private practice in the UK is conducted by doctors who work for the NHS, and there is an increasing sense that the dividing lines between the NHS and independent practice are blurring and will become increasingly blurred, and that care quality standards set in the public sector must be carried through to the private sector, and vice versa.

Private Practice Committee Chair Derek Machin, an Aintree urologist when he is not a medico-politician, presented some preliminary results of the BMA’s annual survey of consultants. The results were interesting if not surprising. The proportion of consultants reporting private practice earnings has decreased to 59%. Of those consultants who do private practice, 45% reported that their income has decreased in the last year; it has stayed the same for 40%, with only 15% reported an increase. The proportion of consultants earning <£10,000 per year has decreased to 23% while the proportion earning >£100,000 has increased to 17%. These data seem to support the view that the private practice market has seen a slight decrease as a result of the financial crisis, and that those with low earnings are increasingly deciding that it is not worth the associated additional commitments in terms of time and cost. When consultants were asked to rate their experience of Private Medical Insurers (PMIs), there was one outstanding winner and one clear loser: Western Provident Association (WPA) was the former and AXA PPP the latter. Fifty per cent of consultants responding to the survey had been challenged by a PMI about their fees; 11% had been threatened with derecognition by a PMI. It seems that financial pressure on the PMIs in general is increasing, and that some of this pressure is being passed on to consultants.

The challenges in dealing with PMIs are matched by the challenges being posed by changes in NHS pensions. The BMA’s Head of Pensions, Andy Blake, gave his terse and rather depressing analysis of the recent Hutton recommendations for public sector pensions. The headlines were these: we will be paying more for our pensions in the future – up to 15% of our gross salary under the current plans; the “final salary” pension will be replaced by something called CARE – career-average revalued earnings; any significant changes are likely to start in April 2015. It will come as no surprise that CARE-based pensions will on the whole be smaller than their “final-salary” predecessors. They are arguably a particular disadvantage to anaesthetists, who get smaller ACCEA awards later in their career than other specialties. The only glimmer of joy was for those of us who are older than 51 now – the change date of 2015 will see us aged 55 years or more and therefore able to take our pension out of the NHS on the “old” basis. This is the first time I have felt happy to be old. Notwithstanding the relief felt by the elderly members of the audience, there was a strong feeling that the BMA should continue to fight hard on behalf of those entering the profession and starting out as doctors. Mr Blake assured us that the BMA would do everything it could to protect the interests of its members and the profession. Who knows whether smaller pensions will create problems in recruiting and retaining the best people for the NHS?

A talk from Western Provident Association’s (WPA) Chief Executive of 23 years, Julian Stainton, was a breath of fresh air. He talked about his organisation – arguably one of the last true Provident Associations in existence – and set out its views of the private insurance market. WPA processes 3,000 claims per year but has only had two complaints from its customers in the last 15 years – and, according to Mr Stainton, in WPA’s view this is two too many. It supports direct GP referrals to consultants, does not support “open” or unnamed referrals, and recognises any consultant whose name is on the appropriate GMC Specialist Register and who holds a relevant specialist qualification. There were nods of support throughout the audience – the stark contrast
between WPA’s principles and practices, and those of other PMIs was evident. WPA’s benefit levels are such that the vast majority of consultants who treat its customers are happy to bill within its benefit maxima – its incidence of “shortfalls” is just 0.6%. One phrase sticks in my mind from Mr Stainton’s talk – WPA aims to provide a service to its customers for their whole life – a period he described as being “from sperm to worm”. Not a pleasant phrase perhaps, but a colourful one.

Professor Laurence Kirwan is an aesthetic plastic surgeon who hails from Liverpool but who practises in Connecticut, New York and London. This rather peculiar practice gives him a unique overview of the difference between the regulation of cosmetic surgery in the US and the UK. His message was that the regulation of plastic surgery in the UK is not as good as it could be. His talk generated the one true moment of mirth in an often very serious day. Although it is ungenerous to highlight typographical errors in an invited speaker’s presentation, his one mistake was a cracker. In extolling the virtues of the American Society of Aesthetic Plastic Surgeons’ (ASAPS) website, he quoted the home page, which explained that if you chose to be treated by a member of the ASAPS, you would be choosing a surgeon who has undergone “at least six years’ training and has at least three ears”. Visions of botched plastic surgical procedures leaving an extra ear in the middle of one’s forehead sprang to mind and placed me as chair of the session in the embarrassing position of corpsing during a lecture. The slide should have said “with at least three years” – the next line reading “training in plastic surgery”. I could not help giggling more as I recalled a childhood joke:

Question: How many ears does Davy Crockett have?
Answer: Three: left ear, right ear and wild front ear.

As in “Wild Frontier” you have to be over 45 years old to understand that one...

All in all, it was an interesting and informative day that was well worth attending. Keep an eye on the BMA website for details of next year’s conference.

Will Harrop-Griffiths
AAGBI Vice President and Deputy Chair of the BMA’s Private Practice Committee
The emergency repatriation of critically injured military personnel requires dedicated, highly trained medical teams with the ability to treat and transport patients from the site of injury, often in dangerous, austere environments, to the relative safety of Birmingham hospital. A casualty wounded in Afghanistan can be returned to Britain following damage control resuscitation and surgery, and be ready for further surgery within 36 hours.

Last year RAF Critical Care Air Support Teams (CCASTs) evacuated around 130 critically injured personnel. There has been no in-flight loss of life in all of the flights from Op Herrick in Afghanistan, despite an average New Injury Severity Score (NISS) of 35.3 (Range: 4-75) and transfer times of up to 15 hours.

The Medical Emergency Response Team (MERT), a Chinook helicopter carrying a doctor-led pre-hospital care team, performs the initial evacuation and resuscitation of casualties from the front line. The team carries out immediate life saving interventions in the pre-hospital environment on the back of a helicopter, flying them to the Role 3 hospital in Camp Bastion, Afghanistan, where emergency damage control resuscitation and surgery is performed. During initial treatment in the resus bay, the RAF AELO (Aeromedical Evacuation Liaison Nurse) gathers patient details, injury pattern and clinical observations and sends the information to the to the UK immediately. Initial signals are received by the AECC (Aeromedical Evacuation Control Centre) at RAF Brize Norton, AE Squadron Ops and Tactical Medical Wing (TMW) RAF Lyneham soon after the patient’s arrival in Camp Bastion, so that repatriation planning can begin.

TMW provides both the tactical (within Afghanistan) and strategic (international flights) Deployable Aeromedical Response Teams (DARTS) and Aeromedical Evacuation (AE) Teams, which make evacuation of casualties possible.

I don’t remember much, I don’t remember why we were there or exactly where we were, but I remember the explosion, this ‘BOOM’, a wave, washing over me and picking me up, before discarding me back down just as fast. And then, there I was, flat on my back, with my ears ringing like I’d been in a night club next to the speaker for two days straight. There was no colour, just dust. Like a fog around me. There was pain, definitely pain, and then Smudge was there, saying something - I couldn’t hear him but his lips were moving. He was covered in dust. These two eyes, like wet jelly, the rest just dust. I felt pain then, real pain, but it was like it wasn’t me feeling it, though I know I was. It must have been the tourniquet. I remember the bouncing; bouncing up and down rolling side to side on my stretcher with the sky above blue and clear. Nothing there but clear blue and throb-"boim pain. The dust came back in then. Trying to breathe and all there is is dust, and Smudge on top of me, his hand over my face and eyes telling me that MERT are here. And the bouncing starting again and the sky is there, blue… clear. I look up and someone is talking to me - I can hear something too… Rotor blades? And the ground is vibrating. The face looks kind. She says something and I feel a pressure over my chest. A hard pushing feeling like I’m being squashed and then it is released. I can breathe again. And sleep washes over me. The pain is gone.

There are two CCASTs immediately ready for duty: one can transport the patient, or patients, within theatre (tactical) and the other (strategic) is resident at RAF Lyneham and available for worldwide deployment.

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1The commentary is fictional, but is based on experiences recounted by injured military personnel in Afghanistan.
intensive care patient repatriation. In addition, there is a ‘second on call’ CCAST that travels to Lyneham once the ‘first-on team’ is activated, in case it is needed for any further missions. The strategic team consists of two intensive care flight nurses, an anaesthetic consultant, an anaesthetic trainee, a technician to maintain medical equipment and a flight nursing assistant. Once activated, the strategic team selects the equipment and drugs likely to be needed for the expected casualty; these are contained within pre-defined and set up modules. ‘Extras’ are also uplifted in case additional patients are identified for repatriation while the team is airborne. Clinical update signals are received to report more accurately on injuries sustained by the casualties, investigation results received and any on-going surgery which occurs, so that further planning for repatriation can be made. For time-critical missions it is possible to recruit a ‘spec’ C-17 Globemaster transport aircraft. A typical time line can be seen in Figure 1.

