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Revalidation: what you need to know

Workforce in 2020 - being flexible

Working in a wider team
ULTRASOUND TRAINING COURSES

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

Course Dates Location Organisers 
Regional Anaesthesia Regional Anaesthesia UK (RA-UK) SonoSite Ltd 
Nottingham (A) Dr Nigel Bedforth 
Brighton (A) Dr Susanne Krone 
Newcastle (A) Dr Ian Harper

Regional Anaesthesia
The two-day introductory course is designed to teach those who have little or no experience on the use of ultrasound in their normal daily practice. The course comprises 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 the placement and compiles 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 regular venous access, but femoral, subclavian and arm venin access will also be discussed.

Ultrasound Guided Chronic Pain Management
The course is aimed at chronic pain specialists, or other interested parties practicing 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.

Introductory Ultrasound Guided Regional Anaesthesia
This one-day course is aimed at physicians and users involved with the placement and compiles 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 regular venous access, but femoral, subclavian and arm venin access will also be discussed.

Ultrasound Guided Critical Care courses also available
Venue: SonoSite Education Centre – Hitchin

For the full listing of SonoSite training register go to:
www.sonositeeducation.co.uk
Tel: +44 (0) 1462 444800  Fax: +44 (0) 1462 444801  E-mail: education@sonosite.com

Seven weeks to Christmas; another deadline!

Some will be well prepared with only the finishing touches to organise, whereas for others (or do I mean me) this is still a world away. I need the pressure of a deadline to concentrate my mind on the matter in hand – there will be presents, and being, but from a last minute rush.

Another deadline faces us all in medicine. Revalidation is about to start for real, and we are pleased that Mr Paul Philip, the GMC Deputy Chief Executive has contributed to this issue. Again, there will be well developed portfolios, and insightful reflections about their work, learning needs and CPD. Others may be taking a path akin to the ‘Redfern’ method of managing Christmas. If you are in the latter group there is a good article from Val Bythell which I hope might calm your nerves.

The GMC’s core guidance for doctors, Good Medical Practice, looks at doctors’ practice in four categories (domains in ‘education speak’), one of which is communication partnership and teamwork. Two very different experiences of communication in multidisciplinary teams are described by trainees – one (page 7) integrated well into the team and was able to make significant and positive changes to the service; the other (page 19) felt stung by a miscommunication based on two different agendas. Different groups (e.g. doctor, nurse, manager) value different things and this can get in the way of delivering good quality care. Inherent differences in power and status in multidisciplinary teams can cause conflict and task, process and relationship conflicts all impact negatively on team performance1,2,3. Part of our roles as doctors is to break down such cultural barriers, so that we all concentrate on delivering patient care.

Richard Griffiths also talks about the impact of good communication – it was the friendliness of the anaesthetic department and the warmth of his medical school Dean...
SAS Research Prize 2013

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) invites applications for the SAS Research Prize. This is exclusively for SAS doctors to encourage them to undertake research. Entries will be judged by the Research and Grants Committee of the AAGBI. All SAS doctors who are members of the AAGBI are eligible to apply for the prize.

Research projects should have been approved by the local ethics committee and Trust. If the project is a joint one, the names of other contributors should be mentioned including the principal investigator.

Applicants should submit a summary of their research of no more than 1000 words, 3 figures and 3 tables. It should be presented in the style of the journal Anaesthesia. The winning entrant will receive a cash prize of £100 and will have an opportunity to present their work at a national scientific meeting held by AAGBI. Other entrants may be asked to display a poster at the same meeting (as judged by the Research and Grants Committee of the AAGBI). Please note that work must not have been previously published, either as an abstract or as a full paper in a journal or website or presented at any meeting.

A submission form is available on the website www.aagbi.org/research/awards/sas-grade-anaesthetists

Please email entries along with the completed submission form to secretariat@aagbi.org or contact 020 7631 8812.

Closing date: Monday 07 January 2013

I welcome all readers to the November edition of Anaesthesia News. I have been the Honorary Secretary for almost 6 weeks and would like to thank the previous incumbent, Andrew Hartlie for all the help and advice he has given me, and that includes the next two years as well.

This month, of course, is the time that hospitals with novice trainees will be releasing them onto call rosters, following their initial test of competence. This is a daunting time for the new anaesthetists but I am sure that our reputation for safety and teaching will help those novice doctors. I hope that all the “newbies” have been invited to join the AAGBI, with all the undoubted benefits membership of the organisation brings. You are all fully aware of the demographic time bomb of the ageing “baby boomers”, me included (born 1960, so just qualify).

I am chairing an updated version of the glossy on the elderly, which will be renamed perioperative care of the older surgical patient. The AAGBI is also engaging with the National Hip Fracture Database to conduct a “spont audit” of anaesthesia practice. This is going to be hard work and I am asking all anaesthetists with an interest in trauma and the elderly patient to ensure that data collection is accurate in all acute hospitals in England, Wales and Northern Ireland. Data on up to 5,000 patients a month can be collected, which is over double the amount of patients who have ever been entered into randomised trials on anesthetic technique for hip fracture.

I hope that you will be planning a trip to London in January for the WGM. One highlight last year was Richard Dodds, talking about “what it takes to win”. The Olympics and Paralympics are now gone but I hope the spirit of mutual support and striving for the best lives on; it’s certainly important in anaesthesia.

Finally I would like to thank all anaesthetists who supported us on the cycle ride from London to the annual conference in Bournemouth. It was very enjoyable, although I had forgotten how hilly it was in Surrey, despite the fact that I was brought up and went to school in Reigate.

You may think that I am rabbity on about a bygone age but I still believe that career choices are made by medical students and foundation doctors because anaesthesia departments often have a “hub” and are on the whole friendly environments to work in.

At this years Scottish Standing Committee, Kathleen Ferguson’s husband stated that medical students liked anaesthesia for the department focus and the teaching they received. I believe that Scotland does produce more than its fair share of anaesthetists, for these reasons.
A year volunteering in Addis Ababa

I have been working with Voluntary Service Overseas (VSO) since September 2011 as the only anaesthetic doctor in a Specialised Hospital serving a catchment population of 5 million people which performs around 3,500 operations each year. If these numbers are enough to make most trainees break out in a cold sweat, I should come clean: I’m not alone. My department consists of a total of 12 anaesthetic nurses with a range of experience from 2 to 25 years, who do all the real work, whether they have a visiting foreign mascot doctor or not. My task for the past eight months has been trying to work out what I can do to help improve their department.

Working in a foreign environment, especially as a long-term volunteer without a UK-based team around you, throws a bucket of issues in your face. Language, culture, equipment, drugs (or a lack thereof), governance, the role of international aid agencies, and conflicting local priorities are just a few of the hurdles. One of the key difficulties that I have noted, however, is working in an entirely non-physician department.

I realised quickly that there was little I could teach my colleagues about the holy trinity of anaesthesia: put up a drip, stick down a tube, and give plenty of oxygen. In fact, as might be expected, the skill-set my nurse-anaesthetist colleagues have developed is very well tailored to their equipment, pharmacy, and surgical population. I gained much clinical experience from them including the use of TIVA ketamine, halothane-induced arrhythmias, and the management of difficult airways with little or no specialist equipment. So what is the benefit of a volunteer medical anaesthetist? In fact, what is the benefit of an anaesthetist at all?

