New President
Dick Birks reports

What is induction for?
Two perspectives

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THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland
Real anaesthetists treat more than one species: Part three

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This is the third and final part of a series that provides a brief overview of anaesthesia for everything except humans. No small task, especially when working with a limited word count. Previously we have looked at the invertebrates, the lower vertebrates and the birds. This article will be on more familiar ground with the mammals.

The mammals are actually quite a small group when compared to the sheer size of the other taxonomic groups, and yet this is the group that we have the most experience with and there is a wealth of knowledge that we can draw upon. The main reason for this is the ability to be able to extrapolate directly from the human anaesthesia field. The human field contributes not only from the work

Mammals are a small but diverse group that range from the small, like this Pipistrelle Bat, to the large.
performed clinically but also from the mammals used as models in pre-clinical drug trials. This is especially true with domestic species such as the dog and rabbit. The monitoring techniques are a useful example of this, for example capnography across the species is very similar.

However care must be taken about direct extrapolation and assumptions that drugs will behave in similar ways across the different mammalian species. After all there is variation between human ethnic groups; why not in animals? The physiological adaptations that many animals have can result in vastly different pharmacokinetic and pharmacodynamic handling of drugs. For example cats lack the ability of glucuronidation, meaning that non-steroidal anti-inflammatories have a much lower therapeutic index than in other species such as dogs. In addition there are the considerations of allometric scaling which have a small influence in human anaesthesia but become much more important when calculating the dose for an elephant compared to a mouse – the latter requires a much higher dose on a mg/kg basis.

With large bodies of data being available on domestic veterinary patients where does that leave us in the zoo and wildlife field? Unfortunately we have to use the basic concept of “extrapolate and hope for the best”. We are not a bunch of trial-and-error anaesthetists but we are limited because a previous body of data is often unavailable, accompanied by a complete lack of pharmacokinetic or pharmacodynamic information for the majority of our patients. Why? The main reason that we don’t often understand the finer refinements of physiological adaptations that our patients have is because there have been no clinical trials. There is a lack of both funding and numbers. Luckily the ability to extrapolate, combined with our ability to classify animals into evolutionary and therefore anaesthetically...
similar groups generally works well. Tapirs are in fact strange horses, wolves are dogs, and so on.

There is a plethora of strange and unusual anatomical adaptations that challenge the zoo anaesthetist. The size of patients is a big factor with patients ranging from 5 grammes (mice) to 5 tonnes (elephants) and beyond (the cetaceans). If we consider one aspect of anaesthesia such as intubation, then this requires the ability to be innovative by building endotracheal tubes from intravenous cannulae, to having specially made 40mm tubes for the larger animals, to having patients where we need ancillary aids such as endoscopes. A good example is the giant ant-eater (*Myrmecophaga tridactyla*) which has an oral opening of 2cm x 1cm, a distance from lips to larynx of approximately 1 metre, an intrathoracic larynx preventing cut down, copious saliva production, an extremely large but delicate tongue, the longest nasopharynx for size in the mammalian world, and a tracheal diameter of 15-20mm. They are nothing if not challenging!

The larger patients provide their own problems with rapid atelectasis occurring, causing ventilation/perfusion mismatches that can lead to acid-base disturbances. This is, quite literally, a massive problem with the megafauna such as the rhinos, elephants and hippos. Intubation and ventilation is essential but requires specialist equipment. In the case of elephants an ingenious system has been set up that utilises demand valves and the Y piece from a circle circuit; this allows field ventilation with minimal risk of barotrauma. These species are often sensitive to the respiratory depressant effects of opioids which further exacerbates the problem: in addition you often cannot manipulate your patient into a suitable position due to the sheer size and the need for a crane. Arterial blood gas monitoring is therefore essential for the success of these sorts of procedures. The mortality rate for hippo anaesthesia, weighing in around 2 tonnes, is in the region of 50%, although there are other reasons in this species and the mortality rate is much lower in other large species. We still have a lot to learn from our patients and we continually strive to improve on these figures. Another example is the giraffe. Until recently giraffes had a mortality rate in the region of 10%; this is now considerably lower and is nearer 2-5%. Although this is commendable, there is still room for improvement when compared to human anaesthetic mortality rates. Giraffes pose all the problems of large animal anaesthesia, but they are also ruminants so regurgitation is a problem, and they are long limbed; if the anaesthetist does not manage the peri-anaesthetic period adequately or the anaesthetic regime is unsuitable then the risk of trauma to the head or limbs can result in euthanasia of the animal being required. With such large animals procedures are meticulously planned well in advance, with basic protocols standardised for emergency procedures. Planning and communication are essential for the success of these events.

Small patients pose the problems of large surface areas to small volumes: similar to paediatrics but magnified by the very small size of some of our patients. Hypothermia is the main concern, and the use of warm air blankets is becoming commonplace now. However hyperthermia is a problem in certain species, particularly the seals. They have a thick insulating blubber layer, so cold water enemas and cooled intravenous fluid therapy can be used if needed. The diving species, such as the seals and the cetaceans, are a good example of how normal physiology can be a problem under anaesthesia. Seals have a dive reflex: they shunt blood away from non essential organs, they become bradycardic, and they become apnoeic. Induction can set up a chain of events that simulates the dive reflex without the finer conscious controls, so that the bradycardia, shunting, and apnoea ultimately lead to cardiac arrest – this is called the “pathological dive reflex”. Changes in approaches to these animals and the agents used means that this can be managed more easily and the problem is seen less often but it is just another example of the idiosyncrasies that the zoo anaesthetist needs to be aware of.

I hope that this series of articles has been an interesting diversion from the world of human anaesthesia. Zoo and wildlife anaesthesia is an often challenging subject, which requires a lot of planning, innovation, but mostly patience and luck!
President's Report
November 2008

This is my first article in *Anaesthesia News* as President. There are now around 10,000 members of the Association (AAGBI). Clearly I do not know all 10,000 and I am sure not all 10,000 know me! Briefly, I am a consultant in Sheffield where over the years my main interest has been in obstetric anaesthesia. Locally I have been Services Organiser, Royal College Tutor, and Regional Adviser. Nationally, I was Honorary Secretary of the Obstetric Anaesthetists’ Association in the early nineties and from the late nineties onwards I have been on the Council of the AAGBI. I am also a Royal College examiner.

Enough of the introduction, what of the AAGBI? I am pleased to report that the organisation is in good shape. As most of you will be aware we have been in our premises at 21 Portland Place for around five years and we now have an extremely committed ‘in house’ team of around twenty staff. Financially, in spite of the credit crunch and the move towards ethical investment of our savings we remain essentially in good financial health. The AAGBI is your Association run by a Council elected by you, the membership. Council members at present represent a broad reflection of current anaesthetic practice in the UK and Ireland, academic, healthcare, healthcare management, training, private practice and so on. We welcome three new members to Council this year and congratulate them on their election. Paul Clyburn (Cardiff), Richard Griffiths (Peterborough) and Isabeau Walker (London) will be known to many of you. While welcoming new members we sadly have to say goodbye to others. Sean McDevitt (Dublin) has been a stalwart member of Council and recent chair of the Independent Practice Committee. Neil Adams (Bury St Edmunds) leaves as chair of Museums and Archives and is replaced by Alastair McKenzie (Edinburgh). Surgeon Captain Charley Johnston finishes as armed forces representative and we welcome Group Captain Neil McGuire to Council. To all those leaving we thank them warmly for their contribution and wish them well for the future.

Another long-serving Council member leaving this year is Di Dickson, who has served in many capacities, including Honorary Membership Secretary, and more recently as inaugural chair of the welfare Committee. She stands down this year, and therefore leaves Council, but remains a co-opted member of the committee. Professor David Rowbotham has diligently chaired the Research Committee and now is the lead for the National Institute for Academic Anaesthesia. We are delighted that he continues on Council as Vice President.

