Committee report: Independent practice issues

Letter from America

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**Organisers**
- Dr Ian Harper
- Dr Barry Nicholls
- Dr Susanne Krone
- Dr Steve Roberts
- Dr Nigel Bedforth

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**Day 1**
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- Workshops – using phantoms / models / cadaveric prosections (A)

**Day 2**
- Consent / training and image storage
- Upper / lower limb techniques
- Abdominal / thoracic techniques
- Cervical plexus / spinal / epidural / pain procedures
- Workshops – using phantoms / models / cadaveric prosections (A) (A) – Anatomy based courses / with cadaveric prosections

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A senior registrar by any other name...

I have always thought that sooner or later, as a consultant obstetric anaesthetist, I would have to return to resident out-of-hours work. By out of hours, I mean nights principally; we already work in the evenings. The arguments are familiar: if you keep on reducing trainees’ hours, and the number of trainees stays the same or falls, and the amount of out-of-hours work stays the same or rises, and you actually want trainees to have a daytime presence, someone else is going to have to do at least some of the out-of-hours work. It isn’t rocket science. So I am amazed that it hasn’t happened to me yet, though I am aware that many consultants do now have significant amounts of out-of-hours work. We still don’t have a comprehensive solution to this, and we debate aspects of the problem (and in particular the merits of one possible solution - the return of the ‘senior registrar’ grade - on pages 8-11 of this issue.

Mandatory madness. Our head of department sent us all an e mail this week letting us know that our mandatory training on conflict resolution was now available as a ‘breeze’ (electronic) presentation, so that we could complete it as soon as possible. The ‘copy to all’ responses were predictable; ‘and I’m supposed to be grateful?’ ‘yippeee’, ‘let me know when it’s on’ etc. I have to say that this feels like the last straw to me. I have pretty much had it with this stuff already. I have failed the blood transfusion mandatory training twice. I could not bring myself to tick the box suggesting that the correct duration for infusion of 1 unit of blood was 1 hour, or that platelets should not be infused faster than 20 mins. Many years ago, as a medical houseman, I remember an unpleasant night trying to resuscitate a woman with major lower GI haemorrhage on a ward. It was an Orwellian nightmare; senior colleagues had refused to get out of bed to help, and a night sister who was observing the spectacle asked at one point whether I was aware that blood should be infused over four hours. I replied that that was OK unless it was coming out a lot quicker than that, and a casual observation of the pool of melaena in the bed led me to believe that this was the case here. Little appears to have changed in the intervening 30 years in terms of the understanding of those writing our mandatory training on blood transfusion.

There are some changes afoot with respect to consultant’s clinical excellence awards. The news is (predictably) not good. Last year there were reduced numbers of National awards, this year the National picture has yet to emerge but most people ‘in the know’ seem to think that numbers of awards are likely to fall again. Colleagues beavering away within my Trust have asked me whether I thought local awards might be at risk too. I guess naively, I thought they might be a bit more enduring – Trusts do after all need people to stand up and be counted when it comes to tedious jobs such as rotamaker if the service is to be delivered, let alone developed. Now, however, I have seen a letter from Mark Porter (chair of the BMA’s CCSC) pointing out that new guidance for employers about the 2011 employer-based awards suggests a greatly reduced ratio of 0.2 awards per eligible consultant, down from 0.32. This makes one wonder whether younger colleagues might be better advised to pursue a secondary career in private practice rather than bothering with the aforementioned ‘tedious jobs’, except that rewards in that area are apparently slimmer than they used to be (see Dr Liban’s review of the current situation with respect to PMI’s which follows this editorial). Of course, in reality we are professional people and will most likely do these jobs anyway. I guess this is the government’s hope too. Be assured that your Association is working hard on your behalf on this matter.
Independent Practice

We know that the majority of the AAGBI’s consultant members are involved in independent practice of some sort and that for most this comprises mainly traditional private medical practice. The AAGBI, as a membership organisation, represents its members in issues such as private practice. These activities are particularly important because our other professional body, the Royal College of Anaesthetists, is barred from representing us in this area by its charitable status. Private practice has been undergoing some significant and worrying changes in the last two years, and the AAGBI has been active in supporting its members and promoting safe care and true choice for their patients.

In July 2008, AXA-PPP, the second largest Private Medical Insurer (PMI), with some 20% of the UK market, suspended its consultant recognition process. When it restarted, it had changed markedly. New consultants seeking recognition were obliged to agree to charge fees that did not exceed AXA-PPP’s benefit maxima, which it published for the first time in a “Fee Schedule”. They also had to agree not to charge patients a “shortfall”, i.e. a top-up charge between the PMI benefit and the actual fee charged. Shortfall payments have been becoming increasingly common in recent years. This is not surprising given that some PMIs have made little change to their benefit levels in the last 17 years. The AAGBI took legal advice about AXA-PPP’s actions and, as a result, referred the PMI to the Office of Fair Trading (OFT). The Group of Anaesthetists in Training (GAT) also made a referral at this time. Although a PMI is entitled to refuse to recognise a consultant for reimbursement for a number of reasons, it cannot legally discriminate against someone on the basis of their age, sex or ethnic origin. Given that a higher proportion of recently appointed consultants are likely to be young, female and overseas graduates, the AAGBI was concerned that AXA-PPP’s actions might be construed to be discriminatory. In addition to this, it was argued that AXA-PPP was using its market position to distort the market in its favour, to the detriment of smaller PMIs. The OFT considered the referral but decided not to prioritise it, being careful to point out that this should not be taken to imply that it condoned AXA-PPP’s actions; it was simply “not an administrative priority” for the OFT at that time.

Newly appointed consultant anaesthetists had to decide whether or not to agree to AXA-PPP’s new recognition requirements. For those not members of groups or partnerships – those termed “sole traders” by accountants – the decision was uncomfortable but simple. If they did not sign the new agreement, they would not be able to charge 20% of the patients on their private operating lists. Unlike surgeons, anaesthetists have little control over the patients on a list and, with reports of threats by AXA-PPP not to reimburse the surgeon or hospital if a non-recognised consultant anaesthetist provided care to an AXA-PPP customer, the majority felt forced to accept the new terms. For consultants in a group or partnership, there was perhaps a little more choice, and some few, large partnerships were able to accommodate a small number of non-recognised consultants, directing them towards operating lists that contained no AXA-PPP customers. However, the new system created difficulties for most.

Towards the end of 2009, Bupa, the largest UK PMI with a 40% share of the market, suspended its consultant recognition process. Bernie Liban, Chair of the AAGBI’s Independent Practice Committee and Richard Birks, then AAGBI President, met with senior Bupa officials and explained their concerns about the impact of restrictive recognition on anaesthetists and their patients. When Bupa re-opened its recognition application system in June this year, it came as no surprise that the restrictions therein were similar to those imposed by AXA-PPP; those given recognition must
charge no more than Bupa benefit maxima. Further, the new agreement included direct billing to Bupa and a demand that newly recognised surgeons make every effort to work only with anaesthetists who charge within Bupa benefits.