What I have noticed is that no matter how experienced or smart my nurse anaesthetist colleagues are (very, in both cases), there are aspects of their training and practice that hugely restrict the development of their service. Evidence-based anaesthesia does not exist, with practice based on initial training and occasional extra teaching. There is next to no internal audit, and no guidelines to set my nurse-anaesthetist colleagues have developed is very well tailored to their equipment, pharmacy, and surgical population. I gained much clinical experience from them including the use of TIVA ketamine, halothane-induced arrhythmias, and the management of difficult airways with little or no specialist equipment. So what is the benefit of a volunteer medical anaesthetist? In fact, what is the benefit of an anaesthetist at all?

There are significant barriers to this, but in the absence of permanent local anaesthetists the nurse anaesthetists must gain the confidence to take matters into their own hands, or remain forever dependent on overseas volunteers telling them what to do. Not least we have the problem that anaesthetists from different countries give divergent advice!

This is not to say that supplying an (admittedly very junior) medical anaesthetist solves the problem, but it may open up new avenues for exploration. My work this year has largely involved a diplomatic offensive of engagement, confidence building, and discussion leading to a three-year review of our practice and a subsequent comparison against the international standards of the WFSA. This has led to innovations including the implementation of the WHO Safe Surgery Checklist, and pulse oximetry monitoring for all theatre and recovery beds – the latter through the generosity of the UCLH Charitable Foundation, Rotary International and the Lifebox Foundation. More projects are planned and work is beginning on an HDU for post-surgical patients (also kitted out with Lifeboxes), and improved recovery and pre-assessment services. I’m also trying to convince my colleagues that a monthly anaesthetic meeting is encourage discussion and peer-to-peer teaching would be a good idea. I am under no illusions that I will see all of these projects out, or that all of them will last the course, the ultimate goal is to encourage my local colleagues to see that they are capable of similar endeavours under their own steam. I’ve been asked to present at the forthcoming national conference of nurse anaesthetists where hopefully I will be pushing this message of self-development to a wider audience, in addition to plugging the WHO checklist and Lifebox.

Where are all the Ethiopian anaesthetists?

Ethiopia is a country of approximately 85 million people and at the last reckoning there were 17 anaesthetists to service it (personal communication). This is not to say that anaesthesia here does not exist; more that is almost entirely the domain of non-physician anaesthetists.

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Anaesthesia in low income countries need not aspire to a UK model. What Ethiopia needs to develop, I believe, is an Ethiopian brand of safe anaesthesia for its own patient population and surgical demand. Visiting anaesthetists do not always have the right answers for Ethiopia; for example my colleagues here cannot believe that in the UK we anaesthetise the patient in a separate room from the theatre. While some aspects of safe anaesthesia are universal and need to be conserved, I think countries with an underdeveloped service need to find their own way to improve.

Would I advise other juniors to volunteer long-term with an agency like VSO? Absolutely. There is a critical gap in our profession like VSO? Absolutely. There is a critical gap in our profession, and we need doctors who can support from others, rather than adopting the practice of another country wholesale.

Then there is the difficult question of at what point in our training are we fit to volunteer? My experience has taught me that once basic training is complete that is not the finished article, but this doesn’t mean they can’t offer something to their hosts. Volunteering as a junior provides an environment of genuine skill sharing, rather than one-way instruction. Some senior anaesthetists have expressed grave concerns about juniors being ‘out of their depth’. Although this is a real possibility, the same clinical problems would exist irrespective of the presence of a volunteer, referral to a centre with a more experienced anaesthetist is almost never a viable option in our setting. As long as we ‘first do no harm’, the support and advice of a medically trained anaesthetist should almost always work to improve the overall outcome. I won’t deny that I have had some real scares – always, arrhythmias and blood loss are the recurring nightmares – but I am also clear that had I not been around then things would have been the same, or worse.

So if you think you can spare a year or two making friends, drinking coffee, and doing some amazing cases, while also trying desperately to work out what ‘building capacity’ means, then throw your hat in the ring. You are needed.

Dr Tom Bashford MBChB FRCA MMedS, FRCA, MRCP
CT2 ACCS Anaesthetics, North Central London School of Anaesthetics (OOP)
Yekatit 12 Hospital, Addis Ababa

References:
1. Di Orio Henery MD PhD, Tikur Anbessa University Hospital

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THE WYLIE MEDAL
UNDERGRADUATE ESSAY PRIZE 2013

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

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

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

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

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

Closing date: 7 January 2013

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

www.vso.org.uk

The Association of Anaesthetists of Great Britain & Ireland

ANNUAL CONGRESS
DUBLIN
THE CONVENTION CENTRE DUBLIN

SAVE THE DATE! 18-20 SEPTEMBER 2013

www.annualcongress.org

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

www.aagbi.org

Chris’ winning essay can be viewed here www.aagbi.org/undergraduate-awards

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Purpose of Revalidation

To assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practicing to the appropriate professional standards [1]. It was noted more than once in dispatches that the public were under the impression that this was already being done; a comparison was made with an airline flight – when boarding a plane, one’s place on the plane, one’s health and one’s capabilities in the airline flying department, rather than a historical record of having been able to fly one at some (possibly long distant) time in the past.

Mr Paul Philip, of the GMC, said that he had never met a doctor (and he has met a lot of us) who was opposed to revalidation in principle. As always then, I guess the devil will come in the detail of the process.

There is a wealth of information on the process on the GMC’s website, which I am sure most of us have by now at least glanced at, and which we might as well pin to our toolbars at this point, as it is activity properly done during this time which particularly distinguishes the consultant grade, and that insufficient time for these activities allocated in job plans will result in a downgrading not only of our individual roles but of the quality of the health service delivered in general. Ian continues to offer job planning seminars at Portland Place, now may be a good time to consider attending one.

The GMC has issued guidance about what it regards as CPD [2]. It is clear that although the RCS’s CPD matrix is extremely useful for us to use as a guide for our CPD, it is our individual responsibility to identify our own learning needs, plan how to meet them and so on in discussion with our appraiser, and to set these out in our PDP.

As an update from Annual Congress, Bournemouth:

One of the many fascinating sessions I attended at this year’s Annual Congress was a series of three presentations and a discussion about revalidation. This is such an important topic that despite the risk of information overload I have jotted down some notes for you. These are just my personal musings; you can watch the entire session for yourself on the video platform at http://videoplatform.aagbi.org/

The evidence needed can be summarised in the following list:

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<tr>
<th>General information</th>
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<td>Brief description of all aspects of work</td>
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<tr>
<td>Keeping up to date</td>
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<tr>
<td>Evidence of CPD</td>
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<tr>
<td>Review of your practice</td>
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<tr>
<td>Quality improvement activity</td>
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<td>Significant events</td>
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<td>Review of complaints and compliments</td>
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<td>Feedback on your practice</td>
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<tr>
<td>Feedback from colleagues &amp; patients (where applicable)</td>
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Good medical practice also requires you to reflect on your practice, and on whether you are working to the required standards. Nancy Redfern described how this might mean in practice; it really is not a giant leap forward from the type of review that we will naturally be doing. For example, think about a clinical episode which took place recently, then try to record what happened, with a simple review of events and a summary of any changes that you think you should make in the future as a result of reflecting on that case.

Your appraisal process may need strengthening to meet the requirements for revalidation – at the end of your appraisal your appraiser should be able to state that

1. An appraisal has taken place that reflects the whole of your scope of work and addresses the principles and values set out in Good Medical Practice.
2. Appropriate supporting information has been presented in accordance with the Good Medical Practice Framework for Appraisal and Revalidation, and this reflects the nature and scope of your work.
3. A review that demonstrates progress against last year’s personal development plan has taken place.
4. An agreement has been reached with you about a new personal development plan and any associated actions for the coming year.
5. No information has been presented or discussed in the appraisal that raises a concern about your fitness to practise.