There is also, of course, movement within Executive and Council. Firstly, tribute must be paid to an excellent President/Honorary Secretary team in David Whitaker and William Harrop-Griffiths. David’s tenacity in pursuit of parity of remuneration for anaesthetists in all aspects of NHS work, and a
better deal for those involved in private practice is legendary, matched only by William’s extraordinary efficiency. We do not lose them: they will contribute to the AAGBI for some time to come. Les Gemmell becomes Honorary Secretary with wide experience of many aspects of the specialty both locally and nationally, Iain Wilson remains Honorary Treasurer for another year and then Ian Johnston, whom we thank for his major contribution as Honorary Membership Secretary, will take over as Treasurer. Many have remarked that it is not a bad ploy in these increasingly stringent economic times to have two Scotsmen looking after the AAGBI’s finances! The final change in the Executive is the election of Ellen O’Sullivan to the post of Honorary Membership Secretary. We believe she is the first Irish member to be elected to the Executive.

Some will be aware that Company Law has changed significantly over the past year - as the AAGBI is a company, this affects us. The Education and Research Trust of the AAGBI is a charity largely funded by the AAGBI company, so these changes have given us the opportunity to review all our memoranda and articles. Rather like propofol and the laryngeal mask being mutually beneficial, so it was a huge stroke of luck that these changes came at the time Will Harrop-Griffiths was Honorary Secretary. There are few with the eye for detail that these changes required and we are indebted to him. Those who were at the Torquay AGM will know that the AAGBI remains a company but in future the Education and Research Trust will be known as the AAGBI Foundation. Under the new Company Law it is not mandatory to hold an AGM, nor do the annual accounts have to be presented in detail. We feel, however, that transparency dictates that we should continue to hold an annual meeting at Congress and the accounts should be available in detail to any member wishing to peruse them. To all insomniacs out there I guarantee that reading the accounts is more effective than a large dose of Temazepam!

What will be the strengths of the AAGBI in the immediate future? The core business of the AAGBI remains the events and seminars programme. The Annual Congress, WSM London, the GAT meeting, seminars and core topics remain successful and in an age of perceived restriction in study leave and funding, all meetings remain in demand. The AAGBI committees are where the real work of the AAGBI is done. The International Relations Committee is hugely influential, particularly in Africa, and its involvement in the global pulse oximetry (GO) project is very successful. The Overseas Anaesthesia Fund (OAF) was set up as a separate charity by the AAGBI and as a funding stream for a variety of projects has exceeded all expectation. The Research Committee continues to provide substantial monies for research and has been actively involved in supporting the new National Institute for Academic Anaesthesia. The Safety Committee, with very effective leadership in recent years has moved from a ‘Cinderella’ committee to a very effective group with industry and NPSA representation. “Anaesthesia” continues to be a major international journal. One of the major changes over the last few years has been the evolution of the ‘sick doctors scheme’ into the newly formed Welfare Committee, which is committed to looking at how we can help members with personal/professional difficulties. We continue our strong ties with the British Medical Association and the Independent Practice Committee looks into issues members may encounter in this aspect of their professional life. Legal issues, including potential charges of medical manslaughter involving members are increasingly being referred to us. At the moment we are lucky to have some Council members who are legally qualified.

Why have a Royal College and an Association? The AAGBI was established in 1932, before the Faculty of Anaesthetists at the Royal College of Surgeons, the forerunner of our own College, was established at the inception of the NHS in 1948. The College of Anaesthetists (1988), subsequently the Royal College (1992) was established under the direction of Professor Michael Rosen and others. Professor Rosen was both President of the College and the Association and indeed many in those days (and now!) had a foot in both camps. The College, as with other colleges, has a remit to look after standards, training and examination and some felt our two organisations might slowly merge. This has not happened, of course, yet both organisations remain successful. The Royal College of Anaesthetists is in the vanguard of all Royal Colleges. RCoA Presidents have taken leading roles in the Academy of Royal Colleges and its Council has been innovative in resolving training and other issues of the day. We should all be grateful for this; for most of us are fellows of the Royal College and members of the AAGBI. All Colleges have an ongoing problem. They are increasingly constrained by government and government bodies, PMetB, MMC and so on. Associations do not have such constraints, so are able to comment freely on challenges facing all aspects of the specialty. Anything but friendly rivalry between the organisations in these difficult times is counterproductive for the specialty and that is why I believe Fellows and Members should embrace ‘la difference’.

Richard Birks
President, AAGBI
8th ANNUAL CONFERENCE, LONDON, (1ST) 2ND & 3RD JULY 2009

We invite you to submit work for poster presentation. Accepted abstracts for poster presentation are entitled to a 15% discount on registration (one author only and can not be used in conjunction with any other discount) and selected finalists will be invited to give an oral presentation at the 2009 EBPOM Conference. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 30th March 2009. Abstracts should be emailed in the form of one A4 side of printed text as an attachment in Word or PowerPoint marked clearly with your name, address, telephone number and email to Admin@EBPOM.org

All presenters, both poster and oral, must register for the conference to present their work.

MEETING CHAIRMEN Dr Mark Hamilton and Professor Monty Mythen
Once upon a time, the NHS was a pretty homogenous beast. Its workings were pretty similar no matter which part of the United Kingdom you were working in. I’ve been a consultant in England and Scotland, and when I moved from one system to the other and back again eight years later, the culture change was fairly minimal – apart from having to remember to move my pension, the biggest mental shift I had to make was in the buying and selling of houses. (After experience of both systems, sorry guys - I think Scotland has it right, as usual.)

However since Scottish devolution, all that has changed. Health is a devolved matter, as it is for Northern Ireland and Wales, and we have all gone off in slightly different directions. Scotland has not moved towards the Foundation Trust model, and retains the traditional centrally directed model of care. The relatively large impact of private providers (and hence parity issues) of healthcare south of the border has not happened in Scotland – a very cautious toe has been dipped in the water, but no more than that, and we are not anticipating expansion of this any time soon. I have no experience of working in Wales or Northern Ireland, but I am sure members there will work in different environments also.

This leaves organisations such as the AAGBI with a problem – how to appeal to all its members equally, when some of the issues which are huge in one territory barely register elsewhere. AAGBI has always represented more than one sort of health service, of course, with its Irish members working in a very different way to the rest of us.

As an example of our diversity, take last month’s article in Anaesthesia News. Unless you are one of the lucky few, it may not have even registered, but we published an apparently straightforward one-page item directed at higher award applicants who wished to seek AAGBI support for their application. Readers, it was like organising a NATO summit. The Officers of the Association have learned that they will be unable to get anything past this editor without at least acknowledging that the matter in question may not be applicable in all territories, or that the rules may be different. Clinical Excellence Awards (or Merit Awards, as we Scots still quaintly call them) have different rules, different deadlines, and yes, different names, depending where you happen to be employed. So in order to get this page put together, we called on our expertise from around the country. That little article had about seven people involved in its construction!

As I write, AAGBI’s Annual Congress is taking place in Torquay (full report next month). In the previous four years we’ve visited Dublin, Aberdeen, Cardiff and Manchester, so I hope it’s clear that serious thought goes into trying to cover all parts of the country – unless you are based in Shetland or the Scilly Isles, hopefully you will have a “local” AAGBI Congress at some point. All these locations have a different feel, so each Congress has its own character. Every year there are Q&A sessions for the great and the good of the Association, and it’s always interesting to see that while many of the issues are the same, things crop up which are of great significance locally but may not have registered in the greater scheme of things. While the Republic of Ireland and Scotland have their standing...
committees to specialise in local issues, it’s important that the main body politic is aware of, and reacting to, all the concerns of its membership. This is why it’s necessary for Council to have a good geographical distribution, so that it picks up these variations. If there is no Council member from somewhere in your vicinity, please think about standing next April! As a granddaughter of Portrush, County Antrim, I am particularly sad that Northern Ireland is not currently represented on Council. In addition, the Linkman system was set up specifically so the AAGBI could get feedback from its whole geographical range – make sure your Linkman is active and acting as a conduit for information to and from the AAGBI.