I can feel someone is there. Slow soft strokes of a sponge. I’m being cleaned and it feels wonderful. A straw is in my mouth and as I start to suck I feel the cold water flood over my chest. I remember the pain, the excruciating throbbing, I am scared to move in case it comes back but I must twist slightly... nothing. No pain. Have I broken my back? Why can’t I feel my legs? “It’s the epidural,” a kind voice says. What? Like what women with babies get? Wow! No pain.

I am moving again. The sky is replaced by lights - one, two, three, four… I count as I move down what must be the hospital corridor. Am I home? Where are my family? A head appears over me. I look down and see a bar code across his chest - The RAF! “We’re taking you home”, they tell me and I fall asleep.

It’s not long before I am awake and being lifted into the back of a vehicle. I can feel the throbbing start again as the vehicle starts its engine and we are on the move. As we come to a halt this stabbing pain shoots through me. Like I’ve just stood on the world’s largest drawing pin. The head appears again “Pain?” Yes, you could say that. I see him fumbling around somewhere, fiddling with something; he’s got a syringe in his hand and one in his pocket. Never mind what they are - it’s doesn’t matter the pain is gone and that’s what matters.
The vehicle stops. I brace myself for the pain to start again as I am lifted onto another trolley - but it doesn’t. Thank you, my barcode man. Up a ramp and into a vast open space... tucked up and cozy. Wrapped in a heating blanket. The head arrives and smiles. How is the pain? Can you cough for me? He explains that I'm going home...

But what about the guys? I left them there?

Training for flights falls into four main areas.

1. Aeromedical evacuation training: this course involves training for the nurses on aeromedical repatriation. The team leader is taken from the nursing cadre and will be the point of contact for all other teams involved, such as flight and ground crews.

2. AEMO: this is the Aeromedical Evacuation Medical Officers’ course for doctors involved in aeromedical repatriation.

3. Operational training: this develops our skills and knowledge for operational deployment so that we can function as part of a team in a variety of situations. It involves navigation, field living and operational procedures.

4. CCAST(E): initially, this is a two week...
equipment course followed by regular refreshers. It teaches all CCAST members about the medical equipment used for missions and also includes necessary transfer of adult ICU patients using this equipment.

The CCAST also has additional capabilities in haemofiltration, air transportable isolator, tactical paediatric retrieval and in the future, will be trained to provide in-flight ECMO. Doctors also undertake training in trade-specific specialties at NHS base hospitals when they are not on call. In addition, they attend aviation medical theory courses during their career and can gain the diploma in aviation medicine.

During the flight I peek across. There is another soldier there. He’s tucked up like me, but he’s not awake. There’s a tube in his throat and a machine helping him breathe. The head is next to him pressing buttons, putting his hands on his chest. Suppose his listening tubes aren’t much good in here, it’s so loud. The monitors around the soldier start flashing and I can hear an incessant beeping. A woman rushes over and the head starts giving out instructions. They’re taking blood samples and putting them into a machine near the bed. She hands the result to the head who picks up a cool-box and pulls out a bag of red liquid and hands another to the woman. They work together hanging tubes around the soldier as he keeps sleeping, alarms going off around him. The bags slowly empty into the soldier, it must be blood I suppose, and the syringes keep pumping things into him, keeping him asleep. The alarms stop beeping and I slowly drift off again.

I can smell food - it’s not the monotonous ‘boil in a bag’ stuff I’ve eaten for the past two months - this smells amazing. But I feel slightly sick.

A CCAST mission requires meticulous planning as one vital piece of equipment left behind could be disastrous. For want of a nail... the kingdom was lost. Much like the shorter inter-hospital transfers that we all perform, equipment is selected,
All injured intensive care patients receive a patient journey log to explain what has happened whilst sedated by the doctors and nurses looking after them. Their friends who come to visit also add comments.
With recent changes to the NHS pension scheme, the revised lifetime pension allowance becoming £1.5 million and the Hutton review of public sector pensions reporting in the near future, these are troubling and confusing times for NHS employees. The AAGBI is responding to requests from its members by giving them access to professional advice on how best to plan retirement, maximise pension payments, negotiate post-retirement contracts with employers, and simplify overall financial planning.

AAGBI Honorary Treasurer Dr Ian Johnston says: “The AAGBI is not a Financial Services Adviser and cannot therefore offer advice directly to its members, so we have teamed up with Cavendish Medical, a company with an excellent track record and specialist knowledge of NHS pensions and financial planning for doctors”.

The Seminars will commence in September this year. Rather than starting in the morning, the seminars will start at 2.00pm and run until about 6.00pm to allow members to take advantage of cheaper travel options. A series of live Webinars is being planned and would start at 6.30pm and run for about an hour. Education Committee Chairman Dr Richard Griffiths says: “We are very excited about the idea of Financial Webinars. Members will be able to access them on-line and there will be a live phone-in at the end of the Webinar to allow members to ask questions of the experts from Cavendish”.

If you are interested in attending one of the NHS Pension and Financial Planning Seminars or would like to access one of the Webinars, keep an eye on future @ AAGBI e-Newsletters and the AAGBI’s website for details: www.aagbi.org

If you have questions about AAGBI Seminars and Meetings, please email seminars@aagbi.org.
Imagine a world where everyone has the same goal and where everyone works with enthusiasm to achieve it. A chance for anyone to see the world from a different angle. This is what it feels like sailing with the Jubilee Sailing Trust - a charity running adventure holidays on two tall ships which have been adapted to allow able-bodied and disabled people to sail together. These voyage around the UK, Europe, the Canaries and to the Caribbean. Each trip usually takes between 5 and 10 days, making it accessible for everyone. I think it is fantastic and have been 10 times over the last 10 years!

From your arrival you are swept up into the mix of 40 people of varying experience and abilities to get involved in all aspects of running the ship under the guidance of the permanent crew. From cooking to cleaning, to 4 hour shifts day and night as a group (watch) when you get to steer (helm), undertake lookout and see the navigation. Everyone learns to haul the ropes, move the yards, unfurl the sails and get involved with manoeuvring the ship. It’s not about ‘letting the disabled sail’, but about living, working, learning and achieving together.

You don’t have to climb up into the rigging if you don’t want to, but being up in the rigging is one of my favourite places. On every trip I love the chance to see those who are nervous or unsteady helped to climb. They can be overwhelmed by the achievement and an inspiration to the rest of us. When bilateral amputees climb, it really makes you think that anything is possible. It’s also wonderful to see a team of people help haul a wheelchair user to the platform to allow them to enjoy what the rest of us might take for granted and gives you a new faith in the human spirit. When a blind man climbing competently around in the rigging points out that ‘you don’t look at your feet much either’ it makes you realise perhaps you should be mindful of your own prejudices.

It’s not just about the sailing, you meet a huge variety of people from all walks of life. Conversation fills the deck; friendships are forged and new relationships blossom. On the first day people are often heard to ask ‘What do you do in real life?’. And it does feel like another world, a place where life is lived with a ‘Can do’ attitude. The inevitable enthusiasm for life overflows into the social side with evenings in the bar, games and songs. I’ve been to many impromptu pirate party. The ship usually stops every couple of days giving us a chance to disembark with new places to explore.

"Sailing with Jubilee Sailing Trust is a fantastic experience that always leaves me on a high, bringing a ‘can do’ attitude back to normal life. I would recommend it to anyone whatever their age or profession. Ship’s doctor gets a half price trip"

See www.jst.org.uk for more information.

Having never sailed before my first voyage in 2000, when I nervously thought it might be an interesting way to fill a university holiday, I can reassure you that anyone can do this. I can honestly say the experience has changed my life. Through friends made on board, I met my husband and I believe it has significantly improved my confidence, as I was a very shy teenager. On every trip I see changes in people and have little doubt there is something for everyone.

People are paired with a buddy on arrival (one able bodied and one disabled although those needing a carer usually bring someone they know). On my first trip my buddy was a 17 year old girl with cerebral palsy and it was amazing to see how she changed being out of her ‘wrapped in cotton wool’ home environment. She proved just how much she could do.