In pilots in my own Trust, a number of appraisal summaries were initially rejected by the responsible officer (RO) because they were insufficiently detailed.

Continuing Professional Development (CPD)

The GMC has issued guidance about what it regards as CPD [2]. It is clear that although the RCS’s CPD matrix is extremely useful for us to use as a guide for our CPD, it is our individual responsibility to identify our own learning needs, plan how to meet them and so on in discussion with our appraiser, and to set these out in our PDP.

Dr Ian Wilson, Deputy Chairman of the BMA Representative Body and Acting Chairman, Consultants Committee, ‘the other Ian Wilson’, gave a useful presentation about job planning. He discussed the issue of SPA activity and reiterated the BMA’s position that it is activity properly done during this time which particularly distinguishes the consultant grade, and that insufficient time for these activities allocated in job plans will result in a downgrading not only of our individual roles but of the quality of the health service delivered in general. Ian continues to offer job planning seminars at Portland Place, now may be a good time to consider attending one.

At the end of the revalidation process locally, your responsible officer will make one of three recommendations about you to the GMC:

• Positive Recommendation for Revalidation
• Deferral
• Insufficient evidence but actively engaging in process and RO is likely to be able to make positive recommendation in next 12 months
• Failure to Engage in Revalidation

GMC begin process to remove licence

There were some interesting points made during the discussion:

In response to a question about appraisal north of the border Ian Wilson commented that the BMA in Scotland does not believe that the NHS is ready to start revalidating doctors by next April. This is a matter the AAGBI takes seriously; I would urge concerned members to contact us via your Linkman or directly to the Hon Membership Secretary at HonMembershipSecretary@aagbi.org.

A couple of other disconcerting points emerged in the discussion. Firstly, whilst the identification of ROs is fairly straightforward for most NHS hospital based anaesthetists, there are substantial numbers of doctors in long-term locum practice or private practice for whom identifying an RO might be tricky. It was not clear from the discussion how this was going to be addressed.

Another point concerned the assumptions about how many of us are actually going to be positively recommended for revalidation. It is tempting to assume, and indeed, Mr Philip reinforced this view, that the vast majority (over 85% was quoted) will be positively recommended for revalidation. However, if you consider the RO’s point of view, that the vast majority (over 85% was quoted) will be positively recommended for revalidation. However, if you consider the RO’s point of view, and the implications of the word responsible, then an alternative scenario seems plausible, in which a substantial minority of us are at least the subject of a deferral. Time will tell how this plays out.

What is clear is that we must all engage with the process now. The AAGBI is doing its best to develop useful resources to support you and Anaesthesia News is keen to hear your experiences of revalidation.

Val Bythell
Vice President
Revalidation – The GMC’s view

The date for introducing revalidation is fast approaching and momentum is building across the UK. For the first time, all licensed doctors will have to demonstrate periodically that they are up to date and fit to practise in order to retain their licence to practise medicine in the UK.

The vast majority of doctors are good doctors with the skills, knowledge and experience to deliver first class care. But just as the capacity of doctors to do good has never been greater, the risks associated with medical care are also greater than ever. Supporting doctors in the delivery of high quality and safe care to patients is what revalidation is all about.

At the heart of revalidation lies the GMC’s core guidance for doctors, Good Medical Practice, which sets out the standards expected of doctors. Good Medical Practice ensures professional standards are maintained, even for part-time and locum doctors. Moreover, the strict revalidation process applies more during the early training years rather than once skills are effectively demonstrated.

At appraisal, the doctor must demonstrate that he or she has spent most of their practice (usually the medical director in the organisation where the doctor spends most of their practice) will make a recommendation to the GMC that the doctor should be revalidated.

At the end of each five year period the doctor’s Responsible Officer (usually the medical director in the organisation where the doctor spends most of their practice) will make a recommendation to the GMC that the doctor should be revalidated.

The process has been designed to be as straightforward and flexible as possible to work for doctors in all different roles and to minimise the impact on their practice. We are planning to introduce revalidation from late 2012 and we anticipate that the vast majority of licensed doctors will have been through the process by March 2016.

Revalidation is not a panacea and we are not claiming it will produce instant results but it will be the first nationwide system of its kind anywhere in the world. On the other hand, we have to acknowledge that revalidation, in large part, is only requiring the health system to do what it should have been doing for many years. Annual appraisal has been included in most doctors’ contracts since the early 2000s, yet until now the record of the NHS in providing appraisal for all doctors in the service has been patchy.

The news is that a huge amount of work has gone into putting the systems in place to be ready to support revalidation across the four countries of the UK and we are now ready to begin.

Revalidation is not a pass or fail. It is about doctors demonstrating that they adhere to the values and principles of their profession and that they reflect on their practice and improve the quality of care they provide year on year.

Paul Philip
Deputy Chief Executive, GMC

I read with interest Dr Redfern’s article on addressing the lack of consultant jobs for trained anaesthetists.¹ A further way to ease the job crisis might be to encourage anaesthetists to work a more flexible and innovative work pattern.

At present, the only real option for flexible working is working part time. However, even this is viewed with caution in some circles. For instance, whilst trusts are required by law to allow substantive consultants to go part time in certain circumstances (eg childcare), part time work is generally discouraged and indeed it is still rare for a trust to Advert a part time consultant position.

This can result in misleading, and hence inefficient, applications and interviews, as consultants who wish to work part time, will effectively have to pretend they are keen to work full time. It also restricts part time consultants moving jobs, even if their skills are better applied elsewhere.

There are of course some legitimate concerns regarding flexible working, chiefly that we learn on the job and less time at work can make it difficult to develop and maintain skills or to network effectively. However, the need for “hours on the job” surely applies more during the early training years than once skills have been established. Moreover, the strict revalidation process ensures professional standards are maintained, even for part-time consultants.

One of the perceived hurdles may be the envisaged logistical difficulties in introducing flexible working. But these should be easy to resolve. Novel IT systems can solve rota planning at the press of a button. Moreover, flexible working can be used to address short term staffing issues, without the need for expensive overtime. Eg ‘The Bradford Bean System’, already introduced by some departments, which enables consultants to do extra PA’s to address short term staffing issues, without the need for expensive overtime. Eg ‘The Bradford Bean System’, already introduced by some departments, which enables consultants to do extra PA’s to

A further example is neatly explained in a letter to Anaesthesia News in 2010² where a department took a risk to give colleagues a chance to work on a 5 PA contract for a year (0 or 10 PA’s some weeks) and in effect job share by mutual agreement.

Everyone recognises that if you work less you earn less. However, this should not mean that people should be discouraged from flexible working as there are many anaesthetists who would be happy to take a pay and pension cut if the flexible vision was more imaginatively encouraged and debated.

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Surely, as long as the service is reliably covered, attitudes can be more open-minded. Work pattern options such as the Compressed Working Week, annualised hours and creative solutions including job sharing should be considered. Consultant jobs are a long term investment and may pay dividends to the NHS for longer if taken at a slower pace. Now that retirement age is 68, why not work more flexibly and with less intensity?