It’s important that all members feel they are served equally by their Association. In recent years, some of the popular AAGBI seminars have gone “on tour” and been held in different parts of the country. Catriona Connelly is the mastermind of this process for Scotland, and I know how much the effort is appreciated. While the London seminars are timed to allow a day trip for as many as possible, for Scottish members it means a pretty early start, plus a reliance on British Airways having its act together – not always a given! A drive to Scone Palace is much more civilised.

A more recent innovation by the events team is the introduction of “Core Topics” days at various regional locations. The final one for 2008 will be in Birmingham on December 10th, and venues for next year include Cardiff, Newcastle, Sheffield, Winchester and Glasgow. There’s clearly a big map somewhere in Portland Place which someone is working with to ensure blanket coverage. So I hope you feel that whatever part of these islands you hail from, the AAGBI is working for you. If not – tell us!

This month we have Dick Birks’s first President’s report. After taking over from David Whitaker at Torquay, he’s getting his feet under the table. Many other changes to Council have taken place, and Dick outlines who’s who now at the Association. We have two views of the hospital induction process for new doctors, from the trainee and consultant viewpoint. While this may look like a carefully planned feature, I received these two unconnected and unsolicited articles within a few days of each other – sometimes it’s all down to serendipity – and am delighted to print them together. And we say farewell to our veterinary series with Jonathan Cracknell’s final contribution – this month we’re on more familiar territory with the mammals.

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I spent today, a precious portion of my brief time on this planet, imprisoned in an airless, darkened room being slowly tortured with mindless drivel. All day I have been fighting the urge to scream or to simply end it all! Why? Because today is the first Wednesday of August and tradition dictates that it is national ‘Torture a Trainee Day’. I believe they also call it, ‘Induction’.

How is it possible to sit for five uninterrupted hours, and not be told one single piece of useful information? Secret seminars must be held all over the country to help people to develop this skill.

We file into the room, hundreds of us, F1s looking eager and enthused, those of us who’ve been here before looking jaded and suspicious of the overly bright smiles worn by the administration staff. A small hope flickers briefly, maybe this year they’ll have refined it, cut the chaff and left only the really important stuff? Fat chance.

The first person to take the stage was a benevolent lady; forgive me if I didn’t catch her name. She seemed touchingly concerned that we had an “interactive and rewarding” session. So concerned in fact, that she spent twenty whole minutes repeating this. I’d like to recount what else she said, there were many names mentioned, of different people in various departments all poised to deal with our every whim. But there were no faces, no facts and actually nothing concrete or useful. She instructed us to read our ‘Integrated Induction Pathways’ - a helpful pack that I’m sure took someone hours to produce, and told us that it contained “everything we would need to know”. Sadly, it didn’t seem to follow that we could take the packs and run.

Next came the Medical Director, who made apologies for the absence of the Chief Executive. Apparently, his overseas trip was unavoidable. I guess the biggest single turn over of his work force isn’t really an event worth acknowledging, let alone attending. Foolish of me to expect that he might want to be there to welcome us across his threshold. How terribly old-fashioned.

He was followed by the head of IT. He instilled enormous confidence by crashing the computer system and having to call in a minion to come and fix it. Muffled laughter from the audience: even the wide-eyed F1s seemed to appreciate the irony. The computer was resurrected, and what followed defied belief. A thirty minute impassioned speech about how, “the hospital will be going paperless...” I sat forward in my seat, thinking at last, something important. Until he continued “...in 2010!”. No. NO. NO!!!! Please tell me you’re not going to lecture us on something totally and utterly irrelevant to the intake of 2008? Oh, stupid me, of course you are. He spent thirty minutes on that stage, and I still haven’t the slightest idea which computer system the hospital uses today. I could tell you the intricacies of a system which will come on line long after I’ve left...well, I could have done if my suppressed rage had not
been buzzing loudly in my ears by then, drowning out all else.

The minutes of my life ticked by relentlessly. There was a man from blood transfusion lecturing about “facilitatable haemovigilance” (I’m sorry, are they even real words?), someone going on about the origins of the bricks used to build the hospital back in the day, a Security Officer who told us not to leave our purses lying around because apparently there are nasty thieves in big cities... There may have been more, but I fear I missed any further pearls of wisdom as, by now, I was rapidly slipping through stupor, into coma.

Then the Fire Officer took the spotlight. Finally, I thought, this might be useful. Why, why, oh why do we have to endure these pointless, patronising, mind-numbingly repetitive days? There was one useful paragraph in the whole day, delivered, I’m pleased to say, by an anaesthetic consultant. He said that we should take responsibility for our own education, apply for study leave and use up all of our study leave allowance. That was it. The rest was meaningless. I am not exaggerating when I say that four o’clock came and I still did not know how to book an X ray, check blood results or even the whereabouts of the operating theatres.

Of course, I know why we have these days. They’re not for the benefit of the trainee at all, and they’re certainly not for the safety of the patient. They exist purely for the hospital’s own protection, nothing more, nothing less. “They” don’t care whether or not the induction is useful, they can’t possibly, or else it would be so wildly different as to be unrecognisable. They care only that when the Healthcare Commission comes calling, they can show them rain-forests of paper, covered in (complicit) signatures; thousands of tiny ticks in countless meaningless little boxes. These all amount to a CNST, or similar, rating that has absolutely no basis in reality whatsoever as nothing we were told in that room today will make a single patient one iota safer. I think I might scream again...

So perhaps tomorrow, I’ll discover the things that really matter to me; how do I get into theatre; will I have a locker; where I can get clogs; how can I log on to the computers? Not grand ideas, not great earth shattering developments, just the real cogs that matter to the real people who keep the big wheel turning. And who will teach me this? The doctors who went before me. As always, then. Not the clip-board-wielding managers or the politicians or all those intent on telling us how to do our jobs, but the people who actually do!

Kate McCombe
Anaesthetic trainee
We’ve all been there. You turned up to a new post at the beginning of August. Someone showed you where the kettle is, gave you the bleep then left you to get on with it. That was your induction over and done with before the first patient had arrived in the anaesthetic room. Not any more. Since the advent of PMetB there have been massive changes in all aspects of postgraduate medical education and the induction process is no exception. August 2008 has seen changes of seismic proportions meaning this is no longer just induction, this is PMetB prescribed, dictated, measured and signed for induction (you’ll just have to imagine the seductive background music and tempting images). The new improved induction has more technical requirements than an Olympic gymnastics routine. The documentation required by our postgraduate department included, but was not limited to, numbers of doctors taking up post, signatures of those who attended induction, reasons why others did not, name of consultant responsible, information given (verbal and written), tours taken, introductions made, and so on.

This year, new doctors had to attend both general hospital and specific departmental inductions. This had to be a formal administrated procedure and I was the consultant responsible for delivering it. I dutifully made myself available for the whole afternoon. This was not difficult as all elective work trust wide had been cancelled to allow the process to occur without clinical duties getting in the way. I turned up during the closing remarks of the morning hospital-wide programme and found that although all six of my new recruits had dutifully signed in, only two had stayed to find out about the fire drill and post mortem service. The other four had skived off: having previously worked in the trust they already knew how to request a full blood count and they weren’t involved in hospital at night. Eventually, I rounded them up and took them off to our department where I furnished them with half a tree’s worth of policies and protocols, the code to the on call room door and the increasingly complicated rota. I answered questions and then took them on the required tour. After pointing out the resus trolley, the difficult airway trolley, the vapour free machine and the chocolate machine, I had them all sign to say I had done it and that they now felt appropriately orientated to their new workplace. Job done I thought. But was it?