The AAGBI has again taken legal advice on this issue and has recently referred both Bupa and AXA-PPP to the OFT. We are delighted that this time we have been joined by the Federation of Independent Practitioner Organisations (FIPO), an umbrella group that represents a large number of professional medical societies whose members are involved in private practice. The points made in these referrals are broadly similar to those made in the original referral, but the significant change is that AXA-PPP and Bupa together can be taken to be functioning as an “oligopoly”, i.e. a situation in which a small group of providers dominate and control a market. Between them, they have at least 60% of the PMI market. The referral stresses the particular disadvantage at which anaesthetists are placed because of the operating list system and because newly appointed consultant anaesthetists will often be asked to work with established surgeons who are not subject to the same billing restrictions.

The current situation is therefore that the PMIs’ actions have created a two-tier system. Established consultants are at liberty to charge fees that they think are reasonable and, provided they have warned patients of their fees before surgery, are allowed to pursue patients for shortfall payments. However, recently appointed consultants who have agreed to AXA-PPP’s and Bupa’s new terms are obliged only to charge fees that are in line with benefits at a level that pertained some 17 years ago, since when not only the Retail Price Index but also the Average Earnings Index have risen by some 60%. This situation makes the running of groups and partnerships very difficult and, sadly, on occasion innocent patients get inadvertently caught in the middle. We think that consultants should do everything they can to simplify financial arrangements for private patients, but this can prove troublesome with the current two-tier system. Whatever financial arrangements are made by sole traders or members of partnerships, we must stress that if consultants have agreed to charge only member benefits and not to charge shortfalls, they should not try to find ways to circumvent this agreement; they should stick to it.

What happens next? We hope that the OFT will decide to prioritise the investigation of the PMIs’ actions. In the meantime, we can only encourage members to think carefully before agreeing to AXA-PPP’s and Bupa’s new terms. If members do sign agreements with the PMIs, we have been advised that they will be free to withdraw from such agreements should the recognition processes be found to be illegal or anticompetitive. Many members have expressed concern that these restrictive agreements will be extended to all consultants at some point in the future. If the PMIs do attempt to extend restrictive recognition to all consultants, and significant numbers of established consultants refuse to sign up the new recognition agreements, there will be created a new and perverse situation in which patients who pay for private medical insurance will be given less choice than NHS patients: they will not have access to some of the established and experienced consultants who are leaders in their fields.

The AAGBI believes that the direct clinical and financial professional relationship between doctors and their private patients is the key to safe, effective and responsible private medical practice. Recent changes to PMI recognition processes seem to be attempting to sever this direct financial relationship such that consultants are asked to bill PMIs directly and to be paid directly by them. We think that this trend should be resisted. Indeed, earlier this year the AAGBI launched its Deal Direct Campaign, in which we suggest that members and the surgeons with whom they work to bill all patients directly and to receive payments only direct from patients. This approach has been supported by the BMA, which has included the AAGBI’s recommended patient letter and contract in a recent publication on setting up in private practice [1].

The AAGBI will do everything it can to support its members in treating their patients safely and fairly. If you have a question about independent practice, please email us on info@aagbi.org.

Dr Bernie Liban
Chair, Independent Practice Committee
Dr Will Harrop-Griffiths
Vice President

“I wonder if the association has made any representations to PPP/BUPA about their behaviour towards new consultants. To force consultants to agree to a lower charging schedule or deny recognition is akin to holding a gun to someone’s head and then claiming they voluntarily gave you their money.”

1) http://www.bma.org.uk/employmentandcontracts/independent_medical_practice/setupprivprac.jsp
What a great weekend it was too – the sun shone throughout (daylight hours only!), the hotel provided a good venue for both the conference and the social events and the presentations were uniformly of a high standard and very well received. The surrounding landscape of hills, valleys and lakes were all enhanced by the summer sunshine and those delegates who elected to spend a few extra days of holiday in the area were duly rewarded by the local hospitality and the wonderful scenery.

Llanddow, as it is known locally, is a renowned spa town and in the Victorian era it was the equal of any European spa; the Metropole hotel was then the largest hotel in Europe. Still served by one of the most picturesque railway lines in Great Britain, Llanddow even had its own aerodrome in the early 1930s and all around the town are reminders of its Glory Days – large Victorian and Edwardian hotels and houses of the wealthy merchant classes of the day. How do we know this? Well, the guest lecturer Dr Colin Hughes, a local historian, told us this and a lot more in his informative lecture on the development of Llanddow as a spa town and some of the medical and other treatments on offer in the town.

What of the rest of the scientific programme? Delegates came to the heart of rural Wales from all over the UK as well as the USA, Canada and Australia; more than 70 in total. They enjoyed a full day and a half of high quality presentations which roughly divided into three categories – people and events, interesting equipment and anesthetic techniques of yore.

### People and Events

The presentations were wide ranging – from the personalities of the Westminster Medical Society to the famous (and not so famous) names who had a say in the way that Anaesthesia has evolved over the last 160 years or so. Full abstracts of all the presentations will be available in the the next edition of the Proceedings of the Society but one presentation about Joseph Clover deserves a mention, if only to whet the appetite to find out more when the proceedings are published. Christine Ball not only “won” the prize for who travelled the furthest to attend the meeting (Melbourne, Australia) but she also entertained the meeting with an apparently true account involving Clover, an ex railway guard with a hangover and a deadly cobra at the newly opened London Zoo!

### Equipment

A variety of anaesthetic equipment was discussed, from the Canadian forerunner of the modern LMA, appropriately presented by a loyal HAS member from Canada, Roger Maltby, to the ‘Penstar’ – a valiant but unsuccessful attempt by Penlon and the Oxford University Department of Anaesthesia to develop an anaesthetic machine for the 21st century. Early respirators and the Welsh Mining Rescue Service, a Bircher vapouriser and a Coxeter portable anaesthetic machine also made an appearance in this section, generating a lot of interest and discussion and offering additional resources to add to what the presenters already knew about their unusual equipment.
In recognition of his services to the history of anaesthesia and to the Society itself, Roger Maltby was presented with Honorary Life Membership of the HAS at the AGM.

Techniques of Yore

Electrical anaesthesia, hypnosis and mesmerism, early treatments for causalgia, early cryotherapy ("congelation") and the anaesthetic treatment of shell shock were all described with varying degrees of enthusiasm by their respective presenters. The delegates showed no great interest in the re-introduction of any of these treatments into current practice during the discussions, despite some efforts to persuade us otherwise.