Our society is changing. 40% of UK households are double income. With this, men, as well as women, are becoming increasingly interested in working more flexibly in order to have more time with friends and family or to pursue other interests. And whilst the UK is behind countries like the Netherlands, where 40% of the workforce are part-time, compared to only 25% in the UK, the percentage in part-time work has been increasing year on year and is expected to continue to do so. If this is the trend for UK industry as a whole, why should it not also be the case for anaesthetists.

Many leading thinkers are also challenging our work culture. For instance, the economist and politician Professor Robert Skidelsky and his philosopher son Edward have recently published a book which asks the simple question ‘How much do we need to have the good life?’ They point out that in 1950s Keynes predicted that, as quality of life improved, people would work less to pursue leisure and happiness rather than work harder to earn ever more money.

Rather than follow the long-hour culture, perhaps we should strive for Keynes’ utopia. He thought people could adopt this ‘good life’ at what is the equivalent in today’s terms of around £40,000 per annum gross. So we are already earning more than enough, especially when combined with the pension and job security offered by the NHS.

My point is simple: there is surely enough work to go around and for us all to enjoy as fully trained anaesthetists, particularly if an increasing number choose to work more flexibly. A cultural change is required for the flexible workforce and with less intensity.

Consultant in Anaesthesia, Barts Health

Annie Hunningher,
Consultant in Anaesthesia, Barts Health

References:

The introduction of the WHO surgical safety checklist has made a noticeable improvement in patient safety. Is it time to introduce a standardised checklist i.e. a timeout prior to a patient transfer? Many examples exist at a local level, although there is no national consensus. In the absence of one such, we would like to propose the use of a mnemonic ‘TRANSFER’ as an aide-memoir about the key points to keep in mind prior to embarking on a transfer. 

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

Cambridge
FRCA VIVA Course 2012
Cambridge University Hospitals NHS Trust, Cambridge

Final FRCA VIVA Day
Wednesday 21st November 2012

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

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

Registration Fee: £200.00

For further information, please contact:
Mr Jonathan Northrop, Postgraduate Medical Centre,
Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP
Tel: 01223 216376
Email: jnn33@medschl.cam.ac.uk

email: jnn33@medschl.cam.ac.uk

Tel: 01223 216376
Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP
Mr Jonathan Northrop, Postgraduate Medical Centre,

Consultant in Anaesthesia, Barts Health

Anne Hunningher,

AAGBI has issued guidelines to facilitate safe transfers and these should be followed irrespective of the nature of the transfer. The choice of the personnel conducting the transfer is often arbitrary i.e. the most senior person with airway skills available that can be spared from clinical duties. It is assumed that this person would make note of the relevant problems and perform a successful transfer.

The introduction of the WHO surgical safety checklist has made a noticeable improvement in patient safety. Is it time to introduce a standardised checklist i.e. a timeout prior to a patient transfer? Many examples exist at a local level, although there is no national consensus. In the absence of one such, we would like to propose the use of a mnemonic ‘TRANSFER’ as an aide-memoir about the key points to keep in mind prior to a transfer.

This mnemonic is not meant to be all inclusive, but it will serve as a reminder of the important points when doing a ‘TIME OUT’ prior to embarking on a transfer. Other key points to keep in mind include the expected oxygen consumption from the cylinders, socket compatibility in the ambulance, carrying a mobile phone and making sure you have indemnity covering you for the transfer. We would also suggest that trainees in the first 2 years of anaesthetic training undergo a transfer training course, to familiarise themselves with its intricacies.

Dr Vigil Kaushik, STH Leicester General Hospital
Dr Alexander Philip, Great Western Hospital
Anaesthetic registrar, East Midlands (South rotation)

T - Team Brief, Tell the patient, relatives, receiving unit
R - Record (documentation)
A - Access (venous, arterial), Assistant
N - Noradrenaline (drugs, infusions)
S - Suction, Senior help
F - Fluids
E - Equipment
R - Route (land, air)

References
Surviving Surgery

Venue: The Royal York Hotel, York
Date: 28th November 2012

Nationally and internationally renowned speakers include:
- IOSP (Oxford)
- AAGBI London
- Martin Westphal (Munster, Germany)
- Richard Cotton (Aberdeen)
- Jonathan Thompson (Edinburgh)
- Jonathan Wilson (York)
- Carol Peelen (Bath)

Topics include:
- Cardiovascular anaesthesia in cardiac surgery
- Anaesthetic management of respiratory failure
- Haemodynamic optimisation: what to monitor and what to do?
- The role of regional anaesthesia in facilitated and major vascular surgery
- The Emergency Laboratory

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Anaesthesia November 2012

In a thought-provoking editorial of relevance to the specialty’s NAPS project on accidental awareness during general anaesthesia, Wang makes an important distinction between contemporaneous awareness of an experience and later recall (memory) of it. Furthermore, the recall can be explicit (where patients state accurately that they have had an experience) or implicit (which may exhibit as change in behaviour or response consistent with having had a particular experience). Wang’s article persuades us to move away from a binary view of anaesthesia (ie, awake vs asleep) to a more fluid notion of different grades of consciousness, aligned with different degrees of memory. This understanding is consistent with much of the neuroscience related to consciousness, which points to neuronal networks of increasing size and/or activity broadly proportional to the level of consciousness. The logic leads to an important method of classifying awareness from the perspective of patient experience. Although compelling there are some unanswered questions. In one study, patients undergoing surgery (no neuromuscular blockade) did not respond to surgery. However, they responded appropriately to a command to move their fingers. What does this mean?

In a related theme, Sleigh introduces us to the sedative drug dexmedetomidine. Introduced to the UK in 2011, he provides a lucid account of its likely role in clinical practice based on his wide experience and researches. Readers will find the pragmatic account and the table of administration especially helpful. In a neuroscientific explanation, he introduces the notion of different forms of sedation. Whereas desflurane produces a state of apparent ‘sleep’ from which the patient is easily aroused by verbal stimulation, midazolam and propofol produce more widespread effects with a fixed level of sedation dependent upon the dose administered. The amnestic effects of these agents also differ, with desflurane producing amnesia in proportion to its dose, whereas midazolam and propofol produce amnesia at doses that do not sedate. The implications of these results is clear (although Sleigh draws back from making them explicit). Different anaesthetic agents act on different receptors to produce ‘anaesthesia’ through different mechanisms, the resulting anaesthetic state being a different combination of hypnotic and amnestic effects, unique to the agent. This is a profound message: there is no single, unitary mechanism of anaesthesia.

Last but not least is the article by van Zundert and distinguished colleagues on the life and works of Archie Brain, commemorating 30 years of the laryngeal mask. It details the early efforts and challenges faced by Brain, the subsequent ups and downs, and the various modifications of the device. While Brain may have faced an easier time with research ethics committees, the very different hurdles he did face are detailed. The implications of the results is clear (although Sleigh draws back from making them explicit). Different anaesthetic agents act on different receptors to produce ‘anaesthesia’ through different mechanisms, the resulting anaesthetic state being a different combination of hypnotic and amnestic effects, unique to the agent. This is a profound message: there is no single, unitary mechanism of anaesthesia.
The sharks: They do pretty much what all sharks do – attack anything that is smaller or weaker than they are.

The jellyfish: These pretty creatures while not having the capacity to digest you like sharks can inflict a lasting sting. The pain of the sting can easily reach 10.5 on a numerical rating scale of 0 – 10!

The sea turtles: The turtles are the ‘cool dudes’ on ICU. Nothing fazes them. For the new trainees for whom ICU can be initially bewildering their presence is reassuring.