What had been achieved? What had they learnt? How much use was it all? They now knew there was no chance of a locker or new theatre shoes but they would have found that out soon enough anyway.

Previously, as a house officer you put effort into conveying to the next incumbent everything they needed to know to get started in the job. You left them a couple
Anaesthesia Aphorisms

Submitted this month by John Asbury, Glasgow, Richard Laishley, Ealing, and Ramana Alladi, Ashton-under-Lyne.

You are only as good as your last anaesthetic.

Double everything the surgeon tells you.

Monitors are only as good as your knowledge of what they are telling you.

A finger on the pulse and a hand on the rebreathing bag are the best monitors.

If you anticipate problems with a patient, check who will be available in neighbouring theatres, when you manage the patient; an extra pair of anaesthetic hands can be a life saver.

Just as patients judge the quality of surgery by the size of an incision and the way it heals, in anaesthetics it is the quality of venepuncture and conduct of immediate postoperative period that counts.

Certain apparently small surgical operations have the potential for torrential haemorrhage e.g. surgery on neck, axilla and femoral areas; the small abscess which just happens to lie over major plumbing.

You can train yourself to use any drug to produce a desired effect. In anaesthesia it is not the drug but familiarity with the drug that matters.

Keep it simple and keep it safe.

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

of sides of foolscap detailing all the important stuff: how to get the secretary to do the filing for you, which nurses would share the ward chocolates and a blurb about the patients. Minor details like codes to the door of the mess were learnt on the job. This simple system worked. Why change it? What should be a brief, focussed, sensible, practical overview has been replaced by an inefficient, over detailed, micro management circuitry of paperwork.

So is the new induction process fit for purpose? That depends on the purpose. If the objective is to absolve the Trust of any responsibility should a new doctor not know where the endoscopy suite is when called to an arrest there, then yes, that box is ticked. However, if the desired outcome is to effectively orientate doctors to their new posts then I do not believe this improved induction process is the way to do it. Throughout the afternoon of Department Induction I found myself repeatedly stating: “this will all become obvious when you do your first shift/list/day on ITU” while thinking that it might have been better to spend the time allocating them to a list to familiarise themselves with the anaesthetic machines, to find their own way to recovery and to introduce themselves to the theatre staff like real grown ups do. These are the things they need to know and learn. Doctors do not need a day in a lecture theatre hearing about their new job and what it will be like the next day when they do start. They need to get on with it and experience it firsthand from the beginning because the words of Confucius the Chinese philosopher are still as true today as when they were first pronounced. “I hear, I know. I see, I remember. I do, I understand”.

Caroline Whymark
Consultant Anaesthetist

Anaesthesia News November 2008 Issue 256
MERSEY

FINAL FRCA VIVA WEEKEND

2.00pm Friday 21st - 4.00pm Sunday 23rd November

The Aim of the Weekend is to Suffuse the Candidates with so much Exposure to the Viva Challenge that, on the day, they will be Immune to the Stress & Stupidity that so often & so unnecessarily Leads to Disaster & Failure

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www.msoa.org.uk ~ Schedule of Courses

for further Details, Plaudits & Application Form

Postscript
Best Viva Result to date – 88%
Worst Viva Result to date – 79%
Now into its sixth year, the GAT Annual Training Survey continues to provide an important insight into the state of anaesthetic training. The survey evolves from year to year but by keeping a core selection of questions it allows the GAT Committee to follow trends within the profession. The current issues with which GAT are concerned and which may have an impact on the quality of our training include: on-call conditions; study budgets; changes to medical recruitment; the European Working Time Directive (EWTD) and the changes to postgraduate medical education training programmes. Surveys such as this enable us to assess the impact of such changes and garner the views and priorities of GAT members over time.

This year’s survey was conducted at the Liverpool GAT ASM in July and was completed by a total of 197 anaesthetists. The majority of the GAT ASM attendees completing the questionnaire were ST1-2s (28.9%), ST3-4s (13.7%), pre-Fellowship (FRCA) SpRs (2.5%) or post-Fellowship SpRs (51.2%). In addition, 1 ACCS (Acute Care Common Stem) Trainee, 1 Foundation Year 2 trainee, 2 SAS doctors, 1 FTSTA (Fixed Term Specialty Training Appointment) Trainee and 1 Consultant completed the survey. The survey consisted of ten questions all relating to current topical issues.

Trainees’ overall salaries are determined by a fixed base salary (reset annually by the Doctors’ and Dentists’ Review Body) on top of which is a supplement according to the pay band. The banding level uses a method that takes into account the number of hours a doctor works per week (commonly 48 to 56), the anti-social nature of these hours and the type of working pattern imposed. In the GAT 2008 Survey, trainees were first asked to specify their level of training and the banding of their current posts. The results are summarised in Table 1.

The survey shows there has been a dramatic increase in 2B posts in comparison to last year, with a doubling in the numbers of trainees working this type of post. The reasons for this increase are explored in the following sections of the survey report.
rota. In turn, there has been a significant decrease in the number of trainees on a 2A rota, although the percentage of trainees working a Band 1A remains roughly the same. It would appear a large number of trainees are working similar hours in 2008 compared to 2007 but have experienced a significant drop in pay.

The survey also asked trainees about pay protection. The principle behind this is to afford some degree of financial protection for trainees during a five or seven year rotation. The BMA states that trainees should receive a salary for each placement on a rotation consistent with the banding that post attracted when the rotation was accepted at interview. In recent years the majority of Trusts have sought to reduce salaries with re-banding, rather than hours worked. In 2008, the proportion of trainees receiving pay protection continues to decline with only 20% of trainees now receiving it, compared with 30% last year and 50% in 2006.

‘Teaching lists’ refers to consultant-supervised theatre sessions. As with last year, trainees were asked how many teaching lists they had received in the previous five weeks of training (Table 2).

65% of Post-Fellowship SpRs had received 0-5 training lists in the last 5 weeks, with 94% receiving less than 15, or less than 3 per week. In comparison, in 2007, 47% received less than 5 and 89% 15 or less. So, there appears to have been a decrease in the number of training lists for year 3-5 SpRs. In contrast, ST1-2 trainees have had a dramatic increase in exposure to consultant-supervised lists (24% receiving only 0-5 lists compared to 55% SHOs in 2007 and 44% 2006). An explanation for this could be the increased number of inexperienced starters in August 2007.

Trainees were questioned about their access to an ‘on-call’ room. The issue of fatigue and professional performance in anaesthetists has been known about since a letter published in Anaesthesia in 1978, and ‘on-call’ room facilities remain a topical and much disputed issue. On questioning, 83% of trainees replied that they still had access to an ‘on-call’ room, compared to 86% in 2007 and 2006 and 90% in 2005. There appears to be a gradual decline in rest facilities for junior doctors. Our annual survey of anaesthetic trainees ‘on-call’ conditions remain a topical and much disputed issue. On questioning, 83% of trainees replied that they still had access to an ‘on-call’ room, compared to 86% in 2007 and 2006 and 90% in 2005. There appears to be a gradual decline in rest facilities for junior doctors. Our annual survey of anaesthetic trainees ‘on-call’ conditions also continues to monitor this trend. We will continue to press for the preservation and reinstatement of sleeping facilities, as supported by evidence from the AAGBI, BMA, the National Patient Safety Agency, and the Academy of Medical Royal Colleges.

Trainees were also asked whether there should be an increase in the duration of training to compensate for the reduction in weekly working hours. 56% of all trainees agreed that length of training should increase. Agreement fell as the seniority of trainees increased. This is in contrast to 2007 when 54% of Post-Fellowship SpRs thought that training time should increase.