Trainee presentations

While many of the main speakers were well known and respected authorities in the field of the history of anesthesia, there were three very good presentations by trainees on (i) a review of the historical impact of aspiration and regurgitation (Andrew Bacon from the USA), (ii) the weekly newsletters (hefte) of the Drager company, first published in 1912 (Birte Feix, West Suffolk) and (iii) the changing face of formal anaesthesia training in the UK over the years (Aditi Modi, West Suffolk). Dr Modi was recently awarded the 2010 AAGBI and HAS Essay Gold Medal for trainees for her essay on this subject; her presentation and content of the talk showed clearly why she won the Gold Medal.

The presentations and the discussions which followed each session generated spirited conversations between delegates and presenters, which spilled over into the refreshment breaks and the evening social events. The Annual Dinner was greatly enjoyed by the delegates and guests and was presided over by the new President of the Society Dr Neil Adams (West Suffolk). Neil was handed the instruments of power (chain of office, red telephone, nuclear button) by the outgoing President, Professor Tony Wildsmith at the AGM and together with the other officers and committee members, will continue Tony’s efforts to ensure that the Society remains buoyant and successful both nationally and internationally.

After a lot of hard work and some anxious moments Adrian Kuipers and I, co-organisers of the meeting, felt that we could relax at last; our weekend in Wales had worked out well and the 24th History of Anaesthesia Summer Meeting had been both academically successful and socially enjoyable. We might even have made a small profit for the HAS coffers.

Dr Barrie Fischer
Almost all departments of anaesthesia are beset by a fundamental problem. How do they provide the medical cover for all the lists, ITU sessions, clinics and other essential activities when a large element of the manpower provision has been taken away? Worse, this is happening at a time when hospitals are being forced to be increasingly financially accountable – shorthand for doing more work with less money. I am of course talking about the twin problems of the EWTD and the restrictions imposed on employing international doctors.

There are a number of possible solutions: we could employ more consultants. With on-costs, an extra consultant will cost the employing trust about £110k to £130k per year, and this is a 25 year commitment; not surprisingly Chief Executives are unwilling to commit to this just now. We could ask our existing consultants to do more clinical work (and dare I say it – to have less paid non-clinical time…). While this is as popular as creating a huge oil slick as a tourist attraction, many trusts have done this already to some extent, but the initial manpower problem remains. We could employ locum consultants – again, this is a current solution in many Trusts, but for those with greater financial constraints a locum consultant is still very expensive, albeit more flexible than a substantive appointment. However, in several parts of the country it is common for trainees to take a locum consultant post before getting a substantive post. How about non-consultant locums? The simple fact is that there aren’t any. If you have managed to find a locum to cover trainee absence from the rota, you have done well. Specialty Doctors? Well, you may be lucky, but doctors from within our own training programmes by and large have their sights set on consultant status, doctors from EU countries with “equivalent” qualifications frequently take a similar view – in any case they are not flocking to our shores. Are junior trainees who have failed to make the grade at the CT2 to ST3 level the solution? – I think we all know the answer to that. Non-medical practitioners? Well, maybe in part, but the area presenting the most acute manpower problem is cover for emergency work which is frequently complex, and PAAs require direct supervision anyway.

It didn’t use to be like this. How have we got here? Allow me to digress into the recent history of anaesthetic training: about 15 years ago or thereabouts the Calman report changed training in all medical specialties. Its intention may well have been laudable: to streamline training to a defined length and allow trainees some degree of assurance that they would remain in employment during their training years so long as they met certain standards. The most significant change was to do away with the Senior Registrar grade. In anaesthesia, this was the grade, as many
will recall, in which trainees developed their specialist interests, undertook a greater role in teaching, and more nebulously, learned to be a consultant. Since then, a number of other changes has influenced the way training has been delivered. Run-through training had come along then been hastily revised with de-coupling, but the principle of national recruitment with one main intake per year remains. The other point about run-through training that has not been revised is that the number of SHO (CT 1-2) posts has been markedly reduced to match the number of registrar (ST 3-7) posts. Unfortunately, at precisely the same time, the then Government changed the rules on immigration, effectively barring many medical graduates from outside the EU (“international candidates”) from working in the UK. We have a long tradition of employing doctors from many parts of the world, which had been to their benefit and also to ours. Crucially, it ensured a much larger pool of doctors for many parts of the world, which had been to their benefit and also to ours journeys. Along the way, training was organised into regional Schools of Anaesthesia, each with a set number of trainees determined now by the PMETB rather than the RCoA, and total numbers of trainees became fixed.

Currently, the shortage of people in training grades is not just reducing their availability to do elective work, an even bigger problem is the lack of doctors available to cover the various out of hours on-call tiers. The RCoA recommends that there are minimum cell-sizes of eight people per on-call tier. This is well supported and a sensible recommendation. However, the fact is that in many parts of the country there simply are not enough trainees, and eight per tier is but a dream. This brings us back to the essential question: how do we cover the work?

From the options above, the most promising solution is the locum consultant. The public expect and indeed have a right to have medical care delivered by fully trained doctors. However, locum consultants recruited from trainees who have just completed their training and are eligible for their CCT are of benefit to the Trust as they are a short-term flexible workforce, and the post is also of benefit to the locum, as it enables them to bridge the gap between being a trainee and a consultant, learning more about the responsibilities of the consultant role whilst in a sheltered and protected environment. But locum consultants are expensive, and they do not expect to cover resident on call rotas. (Maybe they should, but only along with the rest of us with substantive posts…)

This brings me, at last, to the one possibility that I have not thus far mentioned. A new grade, analogous to the old-fashioned Senior Registrar, available to trainees upon receiving their CCT. Let’s call this a Senior Fellow. Let’s look at the requirements from both aspects:

Trainees are currently facing a tricky time as they end their training. There has been a period of considerable expansion in consultant numbers in recent years, but now there is a relative recruitment freeze. There is no money, although there is the work to do. Trainees at this stage quite rightly want to be consultants, and will not accept a lower grade. Few people want a substantive long-term sub-consultant grade. During recent training, trainees have been able to accrue far less experience than their forebears, although their training programmes have in many cases been much better structured and delivered. Nonetheless, it is arguable that many feel less well equipped than they would like to be for a consultant post; this has been noted by a number of sources. Many trainees want extra time in super-specialties to prepare themselves for specific posts. Some trainees would like some specific time to follow a research interest. Some want some management experience. Above all, many trainees feel that they will benefit from a period in which they can work with greater autonomy in their own lists, yet still have help and supervision available at any time. In short, a Senior Fellow will learn to become a consultant, and so place him or herself in pole position for the next attractive substantive consultant post. Surely it must be better than a six-month period of grace in the least attractive hospital on the rotation?