The dolphins: The dolphins make you feel safe.

The rules of surviving as a trainee in ICU are pretty similar to the rules for surviving in the ocean:

Identify the sharks and avoid them – except when you’re a shark yourself (unlikely if you’re still a trainee!).

Identify the dolphins and align yourself closely with them. Not only are they ‘lovable’ creatures but they may rescue you from the jaws of a shark.

Identify the ‘cool dude’ turtles – except when you’re a turtle yourself. For the new trainees for whom ICU can be initially bewildering their presence is reassuring.

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Identify the ‘cool dude’ turtles – except when you’re a turtle yourself. For the new trainees for whom ICU can be initially bewildering their presence is reassuring.

The ‘cool dude’ turtles can sometimes be a double-edged sword. They give in to keep the peace. On most days this is a good thing. However (at times) it can impact negatively on your work especially for senior trainees. If you then say ‘no’ to a similar request from the senior nurses you get the ‘but Dr so and so always does it this way’ which is another challenge.

Sister ‘Jellyfish’? Well I’ll tell you my story and let you decide.

I was the head of a 3-tier on call team and was dutifully doing the night round in my allocated wing of the ICU. In walked Sister ‘Jelly Fish’ clutching a drug chart. ‘Doctor, your junior colleague has written this prescription wrongly. Can you please correct it?’ I check the prescription on the PRN side of the drug chart. Morphine, 10 mg to be administered orally 2–4 hourly and duly signed. I was confused to say the least. ‘What is wrong with this prescription?’ I enquired. ‘Can you write Oramorph for the patient? Your colleague has wrongly written morphine instead’ she persisted.

I patiently explained that actually he was correct. ‘Oramorph’ is a trade name and strictly speaking we are meant to prescribe pharmacological names and not trade names. I stressed that my colleague’s prescription was in order.

Sister ‘Jellyfish’ left looking not entirely satisfied but I was glad of the respite. I rejoiced at the triumph of logic and reasoning. This is the world of science and with patience and perseverance superior knowledge will always win. Alas my celebration was premature! Sister ‘Jellyfish’ charged back into the wing wielding a bottle. ‘Here Doctor, see it says ‘Oramorph’ on the bottle!’ By this point I was fast approaching my exasperation threshold. I pointed out that the reason the name Oramorph had the ® sign at the end was to indicate that it was a trade name. Underneath the name Oramorph on the same label it was clearly and rightly written ‘Pharmacologically identical to morphine’.
The academic partnership of the Severn Deanery and the University of Bristol invite applications for an Anaesthesia NIHR Academic Clinical Fellow post commencing August 2013. The post will be recruited at ST3 level; the successful applicant will be awarded an academic NTN in the Severn School of Anaesthesia. The Fellowship will provide 3 years integrated academic and clinical training for junior doctors who wish to pursue a career in clinical academic medicine and have outstanding potential as future researchers. This academic partnership offers exciting opportunities across a wide range of research areas. The program has been designed to ensure that they attain their clinical competencies and academic goals making them competitive for a successful application for an MC Fellowship, while remaining on track for their CCT. The Severn Deanery and the University of Bristol support a dedicated School of Clinical Academic Training to provide support for all academic trainees.

The purpose of the role was to create a new type of anaesthesia provider, to maintain and enhance the safety of the wake of the expected shortfall in the medical workforce. Anaesthesia in the UK has traditionally been delivered by medical professionals. However, non-medical providers of anaesthesia exist in many countries, including North America and Europe. They have been proven to be a safe and effective addition to the workforce. If non-medical providers of anaesthesia were deemed to be unsafe, the RCAn would not have supported the development of PA(A)s and I would not be here writing this.

PA(A)s are currently either science graduates or have a nursing/ODP background. They undertake a 27 month course of training delivered primarily by consultant anaesthetists. This leads to a Post Graduate Diploma and membership with the RCAn. The course was originally broadly based on the primary FRCA examination. It’s primary focus is on ensuring patient safety and giving the PA(A) a good grounding in the basics sciences, clinical knowledge and practical skills needed to play a full role in the anaesthetic management of patients. The practical skills include airway management, peripheral IV access, central and arterial line insertion.

Consultant medical supervision is maintained at all times to varying degrees, with the consultant available within two minutes of being called. Current RCAn guidelines recommend induction and emergence of anaesthesia are directly supervised, the latter of which is deemed unsafe, the RCAn would not have supported the development of PA(A)s and I would not be here writing this.

Many Trusts around the UK are utilising PA(A)s to facilitate 2:1 working, with 2 PA(A)s being supervised by a consultant anaesthetist in adjacent theatres. PA(A)s can also make a positive contribution when working 1:1; decreasing turn around times, allowing staggered emergence of anaesthesia are directly supervised, the latter of which is deemed unsafe, the RCAn would not have supported the development of PA(A)s and I would not be here writing this.

The review process started with a questionnaire seeking to include all PA(A)s currently in the UK, followed by site visits to Trusts that employed PA(A)s to gain a greater depth of understanding. The questionnaire was designed to provide factual information about PA(A) training, employment and working practices and approximately sixty five percent of one hundred (current number around one hundred)
What were your three biggest achievements from the last year?

1. Increasing the number of SAS members in the Association to more than 850.
2. We have set up a very strong SAS Committee that includes all the executive officers of the Council, elected council members, and SAS doctors that have contributed significantly to the specialty and representation from the RCoA and the BMA. The committee enjoys respect and full support of all the members of the Council, especially the President.
3. SAS members who contributed significantly to the specialty are appropriately recognized. SAS members are presented prestigious awards for their services such as the Pask certificate, Evelyn Baker award, and Anniversary medal. This has raised the profile of SAS doctors in the UK.

What current challenges are you facing?

The changes in medical work-force planning seem to be creating uncertainty as to the role and status of SAS doctors in the new NHS. The future of the SAS grade is unclear but it is important to maintain the status and dignity of SAS doctors amidst this change.

There are still very few realistic opportunities for career progression for SAS doctors and, in several Trusts, no apparent educational framework that supports their current and future role within the Anaesthetic team. I urge all those involved with providing Anaesthesia services to read and reflect on this report and consider the positive benefits that the PA(A) role will bring.

SAS Audit Prize 2013

The Association of Anaesthetists of Great Britain and Ireland (AAAGBI) invites applications for the SAS Audit Prize. This is exclusively for SAS doctors to encourage them to undertake audit. Entries will be judged by the Research and Grants Committee of the AAAGBI. All SAS doctors who are members of the AAAGBI are eligible to apply for the prize.

A submission form is available on the website www.aagbi.org/research/awards/sas-grade-anaesthetists

Please email entries along with the completed submission form to secretariat@aagbi.org

If you have any additional enquiries, please email secretariat@aagbi.org or contact 020 7631 8812.

Closing date: Monday 07 January 2013

What are your priorities for the coming year?

My main objectives are to:

- Raise the profile of SAS doctors in anaesthetics in every possible way.
- Help and advise about issues relating to terms and conditions and job contracts.
- Increase the SAS membership to 1000 by the end of the year.
- Look into ways to reward and encourage SAS doctors. Improve the number of applicants to the SAS research and audit award and SAS Travel Grant.
- Establish SAS representation in all the major committees of the Association and the working parties producing guidelines wherever appropriate.
- Up-grade the SAS section of the AAAGBI Website ensuring it provides useful information presented in a user-friendly way.
- Strengthen the links with the BMA, the RCoA and other organisations and work with them in raising the profile of SAS doctors.