There have been dramatic changes to study leave budgets over the last few years, with drastic cuts, complete removal or reimbursements of less than the amount claimed. Of the trainees responding to this year’s survey, 45.1% had received cuts to their study leave budgets whilst, more alarmingly, 16.7% had experienced cuts to their study leave time.

Trainees continue to be concerned about their future within the profession and view with concern the introduction of post-CCT fellowships, Physicians’ Assistants (Anaesthesia) and the possibility of a sub-consultant grade. In the previous two years’ GAT surveys, 78% and 85% of trainees thought that the introduction of a sub-consultant grade would make a career in anaesthesia less attractive. There was no difference of opinion across the spectrum of trainees’ seniority. Following such clear-cut answers and increasing concern this year we asked, “Would you consider taking a Sub-Consultant or Post-CCT Fellow grade position if consultant posts were scarce?” Responses to this question were interesting. 41% of trainees admitted they would consider one of these posts.

Table 2: Level of Training and number of training lists

<table>
<thead>
<tr>
<th></th>
<th>0-5</th>
<th>6-10</th>
<th>11-15</th>
<th>16-20</th>
<th>21-25</th>
<th>25+</th>
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</thead>
<tbody>
<tr>
<td>ST1-2</td>
<td>24</td>
<td>4</td>
<td>20</td>
<td>9</td>
<td></td>
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<td>ST3-4</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pre FRCA</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post FRCA</td>
<td>66</td>
<td>3</td>
<td>26</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
but the answers were accompanied by comments such as: “I’ve got a mortgage and they know it”; “I’d leave the UK first”; “Do we have a choice?”; ‘Only if there was no alternative’; and “Only if it was in a sub-specialty interest for a fixed period of time for educational purposes”.

After a number of testing years for anaesthetic trainees during which GAT has consistently strived to represent their interests and concerns, we felt it was time to ask an open question: “Which issues do you believe GAT should be addressing over the forthcoming year?”

Answers were numerous and varied, with the most common listed in the box below. The majority of suggestions, perhaps unsurprisingly, concerned sub-consultant posts, European Working Time Directive compliance and maintaining training standards. We aim, over the forthcoming year, to continue to represent trainees’ views and needs, and to concentrate on these key issues. Some of the suggestions, however, may be harder for us to achieve than others…

Liz Shewry
GAT Committee Member

The form completed by delegates at this year’s GAT meeting.

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**Which issues do you believe GAT should be addressing over the forthcoming year?**

**A sample of responses:**

- Sub-consultant Posts
- EWTD
- Training lists
- MMC
- OOeTs
- Research
- On-call facilities
- Physician’s Assistants (Anaesthesia)
- International Medical Graduates
- Pay banding
- Junior recruitment
- Study leave budgets
- Travel Expenses
- Loss of ‘on-call’ salary
- Anaesthesia manpower
- ‘MMC and the disorder it caused’
- ‘Dumbing down of training in all specialities’
- ‘Increasing paperwork’
Dr Joanne Rugen’s account of her year at Stanford University Hospital in Silicon Valley reminded me of my time in Denver nearly 40 years ago. I went for six months: at short notice because Professor Robert Virtue had to retire as he’d reached 65 and his staff men (equivalent to consultants) were leaving in case the new professor didn’t reappoint them. Jack O’Higgins was the Bristol senior registrar already there on the usual annual rotation. He was working at the Veterans’ Administration hospital with Tony Aldrete and the surgeon Tom Starzl who’d started liver transplants. At that time in Bristol I happened to be the only readily available Senior Registrar who had the ECFMG (Educational Certificate for Foreign Medical Graduates) which was essential to work in the United States at the time. We flew to Chicago (where my wife had relatives) and got over jet lag before going on to the Mile High City. Jack and his wife Margaret had sorted things out for us and we moved into an apartment in the same block, a short walk from the University of Colorado Medical Center; CGH or Colorado General Hospital. It was then a new building with aerofoil shutters on all windows. When the sun shone on the sensors they closed but why were there shutters on the North side? Well, 50 miles south at Colorado Springs was the nerve centre of the US Airforce. If a nuclear device dropped nearby the flash would close all the shutters and later the fallout could be washed off the building (right).

In late 1969 the residency programme lasted two years and each resident gave about 300 anaesthetics a year - so 600 in total. A bit of a shock; I’d anaesthetised about 1000 patients a year over the previous four years, which I suppose is why Brits were valued for their technical expertise. The trouble was I gave only three anaesthetics in my six months, but more of that later. The day started at 7.00am with coffee and donuts, and a short talk by one of the residents on a pre-assigned topic, such as the higher oxides of nitrogen. The night before, the residents had seen the patients allocated to them and preoperative problems were also discussed. At about 7.30 we all went to the nine-room OR (Operation Room). The one anaesthesia nurse issued equipment and also took part in training the residents. The residents collected their carts, complete with drugs, syringes & needles, halothane, (which was rationed!) Fluoromar, laryngoscopes...
& ETTs, etc and went to their assigned
OR; no anaesthetic rooms. Each staff
member (I joined their ranks as a Guest
Instructor) had two or three residents to
look after each day that lasted until about
3 pm. Induction was slow because
the protocol was to put up a drip, take
blood pressure, pulse & respiration;
and then give five minutes oxygen, all
while the scrub nurse was laying up the
instruments. I suggested giving oxygen
from the start to shorten this period but
it fell on deaf ears. This short delay was
nothing compared with the time taken by
the surgeons. 10-20 minutes was spent
scrubbing the operating site, then tying
every bleeder after incision and again
and again as the incision was deepened.
Staff men usually assisted the first year
resident with induction but might dash
off and help with a difficult intubation.
After the initial flurry between 8 and
10 am I could retire to my (shared)
office and think about research. Library
facilities were excellent: photocopies on
your desk the next day. In fact the couple
of papers I wrote during that time were
case reports. A young man was sent
in from the US equivalent of a cottage
cord with malignant hyperpyrexia;
it was spotted early by the anesthesia
nurse, the patient was packed in ice and
survived. This produced a multi-author
paper in JAMA. The other was when a
resident couldn’t intubate a patient; there
was an epiglottic cyst in the vallecula. A
Magill laryngoscope was found and I
used it to pass the ETT. The library found
more references than I expected (but not
too many) and I published a case report
‘Epiglottic Cysts’ in Anaesthesia in 1972.

About 3 pm the residents had lectures
or tutorials (which might consist of Prof
Virtue reading from Wylie & Churchill
Davidson). If I wasn’t involved or on call,
covering the ORs still working, I could
play golf, go fishing or take a ride in the
Mustang I’d bought with the CGH Credit
Union loan. There was a Grand Round
on a specific subject on Wednesday
mornings, held in a large lecture theatre
with all medical staff in attendance; I learnt
a lot about the dangers of cadmium. I was
invited to lecture at Denver Osteopathic
Hospital, almost next door, on post-
operative respiratory complications and
prevention. Osteopaths (DOs) had nearly
equal status to MDs; it seemed to be an
early example of equal opportunities.
Staff and residents were expected to
go to a post-graduate meeting, and in
March 1970 the International Anesthesia
Research Society was holding one in Las
Vegas so I signed up with another staff
man and several residents. A week or
so beforehand Las Vegas was paralysed:
there was a barman’s strike! With typical
American ‘can do’ the IARS organised a
slightly shorter meeting in Palm Springs.

It was here that matters crystallised for
me. I introduced myself to Professor W.W. Mushin who was giving the Grand
Lecture. He asked if I was enjoying
myself, and enquired if I planned to
stay. I knew that I might be able to but
I’d only given three anaesthetics in six
months; for critical surgery in ill patients
when I thought it was too difficult for the
first year resident on call. I told Mushin
this and his response was ‘and how will
you feel in a few years time, teaching
but not doing?’ After the meeting we
hired a car and went to San Francisco for
the weekend. Bob Virtue had said the
three places to visit in the US were San
Francisco, New Orleans and Boston. We
left Denver in mid April and came home
via New Orleans and Barbados. Boston
had to wait for a few years.