From the point of view of the department, I see only positives. A one-year post (maybe extendable to two years to help an individual who has not yet found the appropriate substantive consultant post) as a Senior Fellow would enable a number of elective activities to be done by fully trained personnel with distant supervision. Some teaching would be available too, most likely in the more specialist areas. The Fellows can undertake some teaching themselves, and be given time for research if appropriate. The post can be shaped to fit the needs of the department and the candidate. Maybe three days a week in direct clinical activity, some of which would have direct supervision for teaching purposes, with one day for research or delivering teaching? As far as on-call duties are concerned, the Senior Fellow can be available for any role that is required. Resident on-call is an option if gaps exist – this would enhance the Senior Fellow salary. The Senior Fellow may also participate in more senior on-call rotas – although arrangements would need to be in place for consultant supervision. The SF post would be outside the jurisdiction of the Deaneries – formal training will have been completed. At the moment, the only applicable salary scale is the top end of the ST scale. Central recognition of this kind of post may allow an enhanced salary scale to be introduced.

I can anticipate some cynicism, even hostility, to this concept. However, at a recent meeting of over 100 Clinical Directors arranged jointly by the AAGBI and the RCoA, the idea was discussed from the floor and met with significant support. A straw poll of the Clinical Directors present indicated that a majority would look more favourably on a candidate for a substantive consultant post who had done a post-CCT Senior Fellow year than one who had not. Is this a concept whose time has come?

Dr Phil Bayly, Consultant Anaesthetist and Clinical Director Newcastle upon Tyne
From the GAT chair

A more cynical trainee view of the Senior Fellow

This is the personal view of the GAT chair

I read with interest the view “from the Director’s chair”. It is certainly not unique, certainly not revolutionary. It is neither ill-conceived nor formed with malicious intent. However, there are a few significant flaws in the concept.

A clear distinction between the benefit to the Trust/hospital and to the trainee is vital. There continues to be much debate and disagreement around the newly rebranded EWTR. There appears little controversy in stating that certain trainees are suffering from the adjusted rota’s and higher proportions of “inactive” on-call time; this relates predominantly to the surgical and craft specialities. Trainees from these niche markets are often entirely underused during on-call time, being paid to rewrite drug charts in between re-runs of “Friends” shown on the mess TV. That said, recent nationwide specialty-wide reviews have cast doubt on the impact that the EWTR will have on all specialties. Anaesthesia, because of the relatively high intensity on-call conditions, may not have much if anything to worry about in terms of training as long as we reorganise to smarter training regimes. As far as the Trusts go, there is the increasing problem with filling rota’s to satisfy service requirement. The Trust and the trainee requirements, service versus training, are usually in competition!

So, management cannot fill rota’s and potentially (but ONLY potentially) certain specialities may struggle to train doctors to an adequate standard. The Director assumes that the Senior Fellow is the cure for both ills; I would suggest that the Director has his ‘management’ rather than ‘clinical’ hat on and is speaking from a mind that has long forgotten what it is like to be a trainee.

Allow me to explain my brutal slander…

Question: why do consultants want there to be a Senior Registrar? Answer: so that there is another tier of protection from the interruption of their well-earned repose - so that when the inevitable requisite resident senior clinician is called for, they can push forward an army of “Senior Fellows” who will undoubtedly develop some sort of “junior consultant tag” to satisfy the insistent demands of the general public.

As a trainee I can see several more major problems with this grade…

How long is this undefined post to last for - indefinitely, or just until a consultant retires? Is it separate to the locum consultant grade? Will I have to get a locum consultant job afterwards? There is a real danger that trainees with aspirations of being a consultant will flounder in the post with no clear end-point. Why would we as trainees want that?

This is not a training grade. In effect, we will be functioning as consultants with 10 PAs and no SPAs. There will be no study leave time allocation or budget because it is not a recognised post, so to further our specialist expertise we will either have to be lucky enough to get a Senior Fellow job within our area of interest OR use annual leave and salary to attend extortionately expensive courses: brilliant!

Let’s say that the post is for one year and is circumscribed as such - this solves the Trusts’ service quandary by providing extra experienced staff. However, where is the important benefit to the senior trainee? In reality, they will be required to cover the lion’s share of the out-of-hours work, inevitably covering obstetrics or intensive care. When they are present in the daytime they will be rostered to the less salubrious lists that substantive consultants prefer not to cover. Anyone who disagrees with the last point need only look at the job descriptions of the locum consultants currently in their departments.

In addition, what happens after the year is up? Do we get jettisoned to seek a similar post at St Elsewhere hospital to repeat the same process ad infinitum? I find it hard to believe this one-year work extension will position us any better in the increasingly competitive queue for a consultant post.

What of the other options…

Consultants to do more clinical work

This is already happening. The time when you could carry out your SPA work from a distant location (home office, private hospital, golf course) has long gone. Most mandate in-house completion of SPA duties. Trusts are demanding more value for money from their consultants, who have to justify their need for the traditional 2.5 SPAs per week. Clinical Excellence Awards are also in line for a review having remained little changed since their inception in the early 1960s. In a struggling UK economy, this is entirely reasonable. We all know of consultants who appear to do nothing productive for the Trust or trainees in their SPA time. By replacing 1.5 SPAs with clinical sessions, 78 extra usable sessions per year per consultant will be realised. New consultant posts are being offered that contain only 1.5 SPAs. Many of us believe that this bare minimum of SPA time should not be the baseline norm for consultant contracts unless there is a clear mechanism for further SPAs to be demonstrably attained. Some work very hard and give a lot to the profession and hospital. We just need to rationalise who gets them. A consultant job without SPA time is purely a clinical position; a consultant is meant to educate and to develop the specialty. A consultant job without sufficient SPA time is a Senior Registrar in every way other than name.
More consultants

Consultants cost £100K per year, but is that poor value? The population is expanding and people are living longer. There is a year-on-year growth in clinical need and a relentless push by the government to minimise waits and increase the amount of patient to consultant exposure. You can only spread butter so thinly - eventually you just need to put more on your knife: busier, bigger departments will need more staff. Is cutting senior doctor numbers the correct way to save the necessary funds? The medical workforce is like a massive ocean liner: it takes a long time to get it started, but once moving it's difficult to stop or change direction. Until we know what we want from an as yet uncertain consultant remit, it would seem rash to change the fundamental composition of its junior parts.

Bright, intelligent medical students want to reach the top of the profession. That 'top' is still perceived to be the consultant. If the likely outcome of 10 or more years of training and examination is to not to reach that peak, we may start to see a decrease in medical school applications. If the profession is seen in a bad light, it will be a drawn-out, difficult course to shed that image.

Locum consultants and PA(A)s

If the only problem with employing locum consultants is, as the "Director" says, that they are expensive, then the main reason he wants a Senior Fellow grade is also to save money. The Senior Fellow grade seems to be exactly the same as a locum consultant grade in everything other than name.