Our current plans include:

1. SAS Seminar dealing with job related topics, video the meeting and make the programme available on the website for all the members to view.
2. Seminar on ‘Patient Transfer’ for SAS doctors.
4. I am on the working party producing guidelines on ‘out of hours work’. As SAS doctors are very much involved in out of hours work especially in peripheral trusts, I wish to look into ways of providing support for SAS doctors.
5. Provide assistance on the application process for CESR and obtaining substantive consultant post through workshops and appointing SAS champions.
6. I wish to make sure that voice of SAS doctors is heard in all the deliberations of the Council.

The SAS Committee believes that SAS doctors should have similar opportunities to teach and train.

The site visits provided the working group with the opportunity to examine the reality of the PA(A) role in practice, providing detail to support the questionnaire. The working group agreed themes to be explored during the visits including: the integration of the PA(A) role, good examples of working practice, finance, job planning and the views of Consultants, trainees and other colleagues. A limited number of Trusts across the United Kingdom (excluding Ireland) were visited as a representative sample to establish how PA(A)s were currently being utilized and these visits incorporated examples of extended roles. After each visit the review group discussed and summarised the information gathered to ensure clarity and accuracy. With the questionnaire complete and all the visits finished the review group met to finalise the format of the report and agree the detail.

A number of themes emerged during the review process; namely the flexibility and continuity that the PA(A) role can provide, supported by the lack of adverse incidents attributed to PA(A) working practices. For the most part the expressed views indicated that the role makes a positive contribution to trainees, and is widely supported by Consultants in the Trust’s that employ PA(A)s. The extended roles carried out made significant contributions to the departments where they were based and are supported by senior clinicians. An area of concern however was the apparent lack of adherence to RCoA guidelines in some areas. In relation to the themes above the AAAGBI has voiced their support for the APAA’s initiative to establish professional registration and regulation of the role. Unfortunately this process has currently stalled due to recent changes in Government policy. Until this becomes a statutory requirement the AAAGBI believes strong consultant leadership is needed, coupled with robust local governance to ensure PA(A)s have clearly defined roles and registration and regulation of the role.

In relation to the themes above the AAGBI have voiced their support for the questionnaire, and to the staff at the sites we visited for their help. I urge all those involved with providing Anaesthesia services to read and current and future standing within the Anaesthetic team. I urge all those involved with providing Anaesthesia services to read and current and future standing within the Anaesthetic team. I urge all those involved with providing Anaesthesia services to read and current and future standing within the Anaesthetic team. I urge all those involved with providing Anaesthesia services to read and current and future standing within the Anaesthetic team. I urge all those involved with providing Anaesthesia services to read and current and future standing within the Anaesthetic team.
I love London, and I can’t think of a better reason to come to the WSM than to listen to stimulating scientific discussion, meet good friends… and take advantage of the post Christmas sales!

Core Topics

This year we have made a change to the Core Topics day. Instead of having 12 lectures of 45 minutes, we have shortened the lectures to 30 minutes. This means that there are now 18 lectures to choose from. This shorter format means a greater choice of lectures, shorter periods of time to concentrate and more CPD boxes to be ticked!

Topics for this year include:

- Outcome measures in day care
- Anaesthetic management of the septic surgical patient in the operating theatre
- Pubmedding!
- The National Emergency Laparotomy Audit – what you need to know
- Analgesia for labour (including remifentanil PCAs)
- Anaesthesia and the Environment – can we do better?

Management of Key cardiac scenarios:

- The patient who develops on table hypoxia
- The patient with heart failure in the operating theatre
- The patient with valvular heart disease

Management of Key respiratory scenarios:

- The patient who needs OLV or a chest drain
- The patient who develops on table hypoxia – an algorithm
- Strategies for ventilating the difficult to ventilate patient

Pharmacology session:

We have a great series of lectures on:

- dexmedetomidine,
- tapentadol,
- pharmacogenetics – the best fit anaesthetic by Thierry Girard, from Switzerland.

Short term and long term venous access:

- complications of central venous access: recognition and management
- where is my catheter tip?
- long term venous access devices: What can anaesthetists use and insert.

Andy Bodenham is also running a workshop on venous access to compliment these lectures.

Keynote lectures:

We have 3 tremendous keynote lecture lined up for you this year:

- Professor Martin Elliott from GOSH will talk about his pioneering work on tracheal transplants
- Dr David Zidean, Clinical Lead for Emergency Medical Care at the Olympics will talk about ‘the Olympic Experience’
- Mr Nigel Edwards, Senior Fellow in Leadership Development and Health Policy will deliver the GE Healthcare lecture

Debates:

No WSM would be complete without a chance to  debate and this year we have two terrific motions:

- ‘This House believes that I would rather have a difficult venous access trolley than a difficult airway trolley’. Proposed by Andy Bodenham (guts of accessing difficult veins) and opposed by Dr Chris Frerk (guts of NAP4). I wonder who will mention the Tricky Varicose Society Test? (Ref 1)
- ‘Our second debate promises to be testy and fun. Martin Dreer will take on David Bogod, President of the OAA, in a head to head challenge proposing that This house believes that rigid adherence to the classic RSI in obstetric anaesthesia is inappropriate… I can’t wait!’

Workshops:

As ever we are running our very popular ‘How to publish a paper’ Workshop run by the Editorial Board of Anaesthesia, and the Ultrasound Session, run by Regional Anaesthesia UK.

In addition we have 5 new workshops:

- ‘The One Lung’ Bristol team led by Matt Molyneux, who founded this course, are combining forces with the London team to run a workshop on OLV.
- Alicia Dennis from Melbourne, will be running a Problem Based Learning session on TTE and pregnancy based case discussions for 20 people. For anyone interested in this subject, I would strongly recommend that you sign up for this session as soon as possible, as places are limited.
- Spinal sonography
- Vascular Access
- Sea UK

Revalidation Session:

Revalidation is not all about listening to lectures based on facts and figures. In their new CPD Guidance for all doctors, the GMC states that an individuals CPD should take into account domains and attributes in the Good Medical Practice Framework (Ref 2).

The domains are:

- a) knowledge and skills and performance
- b) safety and quality
- c) communication, partnership and teamwork
- d) maintaining trust

In response to this we are running a 90 minutes Session on Revalidation led by Dr Nancy Redfern. This will run as a parallel session to the main stream of lectures, and will consist of 50 delegates and 8 trained anaesthetists who will cover teamwork, communication, maintaining trust and partnerships through a series of mini lectures and CBDs. This will run as round table discussions exploring various issues which are current within revalidation.

Mentoring Sessions:

There will also be the opportunity to have a mentor/taster session. In the GMC’s Good Medical Practice guide it states that ‘You should seek out a mentor during your first years as a doctor and whenever your role changes significantly throughout your career’ (Ref 3). This has implications for the new introduction of revalidation, allowing support for all people undertaking this process. We ran this faster session at the GAT meeting in Glasgow this year to trainsees attended the sessions with tremendous feedback and requests for these sessions to be repeated next year. I urge you to give these taster sessions a go, they are well worth signing up for.

Continuing with the theme of Revalidation we have 2 excellent sessions on Quality and Safety and a Core Topic on Quality improvement.