JST try to have a doctor on each voyage, who is also a regular member of the crew and joins in with everything from the sailing side. There is a trained nurse as part of the permanent crew who is the first port of call for people with medical problems, so you may get through the trip without needing to do anything medical. The likely medical experience is minor or major trauma or acute medical problems. Despite working in a restricted environment, the resources are not as limited as they might be in other remote places. There is space to treat people and a good supply of medications. It is also worth knowing that doctors get a half price trip, and JST are often trying to recruit doctors.

Dr Susan Hayward, ST3 Anaesthetics, Royal Bournemouth and Poole Hospitals
The Development and Organisation of the John Snow Archive and Research Companion Website

by Peter Vinten-Johansen

The John Snow Archive and Research Companion was originally conceived solely as a complement to our book Cholera, Chloroform, and the Science of Medicine: A Life of John Snow, which was published, after some ten years of effort, in 2003. The intention was to set up a website that would provide ‘searchable transcripts of John Snow’s writings (eventually all of them), samples of the word analysis and chronology comparisons used in our research, as well as additional maps and images [1]. The Department of Epidemiology at Michigan State University (MSU) had promised us (the co-authors) space on its server for a site limited in size and scope largely to what is now listed under the heading ‘Online Companion’ within the current website. I agreed to manage the site, but as I was on sabbatical leave when the book was published, one of the co-authors, Howard Brody, led the development of the prototype. This was hosted by the Department of Epidemiology, and one of our medical students, Karl Meisel, transcribed some of Snow’s writings in addition to what I had already done to facilitate the writing of the biography. While on leave I had given much thought to the development of the site, and when I returned to the MSU campus I took stock of what was already accomplished, mentally added what I had dreamed of while away, and realised that my vision required much more server space and person-hours than Epidemiology had agreed to take on. An approach to the leadership of the Center for Humane Arts, Letters, and Social Sciences Online at MSU (MATRIX) brought agreement to host an expanded and revamped website. The following two years were spent in redesigning the John Snow Archive and Research Companion, editing existing content and adding more, so that it gradually developed into an online archive of writings by and about John Snow and his contemporaries. The site was then converted to KORA, so that I could manage it directly from any computer with an internet connection.

Visit http://johnsnow.matrix.msu.edu/index.php to view the Home Page. Down the left hand side of the screen the reader will find a list of choices, the first three of which constitute the Archive portion of the website. About John Snow has a brief biography; then follows the nub of the site, Snow’s Works. Currently this provides searchable text of all Snow’s published writings, some selected presentations, and comments at medical society meetings, listed in two modes, chronological and topical. Under the chronological option Snow’s publications (a complete bibliography), presentations, and comments are individually indexed; under the topical option they are collated under subject headings, so that, for example, clicking on Topical, then on the subhead Anaesthesia and Respiratory Medicine, one may follow Snow’s thinking by clicking on individual titles, from his earliest letters to the editor about arsenic and asphyxia on to the ether year, 1847, and thereafter. Both options lead to full transcriptions, many have links to PDFs of the originals. Eventually I will scan and post PDFs for all items. Snow’s Contemporaries lists and links to relevant contemporaneous publications, official pronouncements, reviews, and the writings of contemporaries, such as Benjamin Ward Richardson and the Reverend Henry Whitehead.

The Research Companion portion of the site begins with an Online Companion to the book itself, Cholera, Chloroform, and the Science of Medicine. It has links to its bibliography, all illustrations and maps that appear in the book, a list of reviews, and the Research Schema, of which more later. Interpretive Studies is designed for old and new scholarship. At present it lists and provides links to a selection of publications about Snow, which will be added to in time. Eventually it will contain PDFs of significant scholarly articles and papers on the topics treated within this website. I am open to suggestions for old scholarly items to post, but I am especially keen on receiving new scholarship. One of the major advantages of internet postings for an author is that space limitation is a non issue. The site already contains examples of reviews and papers before they were editorially trimmed or, in the case of David Zuck’s and my paper on Snow’s anus mirabilis, withdrawn by us from publication elsewhere because the requested truncation would have made a hash of it. Bibliography contains a miscellany of reviews of, and extracts from, books about Snow and his contemporaries. Other Websites and About this Site are self-explanatory. The final heading is the Document Search function. Keywords yields a comprehensive list of titles, not just those in Snow’s Works, but everything that
has been transcribed in Snow’s Contemporaries (admittedly still woefully in need of more material on anaesthesia) as well as titles and content fields (listed as Study Detail) in Interpretive Studies and Bibliography.

Researchers into the history of anaesthesia should consider consulting the Online Companion/Research Schemas mentioned above. They may find that I located something of interest to them while researching the Snow biography. All the word-analysis schemas deal with cholera, but I created tracking files of medical journal references to Snow’s presentations and comments which are more extensive than actual postings in those two categories currently in Snow’s Works. As with PDFs of Snow’s published writings, I periodically scan and post new items, add them to the queue of MATRIX staff for transcribing, which are then edited by me. Chronologies for 1847 and 1848 provide titles of all medical journal entries of relevance to anaesthesia that I found while researching the Snow biography; please keep in mind that these schemas have not been updated since 2002/03.

Programmers at MATRIX are currently adding a new section entitled Ether Chronicles to Snow’s Contemporaries, in which I will post PDFs of all relevant London medical journal articles I have collected over the years; transcriptions will accompany many PDFs, which means that their contents, not just the titles, will be accessible via the Document Search function. In addition, the programmers are incorporating About John Snow into KORA so that I can post documents and images of a biographical nature. When these features go live, I would appreciate comments and suggestions for additional materials. The names of those who contribute to the correction or addition of any document will be noted at the top of the relevant file.

Reference


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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 Sheer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005, Dr Martin Coates (Plymouth) in 2006, Dr Gareth Charlton (Southampton) in 2007, Dr Neville Robinson (London) in 2008, Dr Fred Roberts (Exeter) in 2009 and Dr Sudheer Medakkar (Torquay) in 2010.

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

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at honsecretary@aagbi.org by 5pm on Friday 16th September 2011.
In July 2010, we published a request for anaesthetists to help set up a postgraduate training programme in Zambia. Here, we report on the progress of this venture.

In July 2010 Anaesthesia News ran an article that described a project whose aim was to improve specialist anaesthesia provision in Zambia, a country of relative stability, but with severe economic constraints [1]. The project is one of several that is being supported by the Tropical Health and Education Trust (THET) and Department for International Development (DFID) in collaboration with the Zambia-UK Health Workforce Alliance. The various areas of focussed attention are:

- Improving midwifery and nursing capacity in the country
- Developing a course in biomedical engineering and medical equipment maintenance
- Establishing three Master of Medicine (MMed) degrees, one of which is to be in Anaesthesia (the others being Psychiatry and Pathology)

The article then called for interested UK-based anaesthetists to help to deliver the Anaesthesia MMed training since Zambia lacked the specialist manpower or academic background to do so itself. Which is where I became interested. Like so many fish sniffing at this tantalising bait, a handful of mainly consultant anaesthetists gathered on a rainy day in August at Wimpole Street in London to hear about the project from Iain Wilson (then President Elect of the AAGBI) and Emily Measures (Programme manager for THET). By the end of the meeting most of us were securely hooked by the prospect of an exciting professional adventure and came away enthused, but also with a mammoth task in hand. At the initial meeting I was appointed Programme Head and have since devoted many man hours to the job.

Over the past five months an enormous amount of groundwork has been done. An academic programme Needs Assessment was completed and accepted by the University of Zambia School of Medicine (UNZA SoM) in October, and a draft curriculum developed and submitted for review in November. After some small revisions the curriculum was formally approved by the UNZA senate in January this year. A Training Handbook is currently being developed to assist the UK trainers to deliver the formal teaching programme and is being constructed by contributions from all the members who have so far joined.

As my introduction to Zambian anaesthesia I visited Lusaka in October 2010 with the aims of seeing how things worked ‘on the ground’, meeting the Dean and Vice Dean of UNZA SoM, attending a Zambia-UK Health Workforce Alliance seminar to gain an insight into the complex world of NGOs and their relationship with Zambian healthcare, and also attending and speaking at the three day World Federation of Societies of Anaesthesiologists conference.