The topic of Physicians Assistants (Anaesthesia) - PA(A)s - is a thorny one, and is one that cannot be extensively discussed here. The RCoA and AAGBI have recently issued statements clearly defining their roles. Even if they were thought to be a solution, there are so few of them currently trained that it is not a "now" or "soon" fix.

Although happy to find fault with the Director's suggestions, I don't have the answer. It is easier to simply object rather than find compromise or solution. Money doesn't grow on trees and the medical workforce is like a massive ocean liner: it takes a long time to get it started, but once moving it's difficult to stop or change direction. Until we know what we want from an as yet uncertain consultant remit, it would seem rash to change the fundamental composition of its junior parts.

More consultants

Consultants cost £100K per year, but is that poor value? The population is expanding and people are living longer. There is a year-on-year growth in clinical need and a relentless push by the government to minimise waits and increase the amount of patient to consultant exposure. You can only spread butter so thinly - eventually you just need to put more on your knife: busier, bigger departments will need more staff. Is cutting senior doctor numbers the correct way to save the necessary funds? The medical workforce is like a massive ocean liner: it takes a long time to get it started, but once moving it's difficult to stop or change direction. Until we know what we want from an as yet uncertain consultant remit, it would seem rash to change the fundamental composition of its junior parts.

Bright, intelligent medical students want to reach the top of the profession. That 'top' is still perceived to be the consultant. If the likely outcome of 10 or more years of training and examination is to not to reach that peak, we may start to see a decrease in medical school applications. If the profession is seen in a bad light, it will be a drawn-out, difficult course to shed that image.

Locum consultants and PA(A)s

If the only problem with employing locum consultants is, as the "Director" says, that they are expensive, then the main reason he wants a Senior Fellow grade is also to save money. The Senior Fellow grade seems to be exactly the same as a locum consultant grade in everything other than name.

The topic of Physicians Assistants (Anaesthesia) - PA(A)s - is a thorny one, and is one that cannot be extensively discussed here. The RCoA and AAGBI have recently issued statements clearly defining their roles. Even if they were thought to be a solution, there are so few of them currently trained that it is not a “now” or “soon” fix.

Although happy to find fault with the Director’s suggestions, I don’t have the answer. It is easier to simply object rather than find compromise or solution. Money doesn’t grow on trees and the financial pot is dwindling. In the current NHS system, there needs to be financial rationalisation. It is tempting to blame poor training on the EWTR but there is no evidence that this is happening in education. If the profession is seen in a bad light, it will be a drawn-out, difficult course to shed that image.

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Anaesthetic Teaching in Sub-Saharan Africa

Introduction

In March this year, we were invited by Dr Keith Thomson, a Consultant Anaesthetist in Basingstoke, to participate in a three day anaesthetic conference at C.H.U. Tokoin Hospital, Lome, Togo, West Africa. We were asked to prepare and deliver lectures, and to organise and run workshops. As neither of us had travelled to sub-Saharan Africa before, we were both nervous but excited by the prospect of this experience.

We did not anticipate the enormity of the challenges that lay ahead, not only regarding our teaching skills and environment, but also our outbound journey to Africa!

Getting there: 2 legs become 6!

Our journey began at 4am to Heathrow airport, with several unscheduled ‘vomit’ stops (Lou had gastroenteritis). At Heathrow we joined three of our team, to discover our flight was delayed by 3 hours, and consequently, we missed our planned connection in Paris. This was the beginning of a long 36 hours…

We travelled from Paris Charles De Gaulle airport to Orly airport (via taxi), then flew from Orly to Casablanca with the promise of a connecting flight to Cotonou, Benin. No such flight existed. Following a frustrating twenty-four hours of negotiating and queuing, we boarded our flight to Togo, via Ghana! We arrived in time for the first afternoon of workshops, exhausted but excited to participate.

We look back on that experience with amusement, but at the time, our circumstances did cause concern, particularly amongst those of the group with more experience of the dangers of travelling in Africa. Their presence was reassuring; there is a lot to be said for blissful ignorance!

We travelled with a great group of people, and our experiences certainly united us as a team.

Demographics

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<th>Togo</th>
<th>UK</th>
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<tr>
<td>Population</td>
<td>6.2 million</td>
<td>61.2 million</td>
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<tr>
<td>Percentage &gt;65yrs of age</td>
<td>2.8%</td>
<td>16.4%</td>
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<tr>
<td>Median age</td>
<td>18.7 years</td>
<td>40.5 years</td>
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<tr>
<td>Life expectancy at birth</td>
<td>59.7 years</td>
<td>79.2 years</td>
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<tr>
<td>Infant mortality rate</td>
<td>56.8 deaths per 1000 live births</td>
<td>4.8 deaths per 1000 live births</td>
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Anaesthesia in Togo

There are six Togolese physician anaesthetists, three of which work within the private sector. The remaining three work at the C.H.U. Tokoin teaching hospital, where the conference was held. This is the biggest hospital in Togo, employing 40 of the 100 nurse anaesthetists. The Togolese anaesthetists undergo three years training in the government service and serve the national population of over 6 million. In comparison, at Basingstoke Hospital alone, there are 41 anaesthetists to serve a local catchment population of 300,000.

The hospital has eight operating theatres, with the majority of cases being obstetric, general surgical and trauma emergencies. This is comparable across sub-Saharan Africa. Theatres are equipped with a basic Boyle's anaesthetic machine, and disposable airway equipment, which is routinely re-used until no longer functional. Patients are monitored by clinical examination, augmented only by manual blood pressure measurement.

Induction agents are limited, with ketamine, thiopentone and diazepam the most commonly used. The only available muscle relaxant is pancuronium. No peripheral nerve stimulators or reversal agents are available. Maintenance of anaesthesia is provided by halothane; occasionally isoflurane, or repeated thiopentone dosing. Simple analgesics are used post-operatively, and morphine is rarely used.

One study in 2005 aimed to establish the death rate and causes of avoidable peri-operative deaths in Lome, Togo. 1464 anaesthetics were delivered during a six month period, of which 30 patients (2%) died within 24 hours. The study suggested a staggering 93% of these total deaths were avoidable.

The majority of patients (77.43%) were aged between sixteen and sixty years, with only 11.9% being above the age of sixty. In the sub-group of peri-operative deaths, 56% were ASA 1 or ASA 2 patients, and the remaining 44% ASA 3 or 4.

Eleven peri-operative deaths were categorised as “anaesthetic avoidable mortalities”1. Of these eleven deaths, four were a result of gastric aspiration, two related to post-operative hypoxia, two “overdoses” of anaesthetic agents, one difficult intubation, one undetected oesophageal intubation and one secondary to anaphylaxis. A further ten deaths were deemed “administrative”, resulting from “insufficient or unavailable” blood for transfusion.

60% of the 1464 anaesthetics were emergencies, without use of a rapid sequence induction technique. Over 90% comprised general anaesthesia, with regional techniques (sub-arachnoid block), accounting for 8%.