Quality improvement:

- Dr Arnold will talk about Quality indicators in anaesthesia, Dr Sacks on Human Factors and Dr Primas about Safety in anaesthesia.
- Dr Dave Murray is clinical lead for The National Emergency Laparotomy Audit, and will give an overview of everything you need to know about: the audit, its aims, a justification of what data is being collected and why, and what standards they will be comparing the data against. The lecture will also give an overview of how to manage these patients clinically in your Trust.

Safety:

Dr Nicholas Davies, past chairman of MPS Council will talk about Litigation and the Older anaesthetist, Dr Nick Sevdalis will talk about ‘How to make Morbidity and Mortality meetings more meaningful’ and Dr Guy Haller from Geneva will talk about Drug Administration errors in anaesthesia. Many of you will have read his editorial in the BMJ on this subject.
The pregnant anaesthetist on-call

Although there is no evidence to suggest that either is detrimental to mother or baby, long days and nightshifts may become exhausting in the later stages of pregnancy. Dr Fulton and Dr Savine from St Georges Hospital, London, presented a survey looking at this issue at the GAT ASM in June. Fifty three episodes of pregnancy were surveyed and results showed that trainees stopped daytime on-calls at a median of 32.5 weeks gestation and nightshifts at a median of 30 weeks gestation. Although each pregnancy is different this information may prove useful for pregnant anaesthetists, particularly first time expectant mums, who are unsure how to plan for the later stages of pregnancy.

Latest safety updates

View the latest safety updates and Medical Device Alerts on the AAGBI website

www.aagbi.org/safety/incidents-and-alerts

For breaking news and event information follow @AAGBI on Twitter

Videos

We are now videoing more and more lectures. Not only does this provide an excellent educational resource for departmental teaching, study days and exams, but it also allows you to hear one set of lectures or attend a workshop, safe in the knowledge that you are not missing out on the other lectures! The feedback from these videos has been excellent. In one Deanery when a lecturer had to pull out at the last minute, an AAGBI video was played and it scored the highest mark on the feedback scores!

Samantha Shinde
Chair of the AAGBI Education Committee

References:

Specialist Societies invited to host sessions this year are:

• BATS: The British Anaesthetic Trauma Society. This Society was launched in order to enhance anaesthetic management of victims of major trauma in the UK. They held their inaugural meeting at 21 Portland Place, in November this year and we are delighted that their first national meeting is at a plenary session at the WSM. Topics to be covered are: Changes in protocols for massive blood transfusion, whole body CT and trauma checklist.

• SOBA: Dr Mike Marguson has put together 4 lectures on anaesthetists knowledge of key issues in morbid obesity. (some of this data was collected at the Annual Congress in Bournemouth); how to manage the obese surgical patient, how to manage the obese parturient, and the joint AAGBI/SOBA guidelines on ‘Anaesthesia for the Morbid Obese patient’.

• NASGBI: We have a series of lectures on the initial management and transfer of brain and spinal injury patients and an excellent lecture by Dr Solbach, who will tell us about the most appropriate imaging modality for each neuro and spinal indication and a brief update on what interventional neuroradiologists are getting up to particularly with respect to SAH and stroke.

We are looking forward to the second year of the Innovation session, organised by Bernie Liban as well as the paediatric and obstetric sessions.

For something a bit different we have a session on:

The Science of ageing:
We will have talks on biological v chronological age from the Dr Thomas Research group and Can brain stem cells repair the brain? by Prof Siddhartha Chandran from Edinburgh, as well as a talk by Dr Ana Valdes from the Ageing and Health Institute in Newcastle.

WSM London – Early bird still available

There is still over a month left to take advantage of the early booking rate for WSM London on 16-18 January 2013. Booking before the 17 December will save trainees 17% and ordinary members 10% on the normal subscription costs. www.wsmlondon.org
Practice, practitioner, or placebo? A multifactorial, mixed-methods randomized controlled trial of acupuncture

Introduction
Complex therapeutic interventions, such as acupuncture, achieve their outcomes through a combination of mechanisms including the patient–therapist relationship, treatment expectations, suggestibility, conditioning, and practitioner bias. Acupuncture and acupuncture ‘placebos’ have both been shown to provide greater benefit than conventional care. The aims of this study were to examine the effect of needling, the consultation type, and the practitioner on severe osteoarthritic pain.

Methods
Patients included 279 patients with knee or hip osteoarthritis randomized to receive real, placebo, or sham acupuncture. The primary endpoint was a 2-week self-reported pain score using a visual analogue scale (VAS) ranging from 0 (no pain) to 100 (worst possible pain), collected whilst in the consultation room. The practitioner was blinded to the group allocation and all patients were blinded to the treatment arm allocation. Outcome measures included the Knee Injury and Osteoarthritis Outcome Score (KOOS), SF-12, SF-36, EuroQol quality of life index (EQ-5D) and a patient global rating of change. The authors noted a number of limitations with their study. These included an imbalanced 63:31:15 patient allocation ratio between the sham, placebo, and real groups, and a high number of patients (26.2%) who did not complete the trial.

Results
Of the 279 patients that were initially assessed, 221 patients were recruited. All were given a daily pain diary (100mm visual analogue scale VAS) to complete for 7 pre-treatment days, then recorded their weekly pain and analgesia during treatment and for 1 week post-treatment. Face-to-face qualitative interviews were conducted with 27 participants (purposive sample). The primary outcome was pain (VAS) at 1 week post-treatment completion.

Conclusion
This large and comprehensive study has highlighted that uLMA use is a largely avoidable event, it is associated with significant patient morbidity and mortality. The authors identified 15795 adult patients who had undergone GA with a uLMA between 2005 and 2011, of which 1757 patients 313 were noted to have undergone a laryngoscopy during an LMA anaesthetic. 143 of these patients had undergone a laryngoscopy prior to the LMA being replaced in response to a change in surgical plan. 13.7% of patients who suffered failure of uLMA were subsequently admitted to inpatient care as an emergency admission, with the majority of these being male sex, poor dentition, raised body mass index and rotation in the surgical table. The authors also noted that difficult bag mask ventilation occurred following uLMA placement with a specificity of 88% and a sensitivity of 58% for predicting all postoperative complications. Patients who were unable to complete more than 25% of the distance were almost three times more likely to have a post-operative complication, had a statistically significant longer duration of stay 14 days versus 8 days and 65% of the unplanned intensive care admissions came from this group.

Discussions
This study confirms that the widely performed uLMA has a role to play in risk stratification of patients for major colorectal surgery. With the information gained better planning can take place to ensure peri-operative optimisation and minimise adverse events. Ultimately, this reduces the number of unplanned admissions may be reduced. Based on this study, centres performing major colorectal surgery may choose to adopt the ISWT for routine pre-operative assessment.

Evan McGregor
ST6, South East Coast District of Anaesthesia

Use of the pre-operative shuttle walk test to predict morbidity and mortality after elective major colorectal surgery

Anaesthesia 2012; 67: 833–849

It is well known that major colorectal surgery is associated with significant morbidity and mortality. Our routine pre-operative anaesthetic assessment does not allow us to identify those patients who are going to suffer from post-operative complications. Cardiopulmonary exercise testing is deemed to be the gold standard means of assessing cardiac and respiratory reserve, but it requires significant investment in equipment, training, and clinician’s time. The shuttle walk test, on the other hand, requires minimal investment in equipment and can be performed by non-clinicians.