I left Lusaka with a strong sense of being engaged in a worthwhile project, as well as a sense of how desperately Zambia needed a specialist training programme in anaesthesia. The July 2010 issue of Anaesthesia News gives a more detailed description of the state of anaesthetic practice in Zambia, but the bottom line is that anaesthesia is largely delivered by non-physician clinical officers who have had two years of training and receive very little in the way of ongoing CME or professional support. They are hardworking and keen, but without the specialist backing that is required to cultivate and nourish a high quality service.

The aim of this follow-up article is not only to report back on the project to date, but is also an unashamed attempt to recruit more UK-based anaesthetists into our ranks since sustainability is entirely dependent on expanding our numbers. Therefore I shall address some vicarious questions that I imagine you, the reader, might ask.

What is the nature of the project for the UK faculty?

As a faculty member you will contribute to the pool of trainers who make up the principle ‘training resource’. You will provide advice and teaching materials (lectures and tutorials) for the training programme, and perhaps write a short module specification for your special interest area. As a visiting faculty member you will travel to Lusaka to provide teaching and clinical supervision for the anaesthetic trainees at the University Teaching Hospital.
The project is entirely dependent on a limited pool of funds to subsidise travel and accommodation to and from Zambia, so faculty need to commit to at least 2 weeks at a time. Longer would be preferred.

What is an MMed Anaesthesia degree and how does it fit into specialist training?

The MMed degree is somewhat different to the postgraduate specialist training programmes that we are used to in the UK. It is a qualification offered in other countries, such as South Africa, but usually runs parallel with the College based qualification. The obvious difference is that the MMed is an academic degree directly administered by a university, and as such has a strong research element which requires students to produce a dissertation for their final assessment. Much like an undergraduate degree the university requires annual summative assessments by examination, and has no strong concept of workplace based assessment. From the point of view of faculty, the programme requires a significant taught element in the form of lectures and tutorials, as well as clinical supervision in the workplace.

What is the value of our contribution?

Zambia has very few specialist anaesthetists, and most of these are engaged in the private sector. The UK-based faculty will provide a short- and medium-term repository of trainers that is required to deliver specialist education until such time as the Zambian trainers have sufficient numbers to deliver their own postgraduate training programme.

What is the end-point of this programme?

Self-sufficiency is the stated end-point. Even though overseas-based faculty may continue to contribute to training in the future, they will not be a vital component as they currently are. There are good precedents for this model, such as other established Zambian MMed programmes (general surgery, orthopaedics, medicine, obstetrics & gynaecology, paediatrics and child health, and urology), as well as examples of similar programmes developed in Nepal [2, 3] and Rwanda [4].

Why should I get involved?

Different people will give a different answer to this question, but it is not limited to the obvious response of wanting to contribute to improved global healthcare. This is the purpose that lies at the heart of the project as a whole, but at a personal level other expectations may be realised. There are the many professional benefits such as improving one’s cross-cultural awareness, resourcefulness, experience, adaptability and motivation [5], but I would like to add a further reason. To experience the excitement of delivering anaesthesia and teaching at the front line once again and being refreshed by the feeling that what you are doing is likely to leave a lasting impact on another person, be that person a patient or trainee anaesthetist.

I hope that the challenge offered by this exciting project will seize your imagination as it has done mine. I would welcome any further enquiries you may have and am happy to be contacted at the following email address: John.Kinnear@southend.nhs.uk. Emily Measures, who is Programme Manager for THET, can also be contacted at Emily@thet.org.

References


Prof John Kinnear, Southend
The core topics programme is now in its fifth successful year. Building on the success of 2010 we have expanded the number of meetings for 2011.

We have also changed the format slightly in some areas to enhance the educational value of the meetings, watch out for our weekend course in Manchester.

The aim as before is to offer high quality continuing medical education at a local venue. Where possible local experts and national luminaries will enable participants to be involved in an open forum.

Core topics offers an opportunity to stay up-to-date; to hear from a mixture of well-know national speakers and local experts; to promote emerging talent from your own region, all without ever having to travel far from home.

Prices have been frozen for the fifth year and are as follows:

- AAGBI Ordinary Member £150
- AAGBI Trainee Member £100
- AAGBI Retired Member £75
- Non-Member £200

Core Topics | Date
--- | ---
Dublin | 11 February
Newcastle | 17 March
Cambridge | 29 March
Exeter | 05 May
Sheffield | 13 May
Birmingham | 19 May
Oxford | 03 June
Bournemouth | 17 June
Manchester (Special Weekend) | 09/10 July
Glasgow | 28 October
Cardiff | 10 November
Wessex | 24 November
London | 02 December

For bookings & further information: www.aagbi.org/events/act.htm
In a previous issue, we reported on the background and future plans for the change from Luer connections on spinal, epidural and regional anaesthetic equipment to new safer connectors [1]. The implementation process has been very slow, with the technological problems involved becoming more apparent. The original timescale envisaged a period of at least 6 months during which clinical evaluations could be made before the pre-implementation date of 1st October 2010; this was the point after which no spinal equipment with Luer connectors should have been ordered.

Disquiet about the lack of products available from the suppliers led to a joint letter from the presidents of the AAGBI/RCoA/OAA/APAGBI [2] and an eventual postponement of the implementation date by a year [3]: currently the changeover to non-Luer spinal equipment should be completed by 1st April 2012.

The new Alert requires us to evaluate the equipment before that date. A growing number of manufacturers now have their most commonly used products available for clinical evaluation (i.e. standard needle and syringe sizes for adult anaesthesia). Other areas, including paediatrics and chemotherapy, will have to wait. However, with the likelihood that there will be at least four different patterns of non-Luer connector, and no central governmental lead on how to introduce the equipment, the first clinical uses have been haphazard. There is anecdotal evidence of dissatisfaction in some cases, but the results of these evaluations are only being spread by word of mouth.

A standardised assessment form for spinal equipment has been produced in consultation with anaesthetic members of the NPSA ERG (External Reference Group) (Figure 2). The OAA will also collect and disseminate the results of equipment evaluations. These will be patient- and doctor- anonymous. Quantitative data from formal assessments will be displayed on the OAA website. The requirement for these is that at least 20 evaluations are made using the same needle (type, gauge etc), together with at least 20 control evaluations of Luer needles.

Single or small numbers of uses can also be returned as ‘free text’ comments. This information will be passed on to SALG (the Safe Anaesthesia Liaison Group – joint RCoA / AAGBI / NPSA-(other) and the MHRA [Medicines and Healthcare products Regulatory Agency]. However, the MHRA require patient details for their own incident reporting, and this process therefore does not replace incident reporting to MHRA where appropriate.

Mike Kinsella
I was told recently that if you want to work out what your IQ is in middle age, all you have to do is take the IQ you knew you had when you were 25 years old and deduct 20 times the power of your reading glasses measured in dioptres. A signal event in my relationship with technology led me to believe that this is true. The last of the fruit of my loin left for university some two years ago, leaving Mrs Victor and me in joint solitary splendour at home. To celebrate the emptiness of our nest, I acquired a bottle of Majestic’s very best cooking claret and we ranged ourselves on the sofa one evening attended by a roaring log fire and a bowl of M&S Bombay Mix. I slotted a disk marked “The Great Escape” (it seemed somehow appropriate) into what I knew to be the DVD player, and slumped back into my seat clutching the four remote controls that were necessary to cause the DVD player to bring images to the television: one for the television itself, one for the DVD, one for the ridiculous “home movie theatre sound system” that my children forced me to buy, and one for the Sky-Virgin set-top recording Plus box thing that winks at me from underneath the television. I started to press buttons, confidently at first, but then, as time passed and little appeared on the screen apart from some vacuous tart in a show called “Andalusia’s Next Top Model”, with desperation that was followed by increasing panic. After 15 minutes, and when my fury at my wife’s suggestion that I ‘phone my daughter at university had subsided, I admitted defeat and did what she suggested. I was bested by technology, and I was duly humbled. My once powerful intellect and mastery of gadgetry seemed to be on the wane – for it was not ever thus. I am of a generation who were the first to hit adulthood in the era of personal computers. I remember with pride that I bought my first such device (a BBC Micro B for those who are both old and interested in this sort of thing) as an SHO. Within weeks I was using a programming language called Basic to create a multiple-choice program for those sitting the Primary FRCA exam that produced a smiley face for users when they achieved a correct answer, made a rich farting noise when they got something wrong and secretly recorded all the results for the College Tutor. Perhaps age had indeed addled what intellect I had – the relationship between IQ and reading glasses might be right. However, another and more recent technological tribulation has convinced me otherwise.