47% of total deaths were associated with cardiovascular collapse (namely acute haemorrhage or septic shock), and 30% with respiratory failure. 50% of total deaths were in obstetric patients. These statistics clearly support the necessity of continuing professional development and the need for ongoing education with regard to anaesthetic safety and best practice. ‘Better’ practice however, seems a more realistic target where facilities and equipment are limited and care is challenged to the extreme.

The conference

The conference took place over three days, and was held at the teaching hospital in Lome. The faculty consisted of three consultant anaesthetists, one neonatologist, three trainee anaesthetists and two interpreters. The morning sessions were lecture-based, with practical workshops held in the afternoon, focusing on neonatal resuscitation, airway skills, and obstetric case histories with management discussions. We also arrived with two neonatal dummies, two anaesthetic intubating heads and boxes of donated disposable equipment to complement our practical sessions.

It was attended by 96 anaesthetic practitioners and 2 midwives from 23 hospitals in Togo. The delegates were incredibly enthusiastic, attentive and knowledgeable. During lectures, the delegates were keen to be updated on best Western practice; for example: secondary prevention in the management of head injured patients, despite their limited resources and challenging professional circumstances. They have no recovery, no intensive care facilities and no ventilators. Their practical skills were impressive, and all were keen to demonstrate repeatedly during workshops to be reassured of their proficiency.

At the end of the conference, we had planned to evenly distribute our donated equipment to each of the delegates. However, the true desperation of their clinical circumstances became apparent with the stampede and chaos of delegates grabbing items off the carefully organised table.

Feedback at the end of the conference was very positive. Delegates were appreciative of the time we had donated and our efforts. In spite of the language barrier, we happily developed a friendly rapport with the delegates, often mediated by flamboyant sign-language! We definitely came away feeling we had made a positive impact on their education. However, it is difficult to be certain if our teaching will have any lasting influence on their anaesthetic practice.

Our experience

Shiny

“I felt apprehensive prior to departing on this trip for a number of reasons. I have never taught on a conference like this before, to this number of delegates. Even with previous experience of the ‘lecture theatre’, I prefer to teach on a smaller scale, as I feel the teacher-student interaction is crucial to the learning process. However, with the morning lectures, we could reach the larger audience to impart key information. During the afternoon workshops, we were able to develop relationships with the delegates, which enhanced the learning process.”

Lou

“I was the most junior member of the team (CT2 Anaesthetics), and also nervous about participating in the conference. I thoroughly enjoyed the teaching experience and adapted my techniques to deliver concise information. As a junior trainee I feel privileged to have been given this opportunity. I was very lucky to be part of a magnificent, welcoming and dynamic team which made my whole experience even more memorable.”

Teaching in Africa challenged all aspects of lecture technique and content, and forced us to scrutinise the way we think about delivering education. Teaching in one’s first language is demanding, yet we had the additional challenge of French translation as we lectured. We were incredibly fortunate to have two fantastic translators, (both non-medical), who had sacrificed their time to revise complex medical vernacular. The conference would have been impossible without their expertise. We modified our lecture technique, using shorter sentences with longer pauses, to allow for concise and accurate translation. The results of the end-of-day quiz sessions clearly confirmed that the salient points had been communicated. Alongside gaining insight into delivery of medical education in Africa, we certainly augmented our own teaching skills and knowledge.

This was one of the most rewarding and memorable experiences of our training and teaching to date and we would wholeheartedly recommend teaching and travelling in West Africa to those lucky enough to have the opportunity.

Our Thanks

We were invited to stay on the Africa Mercy Ship which had docked in Togo the month prior to our visit. Mercy Ships are a global charity that provide ‘hospital ships’ to deliver free surgical and medical care to developing countries. They were extremely generous, and took care of us during our stay in Togo, providing excellent food, safe travel and accommodation.

www.MercyShips.org.uk

We wish to thank Dr Keith Thomson for his impeccable organisation and support during the conference and also for his great sense of humour and hilarious anecdotes. Our thanks also go to C.H.U. Tokoin Hospital, Mrs Aicha Bissang (president of the nurse anaesthetists association), Dr Kadjika Tomta and Dr Moussou Tabana, all the delegates and the rest of the faculty for making our experience truly valuable.

Special thanks to the Association of Anaesthetists of Great Britain and Ireland (AAGBI), the World Federation of Societies of Anaesthesiologists (WFSA), and the Shalimar Trust for their generous contributions towards funding this conference.

Dr Shiny Shankar and Dr Louise Young

References

Yes, We Have No Bananas!

And apparently, we don’t have a lot of our usual drugs either! American anesthesiologists, as well as others around the world, have had to face an unprecedented array of drug shortages recently. Many of the very staples of our practice have become, often unpredictably and with little advance notice, in short supply, and anesthesiologists are weary.

No drug is more common, nor more essential to our practice, than propofol, and we are all dealing now with the shortages of this drug. Previously, three manufacturers, (Teva, Hospira, and APP) supplied our propofol. Due to possible contamination issues, both Teva and Hospira have recalled their product, and curtailed manufacturing and supply. Thus, only one manufacturer is left for the entire USA market, clearly an untenable situation.

Recently, our regulatory bodies have allowed another product, propoven, to be delivered to the USA market, although unlike fine food and wine, many Americans are leery of this European product. Is it safe? Is it clean? Will it work just like my regular old propofol? While the answer to all these questions is undoubtedly yes, it is hard to convince some American physicians of such matters and thus skepticism continues. Perhaps due only to extreme cost considerations, but possibly inspired by the propofol shortage, some miscreant American anesthesiologists have even been caught using propofol syringes and single-dose vials on multiple patients, prompting, in at least one case, widespread public health concerns about cross-contamination of patients with agents such as hepatitis C.

Other shortages are being noticed too. For a while, ephedrine was in short supply. We are now hearing of vecuronium and cis-atracurium shortages. Even succinylcholine has been in short supply. Fentanyl and neostigmine have been threatening to go on short supply. Just recently, our labor unit was informed of a national shortage of nalbuphine, one of our standard parenteral opioids for labor analgesia. Although viable alternatives exist for most if not all of these agents, the prospects of such shortages, with new ones being announced on a regular basis, have rocked some of our psychological security.

One of the most severe shortages is that of sodium pentothal (AKA thiopentone). My hospital is totally without any supply of this medication, as is the case in most USA hospitals. On a personal note, I don’t miss this drug at all! If I never give another dose of pentothal, it will be just fine. It’s a nasty drug, made virtually obsolete by the safety and favorable side-effect profile of propofol. To paraphrase one of my mentors, if all the pentothal in the world were thrown into the sea, it would be to the benefit of patients having general anesthesia, and the detriment of the fishes. As long as we have propofol (and that, of course, is still very much in question) I am happy to see pentothal relegated to the realm of obscurity (with apologies to a few of my neuro-anesthesia colleagues).