Looking back I have mixed feelings. My
colleagues in Denver were very warm
and hospitable and I enjoyed my time
there although the work was not very
challenging. The academic environment
was less good. The professor was in
charge and could hire and fire easily.
Opportunities for research were good
but Anesthesia was a division of the
department of Surgery and so subordinate.
The surgeons seemed even more likely
to blame ‘anesthesia’ for intra-operative
problems than in the UK. An
example: I was called by a
competent second
year resident.
to the neuro OR. The senior resident neurosurgeon had encountered a lot of intracranial bleeding; the staff neurosurgeon arrived and said it must be a kinked ETT. It wasn’t; there was an artery bleeding—my loud comment: ‘That’s a funny place for a kinked ETT’. The teaching was very rigid; it had to be, the residents were going out into practice after two years with little practical experience. Perhaps things are tending that way in the UK with the present structured system of training? I think I wouldn’t have remained in an academic environment if we had stayed. I would have kept up my practical expertise and maybe earned ‘loadsa money’ in the private sector. I might even have had my own plane; you certainly needed one to be able to get about from Denver.

I walked to CGH from our apartment, West and then South, the grid pattern of North American cities. Early winter mornings were dark. One of my abiding memories is seeing the sun just catching the snow-clad peaks of the Rockies as it rose behind me. US policy about holidays I think is as tight now as it was then in all walks of life: 4 weeks a year, but there are more public holidays. New Year’s Day was not then a holiday in the UK but it was in the US and in 1970 on a Thursday. We were given Friday off as well and so we set off on Thursday in thickish snow first for the Four Corners: the only place where four states meet. We went on to visit the Grand Canyon Southern Rim; a beautiful sight watching the purple shadows deepen as the sun set.

We stayed the night in Flagstaff, Arizona and couldn’t start the Mustang in the morning; the choke was frozen. We managed to get it going and went to the Petrified Forest and the Painted Desert, then headed North the next day to Tacos, New Mexico in bright sunshine.

Cherry Creek was a place I fished and then only once; I did so well I didn’t dare try again. Having caught 18 hand-sized fish, the South African staff man (with trout flies in his hat!) came over to ask for some to take home for dinner; he was having no luck. Gillian was very put off by the fish flapping about in a bucket when I got back to the flat so we had to go out for dinner.

We’d joined a scheme where by paying a sub we could get two main meals for the price of one at about 20 or 30 restaurants in Denver. I hadn’t done much general reading over the previous few years. In a small apartment with few domestic chores I started improving my literary span. I hadn’t read much Stendhal so I went to the local library. To my surprise I couldn’t find any of his books. When I asked the librarian she said they were listed under Henri Beyle; his real name.

Adrian Padfield
Sheffield

Garbage truck. The writing on the back says ‘Satisfaction guaranteed or double your trash back’!

Editor’s note: Adrian Padfield commissions and co-ordinates many of the articles you read on the History Pages of Anaesthesia News. He always responds to editorial distress calls, and somehow manages to persuade someone to write something entertaining and interesting for every issue. He is stepping down from this largely unsung role after several years, and I would like to thank him for all his behind-the-scenes work.

Hilary Aitken
A watercolour painting (illustrated) by Stephanie Greenwell, the former Anaesthesia News editor, has been selected as the AAGBI 2008 Christmas card, with all profits going to the Overseas Anaesthesia Fund. Many of you will have seen the original which was exhibited in the AAGBI art exhibition in Torquay in September.

The cards cost £4.95 for a pack of ten, including P&P. £1.95 will be donated to OAF for each pack sold. To order, photocopy and complete the form below. Forms can also be downloaded from the AAGBI website.
South West Regional Anaesthesia Course

3rd & 4th November 2008
Royal Devon & Exeter Hospital, Exeter

- Upper and lower limb peripheral blocks
- Ultrasound
- Novel blocks e.g. T.A.P
- Video demonstrations
- Lectures and workshops
- Aimed at anaesthetists in training

Cost: £200
Register early – strictly limited to 30 participants

For details & application forms visit: www.sowra.org.uk
Or email RAcourse@sowra.org.uk

The Association of Paediatric Anaesthetists of Great Britain and Ireland

Annual Scientific Meeting
The Brighton Dome, Brighton
Thursday 12th, Friday 13th March 2009

Thursday 12th March
New Horizons in Paediatric Oximetry
Understanding Pharmacokinetics
The Paediatric Airway: APA guidelines
Free Papers and Posters:
Trainee prizes

8th Jackson Rees Lecture
Michael Rosen (The Childrens’ Laureat)
“Communicating with Children”

Friday 13th March
Preparing The Child for Anaesthesia
Advances in Pain Management
Developing New Drugs in Children
Imaging Techniques in Children

Workshops
TIVA, Airway management, Simulator based scenarios, Ultrasound techniques in Paediatrics

Speakers include: Prof Brian Anderson (NZ), Prof Ros Smythe (Director MCRN), Dr David Polaner (USA) Prof PA Lonnqvist (Sweden), Dr Gail Pearson, Dr Neil Morton

For further information and registration consult the APA website: www.apagbi.org.uk or contact: the APA Event Coordination Team on 02076318804 or email: apa2009@aagbi.org
When a young adult is seriously injured, the impact on them and their family cannot be measured by listing injuries alone. The psychological and emotional burden puts all under stress, and at these times good communication is crucial. It forms the foundation on which to build a relationship between staff caring for the injured patient, the patient and their families. As doctors, we must accept it may not be possible to make a terrible situation better but it is imperative that a situation is not made worse by poor communication.

Within the medical profession we have come to pride ourselves on our good face-to-face communication skills. When we move outside our traditional framework for effective communication, our skills are stretched and we must evolve new strategies to ensure the preservation of good communication. Recently, in our intensive care unit, we have employed the services of the regional interpreting services to facilitate communication with the parents of a patient in our care.

It is a common mistake to think that translation from one language to another is merely a verbatim rendering of a phrase. Sometimes such an attempt would merely yield gibberish, while others offer a translation, yet fail to capture the underlying influence that a word or phrase may have in a culture. For instance, in English, the Japanese value ‘giri’ corresponds to ‘duty’. The Nipponese mindset though, understands it as something far deeper; a burden of obligation, in truth, ‘that burden which is hardest to bear’. Thankfully for Westerners, most Japanese believe the ability to grasp this concept lies well beyond foreigners.

Translation and interpretation are as much art as science. There are two principal modes of interpretation:
1. Simultaneous (SI) - where the interpreter speaks while listening
2. Consecutive (CI) - where the message is rendered after the source language speaker pauses. This may be “short” CI where the interpreter works from memory or “long” CI where notes are taken.

Both these styles have their own benefits and drawbacks but the style should be decided upon beforehand depending on subject complexity and purpose.
The two pillars of interpretation are **fidelity** - how accurately the message is rendered from the source without any alterations to it, and **transparency** - the extent to which the message appears to a native speaker to have come from their language. If a message fulfils the former it is a faithful translation, if it fulfils the latter it is an idiomatic translation. The two are however, not mutually exclusive. Though fidelity ensures a formal equivalence and is the primary goal in any interpretation, it is often impossible and instead we are left to find a dynamic equivalence that conveys the essential thought at the expense of the original sememe and word order. The danger however arises when we sacrifice our fidelity to find transparency and move from the realms of translation into adaptation.

In the United States there are clearly defined standards of practice in the provision of medical interpretation services [1]. These 32 practices are contained under 9 headings:

| a) Accuracy | b) Confidentiality | c) Impartiality |
| d) Respect | e) Cultural Awareness | f) Role boundaries |
| g) Professionalism | h) Professional development | i) Advocacy |

Clearly though it is as much the responsibility of those employing the interpretation services to understand these practices as the interpreters themselves.