We recently had heated floors fitted in our hall. I assure you that this was not my idea, but the fulfilment of a long-held dream of Mrs Victor’s. The control unit looked rather daunting in its complexity but was accompanied by a 50-page instruction booklet that I was sure would guide me towards mastery of a system that claimed it could offer a different floor temperature at 10 differing programmable times every day of the week. After one and a half hours screaming increasingly loud invective at the instruction manual, which seemed to have been written in Japanese, translated into French, then back into Japanese and then finally into pidgin English, I admitted defeat. Was this another example of my waning intellect? I now think not - I have an alternative explanation that I will share with you.

We are in a painful technological transition period. Go back 20 years and devices such as video machines and microwaves were simple. They could only really record, play back and cook respectively and, as a result, the controls were both straightforward and immediately comprehensible. However, while the complexity of these and other devices has increased exponentially in the last two decades, the ways that we tell them to do what they are able to do have not. We still have to rely upon our comprehension of ever-expanding instruction manuals and the performance of an increasingly complex series of key-press combinations on the device or its remote control. In 10
years’ time, all this will most likely be unnecessary. All I will need to do is enter my living room and say “TV on, DVD on, play The Great Escape”, and the devices will serve me instantly. It is this transition phase that makes us middle-aged folk feel inadequate, and I do not think it is the fault of our ageing brains.

It will come as no surprise to you to learn that my theory has relevance to anaesthesia. Our anaesthetic machines are suffering from the same ever-increasing complexity without the matching advances in control mechanisms. As a fresh-faced novice, I had an old Boyle’s machine and a Manley ventilator to deal with. It was obvious how they worked and they were intuitive to use. There were real bobbins that bobbed and rotated and which told you of gas flowing. The ventilator would speak to you as it did its job and would tell you if it was having problems – we all became familiar with the sound of a “hopping” Manley as the device struggled to deliver its preset tidal volume and declared itself to be the time-cycled ventilator it really was.

In my far from humble opinion, the new generation of anaesthetic machines is absolutely ghastly and suffers the technological transition problems I describe above. They sit there like surly and uncooperative white Daleks and offer no hints of how they function inside. The ventilator does not talk to you other than with a squawking and non-specific alarm noise, there are no real bobbins that dance and rotate, and there is an enormous instruction manual that I defy any sentient human being to understand in its entirety. Simply having a screen that declares that the “power-up safety check pre-use daily programme has been successfully performed” does not mean that it is a safe device, just that the computer chip in the middle of it is happy. In years to come, we will be able to command these machines by voice, and the manuals and button-presses that now act as go-betweens will be laughed at as relics of a bygone age – and we middle-aged folk who in our honesty protest at the incomprehensibility of these machines will not be wrongly accused of failing and faltering intellect. Until that day comes, I would much rather have an old-fashioned anaesthetic machine that is intuitive to use and which has dancing bobbins that actually mean something. If my heated floor is wrongly programmed, all I suffer is scalded feet. If my anaesthetic machine malfunctions, a patient could die.

I worry that complexity is increasingly held to be the source of safety in anaesthetic practice. I beg to differ – I think that safety and simplicity go hand in hand, although you may well say that this is just because of may age – and falling IQ.

Keep well,

Victor
The financial strains of modern life make earning additional income attractive, so it is often an easy decision to start private practice. NHS job plans have some flexibility in them and, having fulfilled all your contractual obligations, it is often possible to find some spare time in your week. Devoting this spare time to clinical, managerial, political or research work may seem less attractive to some as Clinical Excellence awards and pension arrangements are changed. However, once private practice becomes established in your financial planning, you can easily find yourself dependent on it, and it becomes an increasing challenge to maintain a healthy work-life balance.

As market forces push our earnings ever downwards, does private practice still pay? The answer to this will depend upon your personal financial circumstances and lifestyle choices, but everyone will have a “bottom line” – a net income below which it will not seem worthwhile to take on the extra work and responsibility involved.

Factors to consider include expenses, taxation, the additional responsibilities, travelling distance, the “hassle factor” and the potential alternative uses of your time. Under the 2003 Contract, consultants are required to offer one additional Programmed Activity (PA) to their NHS employer if they wish to do private practice and enjoy pay progression, so if they didn’t do private practice, they might have more free time! However, for some, the additional income received from extra NHS PAs may be essential as they face the realities of the rising cost of living.

NHS consultant salaries are currently frozen, which in effect means that they are being reduced. A recently appointed consultant has a salary of about £80k from a standard 10 PA contract. A consultant in the latter half of their career with some CEAs will earn more than £100k. Senior consultants with higher numbers of local CEAs may earn around £125k towards the end of their careers. Consultants with national CEAs or additional payments for management work may earn in excess of £150k. Full-time consultants will therefore be at least 40% taxpayers. Due to the loss of the personal allowance, taxation is actually at a rate of 60% between £100k and approximately £115k per annum, and 50% above £150k. Whilst NHS expenses are minimal, private practice costs can be considerable, so many consultants have to pay 20% or more of their gross private practice income in expenses. With increasing National Insurance payments and VAT on most of the things that you buy, your hard-earned money is buying you less and less. Taking all this into account, it can be quite surprising how little we actually have left to spend after we have paid our dues to Mr Osborne, which can amount to 82p in every pound that you earn!

I have done some calculations that will illustrate the net value of additional work performed over and above a basic 10 PA contract. Table A shows the value of an additional PA working in the NHS. Salary bands are “taxable pay”, i.e. net of allowable expenses and pension contributions. Look at the line printed in red – the take-home hourly net income from this additional PA. As you move into the £100k income bracket, the value decreases by 18%, and then nearly doubles above an income of £125k. The few individuals who earn about £150k from the NHS should actually get the same rate as those earning £125k due to the 50% tax bands - some consolation to those who are losing out on the reduction in the number of national CEAs! Sadly, there are probably a lot of consultants in the £100k - £115k bracket, who are therefore earning only £23 per hour for their extra PA. If the average pre-tax private income of an anaesthetist is added to their taxable NHS
Tables B - E detail scenarios for generating additional income that take into account likely expenses, tax and National Insurance. Add your current private income to your taxable NHS salary, minus allowable expenses and pension contributions, to determine which income band you are in and which column you should examine in the tables. You can now see the amount of income you will have in your pocket if you take on additional paid work, and you can compare this to the amount you could earn in the NHS for the same amount of time (Table A). You may have formed a Limited Company, paying 20% Corporation Tax on company profits from April 2011 (Tables B-E, final column). For these examples, it is assumed that you are awarding 50% of the dividends to a partner who is in the basic rate tax band paying no additional tax on dividends, that the company is not paying salaries and that you will, in effect, pay an additional 25% tax on your 50% share of the dividends.

1. The self-pay market. (Table B)

If you choose to work with a surgeon who conducts work outside the private insurance market, e.g. cosmetic surgery, or if you charge more than the standard Private Medical Insurers’ (PMIs) benefit maxima, you can earn in excess of £1000 for a four-hour private operating session. This table calculates the net value of a session that earns a gross income of £1,000.

2. The PMI market. (Table C)

The AAGBI recommends that you set your own reasonable fees, give the patient an estimate in advance and bill the patient directly. However, the reality is often that because surgeons use the PMIs’ more generous surgical benefit maxima as a basis for their fees and bill the insurance company rather than the patient, anaesthetists often decide to act in a similar manner, thereby limiting themselves to lower anaesthetic benefit maxima that may not have increased for some years. The Bupa benefit schedule is commonly used to set fee structures in private practice. An additional 10% of annual earnings is available to current members of the Bupa Partnership as a form of loyalty bonus. A typical orthopaedic surgeon will complete two total hip replacements in a four-hour session. The anaesthetic fee is £325, or £357.50 with the bonus, so we could earn £715 for the four-hour session. This is the basis of my calculations.