Just don’t even think of touching my supply of tea and coffee in the break room!

William Camann, MD
Director, Obstetric Anesthesia
Brigham & Women’s Hospital
Harvard Medical School
Boston, USA
This year’s annual conference was brilliant. Of course, everyone has a different experience, but these are my (edited) highlights – I’m sorry if I don’t mention your talk/poster/paper or whatever; I can’t be everywhere and space is limited!

I think the presentation which I found most thought-provoking was that of Dr Brian Sites from Dartmouth medical school and Dartmouth-Hitchcock Medical Center, New Hampshire. With the aid of several very uncomfortable videos of less than straightforward spinal anaesthesia, Dr Sites challenged the notion that all is well with neuraxial anaesthesia. I guess we have been bathing in the warm afterglow of NAP3, which (at least if you are an obstetric anaesthetist) has given us on the whole reassuring data about the safety of the techniques. Dr Sites’ arguments and evidence suggested that whilst this may be so, we have a long way to go in terms of efficacy even for spinal anaesthesia. The results of analysis of video recordings of routine spinal anaesthesia in orthopaedic patients (which are not yet fully published) suggest that our notions of ‘failure’ with respect to spinal anaesthesia are open to question. I am not sure about the solution to this (neither was Dr Sites), but suspect that it might lie in a combination of better imaging, better use of currently-available imaging and altered behaviour – ‘human factors’ rear their head again. It can be very hard to say ‘I can’t do this’, but Dr Sites’ evidence suggests we had better try harder. The situation might be analogous with what seems to happen in some airway disasters – ‘can’t intubate can’t ventilate’ resulting in harm because of failure to acknowledge failure. My take home message is that ‘sorry seems to be the only word’ is defeatist – ‘can’t’ is a better one.

The Overseas Anaesthesia Fund (OAF) is a great success story (of which more in another edition), and the first OAF-sponsored graduate of a medical anaesthesia training programme in Uganda (Dr Arthur Kwizera) was in Harrogate to tell us about the training programme and to inspire us to greater efforts. Arthur has written an account in this newsletter in the past, and we will follow his progress and that of the whole fund with interest, so I won’t dwell on this now. I was inspired to scuttle off to the OAF stand and fill in a mandate for a regular donation, which I hadn’t got around to doing earlier.

Professor Hugh Hemmings from Cornell, New York, delivered the Dräger lecture – entitled ‘Numbing the mind’ about mechanisms of general anaesthesia. Professor Hemmings explored current evidence for the neurological and biochemical basis of general anaesthesia. This whole area is incredibly complex; there are nine different sub-types of voltage-gated sodium channels. Whilst the evidence that GABA-mediated chloride channels are the important target for intravenous anaesthetics is stacking up, there is some evidence that sodium channels are important sites of action for inhaled anaesthetics as well as for local anaesthetics. Professor Hemmings led me towards the conclusion that this indeed mind-numbing and difficult stuff, but dedicated research workers such as Professor Hemmings are creeping towards some answers.

The Annual meeting and formal Presidential handover took place on Thursday lunchtime. Dr Les Gemmell gave a review of the activities of the AAGBI on behalf of its members over the last year before handing over to his successor as Hon Sec, Dr Andrew Hartle. The Hon Treasurer (Dr Ian Johnston) assured us that the AAGBI’s finances are in good shape. Dr Richard Birks then handed over the helm to our new President, Dr Iain Wilson.

A Common Interests Group forum was fascinating. Dr Alexander Hannenberg, President of the American Society of Anesthesiologists, compared being involved with the healthcare reform process over the last year or so with the production of sausages – you might like the end result, but you really don’t want to watch them being made. A crucial issue for US healthcare is costs – currently 15.3% of GDP, roughly double that of other similar countries. The recent healthcare reforms had the goal of tackling these costs whilst expanding cover to reduce the number of Americans without adequate healthcare provision. The patient Protection and Affordable Care Act was enacted this summer, and this should result in expansion of cover from the current 81% of the population to 92% in ten years’ time. However, the act does not, as enacted, provide for the controlling of costs. President Obama had enough trouble getting this legislation passed as it stands, and presumably decided that something was better than nothing.
There is therefore great pressure on costs, and the question as to how necessary a medical degree and lengthy training are for anaesthesia providers is being asked up and down the United States (eg The New York Times, 6th September 2010). Dr Hannenberg wryly noted that he had spent a lot of time recently writing to newspaper editors.

Dr Andrew Mulcahy, Vice-president of the Australian Society of Anaesthetists, lucidly described a rather different set of issues which are affecting colleagues in Australia. Curiously, and in stark contrast to the situation in the USA, healthcare was not really an issue in Australia’s recent elections. Top of his list was the recent introduction of national accreditation and registration schemes. There were fears of a resulting loss of professional autonomy, increasing costs and the potential for political involvement in training issues and standards. This all sounded familiar... Other big issues were workforce calculations (there is a looming shortage, or just about enough anaesthetists depending on your view). The ASA’s position is that there are just about the right number of anaesthetists, but that incentives and support for those working in rural or difficult areas are required. Casemix was discussed – an interesting fact is that a quarter of Australian anaesthesia cases by funding (or a third by volume) involve procedures usually carried out under sedation, such as colonoscopy. Alternative providers of anaesthesia (nurse practitioners and so on) is not a big issue in Australia at the moment.
Prof Sir Martin Evans (The John Snow lecturer) delivered a masterful account of his contribution to developmental biology. I am not sure that I have ever been in the same room as a Nobel prizewinner before, so this in itself was a privilege. I must say that I found his account slightly disturbing in a sense which owed more to Orwell than to Steinbeck (the lecture was entitled ‘Of Mice, Men and medicine’) – Sir Martin’s frequent references to the ‘making’ of mice was, I think what caused this, together with glimpses of the sheer scale of both what we can do and what we don’t understand in this field. Possibly a fairly serious example of a little knowledge being a dangerous thing? The most riveting bit of information came towards the end of the lecture, with a brief outline of how sickle-cell affected mice had first been made and then cured. I didn’t know this had been done.

The awards ceremony is not usually noted for its entertainment value, but delegates who missed it were unlucky this year. Our new President and Hon Sec, with the simple device of a blank envelope (which should have contained a cheque but, as the Pres helpfully explained, didn’t as the ink was not quite dry on the cheques), managed to inject a splendid note of farce into the prize giving which was worthy of Alan Ayckbourn. This in no way detracted from the real achievement of the young people (I had the impression that most prize-winners were women, but I guess that is the new face of medicine) receiving the prizes. I was only able to attend some of the free papers and posters, but was really impressed by the quality, originality and sheer vitality of the research presented.