It is the right of all parties where comprehension of English is limited, to be offered interpretation services and it is the responsibility of the healthcare organisation to do so. Errors are however common in medical interpretation averaging as many as 31 per encounter [2]. Four basic categories of error have been described in medical interpretation [3]:

1. **Omission**: The interpreter fails to translate a word or a phrase.
2. **Addition**: The interpreter adds a word or a phrase.
3. **Substitution**: The interpreter substitutes a word or phrase for a different one.
4. **Editorialisation**: The interpreter adds their own views as their interpretation of a word or phrase.

Of these errors, omission is the most common [2].

Interpretation services themselves, may be classified into four levels. By understanding the processes involved in interpreting, and being aware of the drawbacks associated with using ad hoc interpreters (levels 2-4), classic pitfalls can be avoided. Effective communication can be promoted even in sub-optimal circumstances.

The least desirable interpretation model will be to use a family member or associate, particularly if that person is not a competent adult. This would be classed as level 4 service. Confidentiality may be an issue and there is the additional risk of harm to the interpreter, who may be upset by the task. They may be influenced by family dynamics and their own ability to cope with the situation unfolding and this in turn may stifle the flow of information. There may also be a tendency to attempt to control the interaction, rather than facilitate it.

The use of bilingual staff from within a healthcare organisation would be classed as level 3 service. Caution must still be exercised, as a bilingual person employed in healthcare may still have little or no understanding of medical terminology. In this scenario there is an additional risk that incorrect or edited information may be given due to the healthcare worker’s own interpretation of the situation. It is unfair to make any assumptions about the abilities of the ad hoc interpreter and in these circumstances thorough pre-interview preparation is paramount.

A level 2 service is the use of commercial organisations who provide generic interpretation services or when the interpretation is not performed face-to-face (for example via telephone link). In the case of the former there may still be some question of overall competence particularly within the medical field. In the case of the latter the interpreter may miss out on important non-verbal cues.

The gold standard or level 1 service will employ a qualified professional interpreter, with experience in the medical field.

The quality of this interaction can be optimised by reference to simple guidelines. The American Association of Medical Colleges (AAMC) has produced ‘Guidelines for Use of Medical Interpreter Services’ [4]. This document gives clear instructions on how to prepare for and conduct an interview.

Most important (and often overlooked) is adequate preparation and briefing of the interpreter beforehand. This allows a clear agenda and goals to be established including style of interpretation, comprehension of the medical scenario and highlighting cultural faux pas. An experienced interpreter will readily identify any potential areas of misunderstanding that may arise due to cultural differences and explain these before the interview. This briefing period also gives an opportunity to assess level of competence when utilising the services of an “ad hoc” interpreter. This may be done by participating with them in a basic conversation, before asking them to describe either anatomy or bodily function relevant to the upcoming consultation.

The interview itself should be conducted using a ‘conduit’ mode of interpretation.
The AAMC guidelines provide a framework for conducting an interview in such circumstances. Their description of conduit style is ‘literal interpretation, in the first person, without omissions, editing or polishing’. During the interview it is important not to become disengaged from the patient or family member being addressed. Eye contact must be maintained and intonation unchanged by the presence of the interpreter. Where possible, speak in the first person (use “I”) and avoid the temptation to enter into a three-way conversation where the interpreter has the pivotal position. At regular intervals ensure comprehension by asking the patient or next of kin to repeat back what you have told them.

The post-consultation period is also important. The interpreter should be de-briefed to ensure that they have understood and translated as faithfully as possible. Enquiries should also be made to ensure that there are no emergent cultural or religious issues that have gone unaddressed. Documentation is vital. Details of the interpreter should be retained and the outcome of the consultation should be clearly written in the case notes. This facilitates continuity in the line of communication and allows for audit.

Even adhering to these guidelines though, we are still left more distant to the conversation than we are used to. We are left lagging behind; awaiting a translation when attempting to react to any change in tone or other cue. We will have selected our words carefully, but even with good interpreters metaphrase will sometimes give way to paraphrase. Despite best efforts errors will occur. We must hope then, that our underlying message will remain intact and any regrets and empathy that lie within it are similarly preserved.

As doctors we find ourselves in a unique position which offers us the most awful of privileges. We are allowed to share in the most personal moments of those in our care. We may find ourselves unwilling spectators to events which we are powerless to prevent or influence. Usually we will be afforded the chance to at least console, but when the limitations of language deny us even that, even with the best interpreters we will find ourselves further removed. We are left then merely to watch what unfolds, connected solely by our greatest strength, but heaviest burden; our humanity.

Perhaps then even a gaijin can understand giri.

Paul McConnell, SpR in Anaesthesia
Catriona MacNeil, Consultant anaesthetist
Southern General Hospital, Glasgow

Notes on Japanese:
Giri (義理): Namiko Abe defines as “to serve one’s superiors with self-sacrificing devotion”
Gaijin (外人): Composed of gai (外, outside) and jin (人, person), literally an outside (foreign) person.

References:
2. Flores G, Barton-Laws M et al “Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters” PEDIATRICS Vol. 111 No. 1 January 2003, pp. 6-14
11 MONTHS
of a Grievance

They had plenty of warnings. Emails had been sent to the manager and Clinical Director informing them that the Sunday 12-hour shift for the SHO they had decided not to replace six months previously was coming up and there were no volunteers from within the department, or from anywhere else, despite the strenuous efforts of the rotamaker. As the date came closer and the emails from the rotamaker became more frequent and frantic there was no electronic (or any other) response. I was the Consultant on call for the Sunday and on the Friday lunchtime I went to see the manager.

Me: I think you have a serious problem. On Sunday you have an acute hospital with an obstetric unit and an intensive care unit and no resident anaesthetist. In my opinion this is not a safe situation.

Manager: Oh. (long pause). She looked like a rabbit caught in approaching headlights.

Me: I don't particularly want to see the hospital closed or all the ICU patients moved out, if that is what you think you have to do. The only guidance I can find is in the Welsh Contract, which suggests triple time for acting down as an SHO. At my time in life (I'm one of the more 'senior' members of the department), I'm not interested in the money on offer, but I'll do the SHO shift for triple time back, taken at a time convenient for the Department.

Manager: OK, if that's what you think. I'll need to check.

(3.30pm)
Me: (phone call to Secretary). Can I speak to the manager about the SHO cover on Sunday?

Secretary: She's in a meeting and not here.

Me: Can she ring me ASAP. I'll email her as well.

I tried to telephone the Medical Director. The Trust management secretary said he was 'unavailable'.

(4.30pm)
No answer to phone calls, No response to email. And I heard nothing more.

So I did 12 hours (8am-8pm) as a resident SHO on July 29 2007. The last time I worked as an SHO was 1983. One of my colleagues provided an at-home 'on-call' person.

I wrote to the site director on August 6 requesting the time back. And then again on August 14. And then again on August 28th. On this occasion I was told that the first request had been forwarded to the relevant manager. I then got a response. "We are unable to honour the agreement that was made.. as it hasn't been agreed by the LNC". On offer was either the money or time back on an hour for hour basis. The letter finished

"..I am happy to meet with you to discuss this". Being wary of "informal meetings" with managers I then contacted my trade union (HCSA) who also exchanged letters with the management. When the hospital management wrote in October 2007 "we refute that there has been a breach of contract" the Union asked that this be dealt with by the Trust grievance procedure. After a reminder six weeks later, the hearing which represented the first stage of the grievance procedure took place in February 2008. On one side of the table was me, accompanied by my Trade Union representative. On the other side of the table a different manager, and a representative from HR. We stated my case - an agreement had been reached with a manager acting on behalf of the Trust, which had not been honoured. All I wanted was that the agreement be honoured. I didn't want and had never sought money. The meeting concluded with the manager needing to obtain statements from the others involved in the original agreement. The grievance procedure puts time limits on the steps of the process, and within the stated 10 working days I received a reply. "I feel I have no alternative but to honour the agreement that was made........". Because of existing rotas and other departmental absences my compensatory time back in lieu started in June 2008, 11 months after the event.