3. The NHS market (Tables D and E)

The NHS contracts with private hospitals to undertake a variety of surgical procedures. The AAGBI recommends that anaesthetists be paid at the same hourly rate as surgeons

### Table A. NHS - additional 1 PA

The net value of an additional PA for a consultant on a 10-PA contract. The calculations are based on a 42-week working year to allow comparability with independent practice, i.e. the value of the sessions actually worked outside of annual, study, professional and sick leave. Ni = National Insurance

<table>
<thead>
<tr>
<th>NHS Salary (£)</th>
<th>£80,000</th>
<th>£100,000</th>
<th>£125,000</th>
<th>£150,000</th>
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<tr>
<td>Tax band 40%</td>
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<td>Pay/PA/42 weeks</td>
<td>1000</td>
<td>1000</td>
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<td>Expenses 20%</td>
<td>200</td>
<td>200</td>
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<tr>
<td>Net income</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>Tax + NI 2%</td>
<td>336</td>
<td>496</td>
<td>336</td>
<td>416</td>
</tr>
<tr>
<td>Take Home Income/list</td>
<td>464</td>
<td>304</td>
<td>464</td>
<td>384</td>
</tr>
<tr>
<td>Earnings/hour</td>
<td>116</td>
<td>76</td>
<td>116</td>
<td>96</td>
</tr>
</tbody>
</table>

### Table B. Premium rate private practice

The net value of private practice with fees in excess of standard Private Medical Insurer (PMI) benefit maxima – “premium rates”. Ltd Co = Limited Company. * No National Insurance payable

<table>
<thead>
<tr>
<th>Total Earnings (£)</th>
<th>£80-100k</th>
<th>£100-115K</th>
<th>£115-150K</th>
<th>&gt;£150k</th>
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<tr>
<td>Tax band 40%</td>
<td></td>
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<tr>
<td>Fee</td>
<td>715</td>
<td>715</td>
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<tr>
<td>Expenses 20%</td>
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<tr>
<td>Net income</td>
<td>572</td>
<td>572</td>
<td>572</td>
<td>572</td>
</tr>
<tr>
<td>Tax + NI 2%</td>
<td>240</td>
<td>240</td>
<td>297</td>
<td>171</td>
</tr>
<tr>
<td>Take Home Income/list</td>
<td>332</td>
<td>217</td>
<td>332</td>
<td>275</td>
</tr>
<tr>
<td>Earnings/hour</td>
<td>83</td>
<td>54</td>
<td>83</td>
<td>69</td>
</tr>
</tbody>
</table>

### Table C. Medical insurance rates

The net value of private practice when fees are set in accordance with PMI benefit maxima.

<table>
<thead>
<tr>
<th>Total Earnings (£)</th>
<th>£80-100k</th>
<th>£100-115K</th>
<th>£115-150K</th>
<th>&gt;£150k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax band 40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee</td>
<td>1004</td>
<td>1004</td>
<td>1004</td>
<td>1004</td>
</tr>
<tr>
<td>Expenses 35%</td>
<td>351</td>
<td>351</td>
<td>351</td>
<td>351</td>
</tr>
<tr>
<td>Net income</td>
<td>653</td>
<td>653</td>
<td>653</td>
<td>653</td>
</tr>
<tr>
<td>Tax + NI 2%</td>
<td>274</td>
<td>405</td>
<td>274</td>
<td>340</td>
</tr>
<tr>
<td>Take Home Income/list</td>
<td>379</td>
<td>248</td>
<td>379</td>
<td>313</td>
</tr>
<tr>
<td>Earnings/hour</td>
<td>76</td>
<td>50</td>
<td>76</td>
<td>63</td>
</tr>
</tbody>
</table>

### Table D. Surgeon: NHS work in independent hospital (60% Bupa)

The net value of NHS work in the independent sector for surgeons agreeing to fees of 60% of Bupa surgical benefits

<table>
<thead>
<tr>
<th>Total Earnings (£)</th>
<th>£80-100k</th>
<th>£100-115K</th>
<th>£115-150K</th>
<th>&gt;£150k</th>
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<tr>
<td>Tax band 40%</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fee</td>
<td>703</td>
<td>703</td>
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<tr>
<td>Expenses 20%</td>
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<td>141</td>
<td>141</td>
</tr>
<tr>
<td>Net income</td>
<td>562</td>
<td>562</td>
<td>562</td>
<td>562</td>
</tr>
<tr>
<td>Tax + NI 2%</td>
<td>236</td>
<td>348</td>
<td>236</td>
<td>292</td>
</tr>
<tr>
<td>Take Home Income/list</td>
<td>326</td>
<td>214</td>
<td>326</td>
<td>270</td>
</tr>
<tr>
<td>Earnings/hour</td>
<td>82</td>
<td>54</td>
<td>82</td>
<td>68</td>
</tr>
</tbody>
</table>

### Table E. Anaesthetist - NHS work in independent hospital (70% of surgical fee)

The net value of NHS work in the independent sector for anaesthetists agreeing to fees of 70% of the surgeons’ fees as in Table D
when treating NHS patients regardless of whether care is provided in NHS or independent hospitals. Surgeons often spend more time than anaesthetists on major cases, as they are likely to visit patients more often after surgery and do more associated administration. For these reasons, and for the purpose of these calculations, I have assumed a surgeon’s fee of 60% of the Bupa surgical rate for a total hip replacement (a commonly used basis for surgical fees) and have suggested that the anaesthetist’s fee should be 70% of this. I have set the surgeon’s expenses at 35% of gross income and have presumed that the surgeon will put in five hours’ work for a four-hour list.

I have chosen not to calculate net incomes from treating NHS patients in independent hospitals at non-parity rates. Suffice it to say that if you choose to work for 60% of Bupa anaesthetic benefit maxima (as opposed to surgical benefit maxima), your net income per hour can be as little as £30. The AAGBI does not recommend working at non-parity rates.

The rewards from premium-rate private practice (Table B) are enough to persuade many people to take on this work – the net income is several times that of basic NHS work. The PMI market pays less (Table C), and NHS work paid at parity is about the same as PMI work (Table E). We earn slightly more than the surgeons in the same income bands (Table D), but if we are earning in the range £100k - £115k, as many of us are, we will probably be earning less than the surgeons, who are usually in a higher income bracket because of their higher PMI benefit maxima and private fees.

Time is valuable, whether it is spent with one’s children, developing one’s NHS career or making oneself available for more lucrative private opportunities. How you spend this time is up to you, but in coming to this decision you need to assess the real net value of independent practice. If an additional NHS PA is available, it will almost certainly be preferable for all but the most junior NHS consultants – it is certainly preferable to non-parity NHS work in the independent sector. The NHS work is regular, with no additional travelling time, is indemnified, is supported by the full NHS infrastructure, is sessional rather than case-based, is paid during leave periods and is relatively free from hassle. Someone else is usually on call afterwards and you don’t have to be available for the patient’s entire hospital stay. Higher NHS earners might think about limiting the amount of private work they do that is billed at PMI benefit maxima if this pushes them into the 50% tax band. Alternatively, you can move to an individualised fee structure that may more appropriately value your time and expertise.

It is notable that the formation of a limited company improves net remuneration regardless of your income bracket, but the difference is the most for those earning £100k - £115k. There may be further benefits if the company decides to pay salaries to the directors or various benefits in kind are taken. Expenses may exceed 20% because of higher accountancy charges. Our assumptions will not be valid for all, particularly if your partner is already earning and might be pushed into the 40% tax band by the dividends. Tax legislation might change, administration is time consuming and the risk of a tax investigation is probably higher.

All earnings will be considerably eroded if the proposed additional income pushes you into a higher medical defence organisation insurance bracket or your expenses become more than 20% because of, for example, greater travelling distances. The value of the private hospital time can also be drastically reduced by inefficient list utilisation – you would be wise to choose a fast, safe and busy surgeon! Surgical speed is not as relevant in the NHS in this respect, making NHS alternatives even more attractive.

Additional PAs may not be available for much longer in some hospitals, and can be removed at three months’ notice. NHS salaries are currently frozen and increments may be delayed. It may therefore be appropriate to invest in private practice, accepting lower returns initially, whilst contacts and reputations are built for the future. However, the private sector has uncertain prospects and the pressure on fees may continue to be downwards.

Money does not always bring happiness, and it is always worth re-evaluating the real worth of private practice. When faced with the choice of going fishing or earning a net income of £30 per hour by doing non-parity NHS work in the independent sector, I know what I would choose!