Methods
This is a prospective, single-centre observational study of consecutive patients over the age of 40 undergoing major elective laparoscopic or open colorectal surgery. Each patient completed the Incremental Shuttle Walk Test (ISWT) under the supervision of a single investigator. The patients underwent an incremental increasing number between two courses coming ten metres per shuttle. The test was stopped when the patient could no longer manage the course, or the required speed or became too breathless to continue. The primary endpoint was the 30-day all-cause mortality, and secondary endpoints were 30-day major morbidity (organ failure, major surgical and medical complications, intensive care or high dependency admission), length of stay and location at 30 days.

Results
120 patients completed the study. The mean (SD) shuttle walk distance was 276.0 (134.5) metres for patients who developed complications and 398.0 (138.9) metres for those who had none (p = 0.001). Statistical analysis determined that patients with a shuttle walk distance of 276 metres or less were at an increased risk of death and difficult medical ventilation. In the multivariate logistic regression analysis, patients who had undergone a shuttle walk distance of less than 276m had a 3.83 (95% CI 2.03–7.24) increased odds of mortality at 30 days post surgery compared to patients who had done better in their shuttle walk test.

Conclusions
The ISWT is an easy and inexpensive test that can be performed by non-clinicians. It runs on a computer and can predict mortality and morbidity after major colorectal surgery. It is safe, repeatable, and reliable. It is well known that a test with high sensitivity is likely to result in a high number of false negatives and a test with high specificity is likely to result in a high number of false positives. This test has high sensitivity and low specificity. If we use a short shuttle walk distance as our cut-off value of 276m, we classify patients who have done well in their shuttle walk test as having a lower risk of death than patients who have done poorly in their shuttle walk test. This is probably an overestimate of real risk as we know patients with shuttle walk distances above 276m do well as well. However, based on this study we can conclude that patients who perform poorly in their shuttle walk test are at increased risk of death and difficult medical ventilation. This test is easy to perform, simple to use, safe, and can help us identify patients who are at increased risk of death and difficult medical ventilation after major colorectal surgery.

Alistair Gibson
ST5, Western General Hospital – Dental School

References
Dear Editor,

Seek salvation in “Doyle’s Gap”

We have unearthed a deadly weapon with which to arm our Anaesthetic colleagues in their daily battle in freeing themselves and their patients from the sprawling, tangled web of cables and lines that breeds uncontrollably on transferring patients to and from operating tables, trolleys and beds – “Doyle’s Gap”.

A dreaded phenomenon occurs on patient transfer (1, 2), feared by all Anaesthetists – a finely ordered, delicate and rather beautiful arrangement of intravenous fluid lines, breathing circuits, and cables pre-transfer metamorphoses into a fanged monstrosity, an intimidating wounding mass, resembling the grotesque head of Medusa after transfer. This manifestation is met with Anaesthetists’ horror, and the disapproving glances of waiting surgeons, theatre scrub staff, and ICU nurses as the valiant Anaesthetist attempts to gain control of the beast. The pleading cries of the Anaesthetist that the cables were perfectly aligned before transfer, is met only with stone faces. Introduce a temperature probe, urinary catheter, CVP or arterial line into the patient voyage and the monster that is born is of nightmarish proportions, overwhelming even the most courageous of Anaesthetists in Gorgon-filled terror. No amount of frantic untangling of the mayhem of lines can undo this terrible transformation.


Obsessive compulsive disorder is an essential attribute of the Anaesthetic warrior (Warning: OCD supersedes courage). Survival tips for all intrepid Anaesthetic warriors:

• Anaesthetists must obey two rules: i) ensure adequate line slack before transfer; ii) ensure all dressings adequately secured before transfer. (Warning: Beware “Doyle’s Gap” Novices)
• “Doyle’s Gap” will not be found in any Manual Handling Guidebooks (Warning: The mere whisper of “Doyle’s Gap” strikes fear into the hearts of all HCAs).
• “Doyle’s Gap” rises and falls with patient anatomy and pathology. Anaesthetists forced to embark on other methods of patient transfer must be wary. (Warning: prepare to do battle once more).
• The safe passage afforded to lines and cables by “Doyle’s Gap” should be accompanied by a trumpet salute from awaiting subjects. (Warning: Trends will vary between institutions).
• “Doyle’s Gap” will abolish the Medusa-induced glances of waiting surgeons and theatre scrub staff; it will not undo the stone faces of ICU nursing staff. (Warning: “Doyle’s Gap” cannot make miracles happen).

Dr Patrick Ward
SpR Anaesthesia, Charing Cross Hospital,
Imperial NHS Healthcare Trust
Dr Patrick Doyle
Consultant Anaesthesia, Charing Cross Hospital, Imperial NHS Healthcare Trust

References:

Vannessa Vallance
ST4 Anaesthetics, West of Scotland

Lorna Young
ST4 Anaesthetics, West of Scotland

Lisa Gemmell
ST4 Anaesthetics, West of Scotland

Miriam Stephens
ST4 Anaesthetics, West of Scotland

Vanessa Vallance
ST4 Anaesthetics, West of Scotland

Dear Editor,

Flying Object in Catheter Mount

Various clinical and non-clinical objects have been found in catheter mounts that have lead to mortality. We report two consecutive incidents involving two different catheter mounts which occurred during an elective general surgical list.

The first patient required intubation for an elective laparoscopic cholecystectomy while the second patient required intubation for an inguinal hernia repair. These patients were both of ASA grade II and were successfully intubated. However, on compressing the reservoir bag to deliver anaesthetic gas to the patient, a clear plastic object was observed to traverse along the catheter mount from the machine end to the patient end of the mount, causing partial obstruction. In the first case the object settled in the patient end of the mount, as demonstrated in figure 1 while in the second case the plastic body settled at the machine end. On both occasions the catheter mounts were immediately replaced and their surgical procedures progressed as planned. Staff were immediately informed of these two incidences with a critical incidents form filled-out. Catheter mounts that were all the same batch number were withdrawn from theatres, the Healthcare products Regulatory Agency were informed. The manufacturer is currently investigating the matter.

With shift based working patterns and on call demands, it can be difficult to coordinate viva exam practice with peer trainees, particularly those based in other hospitals. We, as a group practising for the Final FRCA SOE exam, used ‘Skype’ video calls as a way of attempting to overcome this problem.

Since it proved challenging to arrange regular meetings in person, we decided to use video calling opportunistically where 2 or more of us had free time in order to increase the number of scenarios we were able to practice. Benefits of using such a video calling system include that it is simple to use, easy to access and low cost. In addition, it negates any travel time that would be required to meet in person, thus improving use of study time overall.

Its effectiveness can perhaps be demonstrated by the fact that each of us passed the viva exam at our first attempt!

Iarna Young
ST4 Anaesthetics, West of Scotland

Lisa Gemmell
ST4 Anaesthetics, West of Scotland

Miriam Stephens
ST4 Anaesthetics, West of Scotland

Vanessa Vallance
ST4 Anaesthetics, West of Scotland

Dear Editor,

On both occasions two different staff members removed the catheter mount from its wrapper at the time of use, as recommended by “The Association of Anaesthetists of Great Britain and Ireland.” The potential occluding plastic was not identified on visual inspection without careful air flow through the catheter mount and was of regular shape, made of the same plastic as the catheter mount and not its wrapper.

Although careful machine checks are frequently performed, this report along with previous documented cases highlights the importance of checking single use devices and ancillary equipment for potential occluding bodies that may lead to fatal consequences.

Dr Nina W. Habib
CT1 Anaesthetics, Yeovil District Hospital

Figure 1: Occluding body within catheter mount

Figure 2: Foreign object removed from catheter mount

References:
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