The contractual situation

Anaesthesia News November 2008 Issue 256
The 2003 Consultant Contract is clear. Where ‘practicable’, in emergencies Consultants are expected to provide cover. In the case of predicted absences, Consultants should make the employer aware of the problem but it is the employer’s problem to solve. However Consultants can be resident on call only by express agreement. Emergency cover seems to mean the first 48 hours – ie to cover the time it takes for the Trust to make alternative arrangements. After 48 hours (or so), it is the Trusts’ problem. In my particular situation they had several months’ warning.

The grievance procedure

All organisations have to have a mechanism for the resolution of disputes with employees. The first question an industrial tribunal (if it comes to it) will ask is “have the local arrangements for resolving disputes been used “. Our grievance procedure is essentially an adjudication process.

I was accompanied by my Union representative, but you can also be accompanied by a work colleague, or other non-legal ‘friend’. My case was put to the manager who, after gathering statements from everyone involved, made a decision (in this case, in my favour). Had I not been happy with the decision, I had 14 days to inform the Trust that I wished to take it to the second stage. This would involve a similar process, heard by a non-executive Director, at which I could call witnesses and submit other statements if I wanted. I had various colleagues lined up to appear as witnesses on my behalf, if necessary. Should I still be unhappy with the decision of the second stage, the external legal process would still be available to me.

The Trade Union view

Stephen Campion, Chief Executive of the HCSA, commented that grievances such as this are all too frequent in today’s NHS. He was pleased that this grievance was successfully resolved. This by no means unique case demonstrates three things. Firstly, that you never know when you may be faced with problems that need resolving with professional advice and representation. This sort of employment dispute can happen to anyone. Secondly, that persistence pays off where there has been such a breach of agreement, and thirdly, that consultants and senior medical staff need trade union support over employment matters, just as they do for medical defence protection.

Lessons I have learned

- Perseverance pays off
- Any individual may need to go through a formal grievance, but it should be a rare event. Help and advice from someone who knows the system is invaluable. I just sat and listened - and quite enjoyed it all really.
- Watch at job planning that they don’t try and slip in an open-ended clause about covering for absences. They can, and they might try.

What I would do next time

As early as possible, highlight the problem to management. Ensure you get an acknowledgement. A deputation (you and a witness) should go to the manager’s office if necessary. The five hours I gave them to sort the problem they should have addressed months before wasn’t enough. I would go first thing in the morning, with a ‘friend’ rather than at lunch time.

If they still haven’t done anything, and it becomes a crisis, I would:

- Tell the manager (again) that they have a problem. I wouldn’t offer any solutions – if they want to approach you, then that’s up to them.
- Ring the Medical Director/Clinical Director and tell them there is a problem which the managers have not addressed.
- Telephone my Defence Society and Trade Union and be guided by them about what level of medical care I should provide to the patients already in the hospital. However, any new patients who turn up are the Trusts’ problem, not mine.

- Be aware of the Grievance procedure.

The author is a Consultant Anaesthetist working in an English NHS Hospital.

Comment

Although we all hope that managers will behave like reasonable people, recognise a problem, play by the rules and honour their acceptance of a constructive solution, this is not always the case. Some of them clearly hope problems will go away if they are ignored, or perhaps fail to recognise the implications of the situation in terms of patient care.

This article is an excellent example of the use of the grievance procedure, which members may wish to save for future reference. Although there can be few of us who are unaware of the existence of Grievance procedures (mandatory since 2004), many of us would still be at a loss as to how to initiate the process.

Happily on this occasion it produced the desired result although it is difficult to see why it should have been necessary. Members wanting more information in this area should refer to the NHS terms and conditions of service, or, if they are members, they can access further useful information via the BMA or HCSA websites.

Di Dickson, Chair, Welfare Committee, AAGBI
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Ultrasound Training Courses 2008

2008 course dates:

US Guided Regional Anaesthesia – Introduction
10-11 November – Hitchin

US Guided Regional Anaesthesia – Advanced
2-3 October – Liverpool
5-6 December – Nottingham

Critical Care
19 November – Hitchin

Ultrasound Guided Venous Access
13 November – 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.

US Guided Regional Anaesthesia – Introduction
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.

US Guided Regional Anaesthesia – Advanced
The two-day advanced practical course is aimed at anaesthetists already proficient in regional anaesthesia and comprises of didactic lectures on ultrasound anatomy and regional anaesthetic techniques. It includes practical workshops on brachial plexus and abdominal blocks. Topics covered will include regional techniques for upper and lower limb surgery and neuraxial blocks.

Critical Care
This one-day course is aimed at all critical care physicians and surgeons. The programme is suitable for those who already have some basic ultrasound experience as well as those who are new to the clinical applications of focused ultrasound at the patient bedside.

Ultrasound Guided Venous Access
This one-day course 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.

Fee: £350.00 (two-day courses), £250.00 (one-day courses) includes VAT, lunch, refreshments and course materials.
Combating Climate Change

In response to Val Bythell’s editorial (September 2008 [1]), I would like to make the following suggestions:

1. Join the Climate and Health Council [2] to meet with like minded people and add weight to your voice.
2. Join the Campaign for Greener Healthcare [3]. High profile doctors like Hugh Montgomery have added their voice to the campaign.
3. Encourage your Trust to ask The Carbon Trust [4] to do a site survey to reduce fuel bills. The survey is free if the Trust’s utilities bill is over £50,000.
4. Engage with your Trust’s Facilities Director. He should be able to help with encouraging waste segregation at source so cardboard/paper/plastics and glass can be recycled. Companies are now willing to BUY baled plastic of which hospitals normally have huge amounts. If done at source it should be simple to avoid the contaminated/non-contaminated waste argument.
5. Encourage sustainable procurement. The NHS carbon footprint document [5] shows that 22% of our carbon footprint comes from pharmaceuticals. How can the AAGBI engage with companies to reduce plastic packaging and unnecessary packaging?

Try to procure goods and services as close to home as possible.

6. Encourage ‘switch off’ programmes for office equipment. Engage with your IT department to encourage ‘power down’ of machines out of hours. Avoid screen savers, switch monitors off. Good literature is available from the Carbon Trust to encourage this.
7. Reduce water consumption. Low flush loos, ‘sensor’ activated taps for scrubbing are available.
8. Install low energy light bulbs everywhere. Motion activated lights for infrequently used areas.
9. Support your Trust’s transport policy. Cycle more BUT campaign for safe and secure weatherproof bike parking [6]. Also ask for better changing/showering facilities at work.
10. Plant more trees and encourage ‘green’ areas within your trust. Greening the view from the patients’ window speeds post op recovery [7].
Shade prevents overheating in urban environments.
11. Find a company willing to recycle “disposable” metal instruments. (I spoke to Robinson Healthcare and they were very positive)

12. Encourage tele-conferencing wherever possible to avoid unnecessary flights to meetings.
14. Anaesthetically, encourage low flow anaesthetics or consider TIVA. I’m sure someone’s done the calculations!

A lot of these comments are derived from the above sites and documents so I could be accused of plagiarism. However, it would be great to reach a wider audience. Perhaps the AAGBI link person in each Trust could find an “environmental champion” within their department to help move things along.

I got into Anaesthesia News (April 2006) with cardboard recycling but have since come up against a brick wall. My particular Trust does not seem bothered, even when I’ve told them it may save money.

Maggie Nicol
Southend Hospital

References:
2. www.climateandhealth.org
3. www.greenerhealthcare.org
4. www.carbontrust.co.uk
8. www.sdu.nhs.uk