Sean Tighe
Consultant Anaesthetist, Countess of Chester NHS Trust

Editor’s note: Dr Tighe is an excellent anaesthetist but he is not a trained accountant or a financial adviser registered with the Financial Services Authority. The calculations in the tables are approximations and real values may differ considerably. Many assumptions have been made. This article is aimed at promoting debate about the issues discussed, and readers should not take decisions on the basis of the calculations or comment provided in this article. The AAGBI recommends that its members only take financial advice from appropriately trained and qualified professionals.
Niraj G, Kelkar A, Jeyapalan I, Graff-Baker P,
Williams O, Darbar A, Maheshwaran A, Powell R.
Comparison of analgesic efficacy of subcostal transverses abdominis plane blocks with epidural analgesia following upper abdominal surgery

Transversus abdominis plane (TAP) blocks are becoming increasingly popular. But whether they are effective remains to be established. This study by Niraj et al. compares the efficacy of administering postoperative bupivacaine boluses via TAP block catheters (inserted during anaesthesia) versus standard postoperative patient-controlled epidural analgesia for upper abdominal surgery. The authors find equivalent pain scores (both with and without cough) for up to 72 h after surgery. Before readers conclude that this is the end of the TAP block story there are several observations. First, both groups actually received epidural analgesia during surgery with an equivalent dose of bupivacaine (20 ml 0.25%); it was only the postoperative pain regimens which differed. Second, although pain scores were equal, it is noticeable that the TAP block group required twice as much tramadol. Third, almost half the TAP catheters needed re-siting within the first 24 h after surgery, which must represent a considerable use of staff resources. Clearly, there is room for much more research on this fashionable block.

Peden CJ.
Emergency surgery in the elderly patient: a quality improvement approach

This editorial on emergency surgery in the elderly patient builds on findings of two important documents – the latest National Confidential Enquiry and the Parliamentary and Health Service Ombudsman’s ‘Care and Compassion’ report on treatment of the elderly. Release of this second attracted much press coverage as the Ombudsman, Ann Abrahams, was forthright in her opinion that the NHS is “failing to meet the needs of older people with care and compassion and to provide even the most basic standards of care”. Presented as individual, anonymised narratives, Abrahams’ report however fell short of analysing why the efforts of NHS staff – many of whom enter the profession committed to care – are not translated into compassionate results. We might readily identify some of the reasons. For example, feeding one elderly patient carefully consumes time and if the ward is short-staffed then it is impossible for one nurse to feed two patients at the same time. It is the second, uncarer for patient (not the first) who forms the focus of Abrahams’ report. Peden’s article stresses the need for a more co-ordinated and planned ‘systems’ approach, stressing multi-disciplinary involvement is needed for good outcomes from emergency surgery in the elderly. Interestingly, Peden cites the success of the Peterborough hip fracture pathway. Yet it would seem achieving such quality comes at a cost: not reported by Peden is the news that Peterborough’s current financial deficit is £6 million, estimated to reach £35 million by the end of next year! Peterborough Today identifies the rise in emergency admissions, with consequent surgery and critical care costs as major contributors to the deficit. Money clearly well spent, but it will be interesting to see if such initiatives – expensive as they inevitably are - survive the financial and organisational upheavals in the NHS.

McKenzie AG.
The bicentenary of James Young Simpson (1811–1870)

Aficionados of the history of anaesthesia will enjoy McKenzie’s vignette of James Young Simpson. One fascinating aspect is the wide range of Simpson’s contributions not just to anaesthesia but also to obstetrics, infection control and (last but not least) archaeology. (This is somewhat reminiscent of John F Nunn’s contributions to Egyptology). McKenzie is honest about some missed opportunities, namely Simpson’s insistence on using chloroform despite reported deaths and his failure to pursue adverse effects of anaesthesia on the uterus and foetus.

J. J. Pandit, Editor, Anaesthesia
Dear Dr Bythell,

I was interested in your comments (Anaesthesia News, March 2011) about moving our clocks forward permanently. What nobody seems to mention is that this has been tried before. In October 1968 (the month I became a consultant) we did not revert to GMT but stayed on summer time, and used summer time /double summertime for the next 3 years. In 1971 there was a free vote in the House of Commons on the issue and it was decided by one of the biggest margins in history to revert to GMT/summertime. All the arguments being used today had been propagated then and found to be baseless. I refer to "business with Europe will improve, tourism will increase and deaths on the road will decrease".

It was and is manifestly absurd to have a single time zone from Eastern Poland to Western Ireland. It was also most unfair on the people of northern Scotland. America has 4 time zones and manages well. Portugal, a small country dominated by Spain, converted to European time in 1992 for the same reasons as are used here and reverted to GMT/summertime in 1996. Their longitude is, as I am sure you know, close to ours.

Long may we stay with GMT!

Raymond Ahearn
Retired consultant anaesthetist

Dear Editor,

“Alice in Wonderland syndrome”

Whilst filing my most recent copy of Anaesthesia on the shelf I did wonder whether I was suffering from acute Alice in Wonderland syndrome [1,2]. I quickly looked outside and everything seemed to be in perspective. Reassuringly, there were no somatomorphic changes. Micropsia in March - I hoped I wasn’t going as mad as a March hare [3]. The increasingly disappearing text on the spine of the journal over the last 3 years is clearly evident in the enclosed photograph. Curiouser and curiouser! I wonder whether it is a need to reduce the carbon footprint or even just the carbon “print” of the journal, in these times of austerity. I await March 2012 with bated breath and a suitably powerful microscope.

Warm wishes,
David Pryor
Consultant anaesthetist
St James’ University Hospital, Leeds.


Response from the Editor in Chief
Dr Pryor should rest assured: this is not an attempt to ‘mess with his mind’ (though it reminds me of a tale heard recently on the radio, in which disgruntled employees bought a hat, identical (except for being one size smaller) to that worn by their unpopular boss, swapping them around every few days until, after several months, he retired due to ill health, having become convinced he was a sufferer of a rare expanding/shrinking head syndrome). It’s true that the journal has undergone a few changes recently in terms of paper thickness and printers (reducing its carbon footprint by 91% in the process, of which we’re all very proud) - but the publishers and I are equally baffled by the shrinking text. Have no fear, we shall be looking into it! Meanwhile, thank you for pointing it out.

Steve Yentis

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
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AAGBI Membership Survey

COMING SOON

Your chance to have your say!

In September 2011 the AAGBI will be conducting a membership survey.

We are keen to find out from you, our members, what you think about us, our work and the services we provide you.

New Council Members are elected each Spring, and take office in September, but we want to know that our activities reflect the views, opinions and needs of our members.

Thank you for providing your ideas for topics however we still need your support in September when the survey lands on your doormat with Anaesthesia and Anaesthesia News – we do hope you can take part!

If you have any questions about the membership survey, please contact members@aagbi.org
Introduction
Foreign body inhalation is a leading cause of morbidity and mortality amongst young children. This review of the recent literature looked at 30 studies covering 12,979 cases. The children are usually young (mean age 2.1 – 3.8 yrs), aspirated objects were often organic (commonly nuts and seeds), and more than 80% lodge in the bronchial tree (52% right side vs. 33% left).

Management
Clinical features: A history of a witnessed choking event is highly sensitive, and has a high positive predictive value for aspiration. However, the specificity and negative predictive values are lower, suggesting that children can appear to choke without aspirating, but that the lack of a witnessed event should not exclude the diagnosis. Cough is sensitive but not very specific for foreign body aspiration, whereas stridor and cyanosis are very specific but poorly sensitive. Delayed presentations may feature unilateral decreased breath sounds, wheeze, pneumonia, or pneumothorax.

Investigations: Only around 11% of foreign bodies are radiopaque and visible on CXR. More common radiographic signs are localised emphysema, atelectasis, and air trapping leading to unilateral hyperinflation (best seen at end expiration). Thoracic CT and virtual bronchoscopy (computer-generated CT images which provide intraluminal views) are now finding favour as definitive diagnoses in the stable and co-operative patient. CT findings correlate highly with bronchoscopic findings, leading some authors to suggest that negative findings on CT may obviate the need for conventional bronchoscopy. In unstable or uncooperative patients, in whom the risk of anaesthetising and transferring to CT is high, bronchoscopy is the mainstay of diagnosis.

Bronchoscopy: For those children in whom the pre-examination probability of foreign body aspiration is lower, flexible fibreoptic bronchoscopy is advocated. This can definitively exclude the diagnosis without exposing the child to the risks of rigid bronchoscopy. It can also visualise lower levels of the bronchial tree (52% right side vs. 33% left). For these reasons, rigid bronchoscopy is still the diagnostic and therapeutic standard.

Complications
The major complication rate was 0.96%, and included laryngeal oedema, bronchospasm, pneumothorax, pneumomediastinum, tracheobronchial laceration, cardiac arrest, and hypoxic brain injury. Many of these were associated with use of the rigid bronchoscope. The mortality rate was 0.42%.

Anaesthetic considerations
Preoperative assessment. This should include a ‘what, where and when’ history, i.e. what object, where has it lodged, and when was it aspirated? An upper airway site of deposition can quickly become complete obstruction; these children need to be taken for definitive therapy early. Lower airways deposition is less of a risk, and may allow time for optimal equipment and experienced personnel to be convened prior to definitive therapy. In one study with stable patients, bronchoscopy was delayed to the first daytime slot with no increase in morbidity. Delayed presentations increase the risk of airway oedema, granulation tissue, and infection, which can produce significant post-operative complications. Of note, there are no reports here of aspiration of gastric contents, which argues against delaying therapy to allow for stomach emptying.

Choice of anaesthesia. There is no consensus. Most studies prefer a spontaneously breathing inhalational technique for induction; however, conditions for bronchoscopy tend to be better with deep anaesthesia and neuromuscular blockade. The presence of a rigid bronchoscope in the tracheobronchial tree is intensely stimulating; coughing and bucking can cause significant morbidity. Having said this, the review finds that complications during bronchoscopy are more related to the experience of the bronchoscopist than they are to anaesthetic technique. Spontaneously-breathing techniques using propofol and remifentanil have been described. These may provide a deeper plane of anaesthesia and thus better bronchoscopic conditions. Flexible bronchoscopy can be performed under local anaesthesia, with or without sedation.

Conclusions
Foreign body aspiration in a child is a potentially lethal event. CT and flexible bronchoscopy are increasingly being used to provide diagnostic information in the stable child. The latter can also be used to remove the foreign body. In the unstable child, urgent rigid bronchoscopy is the diagnostic and therapeutic option of choice. There is no consensus on the optimal anaesthetic technique.

Pratheeban Nambyiah, ST4 Anaesthetics, Norfolk and Norwich University Hospital
Effects of tranexamic acid on death, vascular occlusive events, and blood transfusion in trauma patients with significant haemorrhage (CRASH-2): a randomized, placebo-controlled trial.


This multi-centre trial includes data from 20,211 trauma patients from 274 hospitals in 40 countries of varying economic status. The majority of patients were recruited from India, Columbia, Egypt and Nigeria. Injury is known to be a major cause of death worldwide with low and middle income countries bearing the brunt (90%) of trauma deaths [1]. Haemorrhage is the cause of one third of all in-hospital trauma deaths. In England 5,400 deaths are estimated to occur annually due to major trauma[2].

Pathological fibrinolysis can occur as part of the haematological response to trauma [3]. Antifibrinolytic drugs used for surgical patients can reduce the need for blood transfusion [4, 5], since surgical and trauma-related tissue injury are similar, it follows that antifibrinolytic drugs may reduce mortality due to haemorrhage in trauma patients.

Inclusion Criteria:

- Adult (>16 years) trauma patients
- Significant haemorrhage evidenced by systolic blood pressure < 90 mmHg or heart rate > 110 beats per minute, or both, or a patient considered, by the responsible doctor, to be at significant risk of haemorrhage as defined above
- Presentation within 8 hours of injury
- Responsible doctor substantially uncertain about whether or not to treat with tranexamic acid
- Patient consent, proxy consent or consent waived or deferred

The majority of patients were randomised locally via a pack system; packs bearing randomly generated numbers, whilst 95 patients were randomised by the University of Oxford Clinical Trial Service Unit.

Intervention:

A loading dose of 1g of tranexamic acid given over 10 minutes, followed by an infusion of 1g over 8 hours or a matching 0.9% saline placebo regimen.

Results:

The use of Tranexamic acid showed a survival benefit. 28 day all cause mortality was 14.5% in the treatment group vs. 16% in the placebo group. This represents a relative risk of 0.91 of death with tranexamic acid (95% CI 0.85 – 0.97, p=0.0035).

Death due to bleeding was also reduced in the tranexamic acid group (RR of death due to haemorrhage 0.85, 95% CI 0.76 – 0.96, p=0.0077).

There were no differences in the incidence of vascular occlusive events, death due to multi-organ failure, head injury or other causes between the groups.

Interestingly, in the group of patients assigned as ‘at significant risk of haemorrhage’ blood products were give to 50.4% of the tranexamic acid group (mean of 6.06 units of blood) and 51.3% of the placebo group (mean of 6.29 units of blood). Representing no statistical difference in transfusion requirement between the two groups.

Summary:

Early administration of a short course of tranexamic acid has been shown to reduce mortality in trauma patients with, or at risk of, significant haemorrhage. This benefit is achieved without an increase in vascular occlusive events. Given the wide availability and modest cost of the drug, this trial and the subsequent use of tranexamic acid for bleeding trauma patients is likely to have a significant benefit, especially in countries with a high incidence of trauma mortality.

This trial also raises the potential for the use of tranexamic acid in non-trauma patients with haemorrhage related mortality and morbidity. The World Maternal Antifibrinolytic (WoMAN) trial is now recruiting patients to assess the effect of tranexamic acid on the risk of death and hysterectomy in women with post-partum haemorrhage.

References:


Claire Sandberg, ST4 Anaesthetics, Norfolk and Norwich University Hospital


This multicentre double-blind randomised control trial reports a survival advantage following 48 hours of treatment with the neuromuscular blocking agent cisatracurium in early, severe Acute Respiratory Distress Syndrome (ARDS).

 Patients in 20 French ICUs who were intubated for acute respiratory failure, had both a PaO$_2$:FiO$_2$ <150 (with the ventilator delivering a PEEP >5cm H2O and a tidal volume 6-8ml/kg of predicted bodyweight) and had bilateral pulmonary infiltrates without evidence of left atrial hypertension for less than 48 hours were eligible for inclusion. 340 patients were randomised to receive either cisatracurium or placebo for 48 hours. All patients were then ventilated according to the ARDSnet low tidal volume protocol [1]. The primary outcome of the trial was the proportion of patients who died before discharge or within 90 days of enrolment. Secondary endpoints included incidence of barotrauma, organ failure free days and survival following ICU discharge.

After adjustment for PaO$_2$:FiO$_2$, SAPSII and plateau pressure, the hazard ratio for death at 90 days in the neuromuscular blockade vs. placebo group was 0.68 (p=0.04). The crude 90 day mortality for those receiving cisatracurium was almost 10% lower than in their counterparts managed with placebo, 31.6% vs. 40.7%, although this effect was confined to the two thirds of patients who presented with a PaO$_2$:FiO$_2$ <120. The cisatracurium cohort also had significantly more ventilator free days, lower incidence of barotrauma and more non-pulmonary organ failure free days than the placebo group. Intriguingly, the rate of critical care myopathy, a major concern surrounding the use of neuromuscular blockers, did not differ significantly between the two groups at discharge from ICU.

This well designed, prospective, multi-centre trial is important because it is the first to show a pharmacologically mediated survival advantage in ARDS [2] and challenges the current trend against using neuromuscular blockers in managing the condition. However, the generalisability of its findings might be reduced by the high exclusion rate (986 patients of 1326 assessed) and the observation that the mortality reduction was confined to those patients with the worst gas exchange. Further, whilst the authors postulate mechanisms underlying the survival advantage of cisatracurium, they do not report that neuromuscular blockade was monitored in the patients; nerve stimulators were not used. This, along with their failure to consider other paralytic agents, renders it possible that it is an attribute of the cisatracurium, rather than paralysis per se, which confers the beneficial effect. All the same, if the robustness of these findings can be shown through replication of this study, ARDS mortality could be reduced considerably through a relatively straightforward intervention.

Doug Stangoe
FY1, Basingstoke and North Hampshire Hospital


Amanda McCormick of MCL has produced Anaesthesia News on behalf of the AAGBI since 2004. Development of our own in-house desktop publishing capabilities and strengthening of our design team has been taking place over the last year, and we are now in a position to produce Anaesthesia News in-house. Sadly, this means that we will no longer be using Amanda and her excellent team to produce Anaesthesia News. I and my predecessors have always relied heavily on MCL to help us do a decent job, and I will certainly miss Amanda. On behalf of previous editors, the AAGBI and readers I would like to thank Amanda and MCL for doing a fantastic job and wish them a very successful future!

Val Bythell
Editor

If you can think of anybody who would benefit from my help then please feel free to give them my telephone number or email address.
Many thanks, Amanda.
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Farewell and thank you …

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