Two debates rounded off the conference. The first motion debated was ‘This house believes that anaesthetic trainees should be advised to check whether lung ventilation with a face mask is possible before giving a non-depolarising neuromuscular blocking drug’. Dr Chris Freerk proposed the motion and Dr Ian Calder opposed it. To cut to the chase, after a very entertaining debate Dr Calder increased his majority against the motion to 70% of the audience. One of the interesting issues highlighted was the origins of the idea – where and when had the notion that it might be safer to establish that it is possible to ventilate with a face mask after induction, prior to giving muscle relaxants, arisen? Dr Calder had gone so far as to phone up a retired contributor to Miller’s textbook to ask him – he was uncertain of the origins of the idea, and said he had just put it into his chapter because it seemed like a good idea. How extraordinary that a quarter of a century later this idea is almost inscribed on a tablet of stone, with virtually no evidence to support it. I personally can’t see any sense in the idea, and suspect that bravery is important here – once you have committed yourself to giving an anaesthetic, you can’t be half-hearted about it.

This leads us on to the next debate – the motion ‘This house supports the recommendations of the package insert that declares that propofol should only be given by those trained in anaesthesia, or, where appropriate, trained in the sedation of patients in intensive care’ was ably proposed by our new Hon Sec, Dr Andrew Hartle, and gamely opposed by Dr Gavin Lloyd, who is a consultant in Emergency Medicine at the Royal Devon and Exeter. I guess it is not too surprising that the majority of the audience (64% after the debate) voted for the motion, but Dr Lloyd described the state he aimed to produce in his patients in A&E as anaesthesia, rather than sedation, and denied that it was absolutely necessary to adhere to the usual standards for fasting and monitoring patients undergoing anaesthesia in his particular circumstances. I abstained before the debate, and voted for the motion at the end.

We’re in Edinburgh next year; see you there!

Dr V Bythell
AAGBI charity Christmas card purchase form

The AAGBI wishes to acknowledge the help of Dr Anne Sutcliffe in creating these cards. These digital photographs, called ‘Tree and Shadows’ and ‘Winter Trees’, were taken by Dr Sutcliffe in Switzerland and near Loch Lomond respectively. Both images were exhibited in the 2009 Art Exhibition at the Annual Congress of the Association. Anne organised the AAGBI Art Exhibition from 2004 to 2008.

Proceeds from the sale of these cards will go to the Association’s Overseas Anaesthesia Fund, whose aim is to raise the profile of the specialty and promote safer anaesthesia in the developing world. For more information, go to www.aagbi.org/off.htm

If you would like to purchase the charity Christmas cards, please complete this form which is also available on our website www.aagbi.org.

The packs will be mailed to you from the AAGBI in London. The cards are available to purchase as a minimum order of a pack of 10, containing five of each design.

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Please pay by Sterling cheque drawn on a UK bank account and made payable to the AAGBI, or please debit my credit card (only Visa/Visa Debit/Mastercard/Maestro) or Switch card:

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Please return to: Chloé Hoy, AAGBI, 21 Portland Place, London, W1B 1PY. Or fax: 020 7631 4352, phone: 020 7631 8867, or email the above details to secretariat@aagbi.org
On the morning of Thursday September 23rd a group of enthusiastic people gathered outside the conference hall for the inaugural AAGB&I Congress Run. The weather was kind, and the runners posed for this team photo in the dawning light.

There was an international field, with the Canadian Society President in the group along with the wife of the President of the ASA. The AAGB&I council were well represented and there were rumours that one member of council had been training at altitude, at his North Wales mountain retreat.

Industry was well represented, Dräger, had kindly provided the most sought-after piece of anaesthesia clothing, the fun run T-shirt and Ambu entered a full team.

The run followed a route recommended by Terry, from the ‘Up and Running’ sports shop, based in Harrogate. The route was through the Valley Gardens, a gentle stroll for the ironman from Yorkshire, but a definite climb for those from the “softer” South.

All entrants had donated a minimum of £5 to the Overseas Anaesthesia Fund, a worthwhile cause together with the prize of the Dräger T shirt.

The views from the run over the North York moors were spectacular, although many were looking down at this point as the first 2.5km was up hill. The Chairman of Education acted as a sweeper, a role that proved necessary as the reduced PO2 at the top of the Valley Gardens did slow a few competitors down.

Everyone finished and there was a definite sense of achievement at the finish. New friends were encountered on the route and overall the fun run was very enjoyable. Rob Sneyd won the professorial race with ease and was later spotted receiving “lipid rescue” at breakfast (bacon, eggs and black pudding). Felicity Plaat held off a sprint finish from William Harrop-Griffiths to the claim the bragging rights amongst the London council members, for a year at least.

There will be a short 5km run around St James Park at the Winter Scientific Meeting in January 2011 - see the AAGBI website for details.

Next year we are in Edinburgh, so get into training, come along. All levels of ability are welcome.

Many thanks again to ‘Up and Running’, Dräger and the crew from Ambu.

Richard Griffiths, Chair, Education Committee

Dr Harrop Griffiths and Professor Sneyd prior to lipid rescue
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

THE WYLIE MEDAL
UNDERGRADUATE PRIZE 2011

The Wylie Medal will be awarded to the most meritorious essay on the topic of ‘anaesthesia and patient safety’ written by an undergraduate medical student at a university in Great Britain or Ireland.

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

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

For further information and an application form please visit our website: www.aagbi.org
or email secretariat@aagbi.org
or telephone 020 7631 8807

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**A new valve for draw-over anaesthesia:**

*Anaesthesia* 2010; 65: 1080-84  
S Payne, R Tully and R Eltringham

One of the many challenges in countries with poor resources is how to deliver good quality, safe anaesthesia using equipment that is simple, robust, and easy to maintain. It is not surprising that in many such settings, draw-over anaesthesia is popular. One of the disadvantages of draw-over anaesthesia is that the traditional non-rebreathing valves such as the Rubens, Ambu and Laerdal usually need to be placed close to the patient. This makes the breathing system cumbersome and increases the chance of inadvertent tracheal tube displacement. The new Diamedica non-rebreathing valve (which has separate but interlinked inspiratory and expiratory valves) is designed to be positioned remote from the patient’s airway, connected by lightweight plastic Y tubing.

Payne and colleagues have evaluated the resistance to varying gas flows representative of normal tidal flow rates and found resistances comparable or more favourable to those of traditional non-rebreathing valves.

In low resource settings, it is important that equipment is reusable and can withstand repeated cleaning and sterilisation. The authors therefore went on to measure resistance following simulated sterilisation and found that the Diamedica’s performance was unchanged, whereas the Ruben valve’s resistance to gas flow increased dramatically.

**A survey of intensive care unit visiting policies in the UK:**

*Anaesthesia* 2010; 65: 1101-05  
JD Hunter, C Goddard, M Rothwell, S Ketharaju and H Cooper

Long gone are the days when hospital wards consisted of a row of beds on either side populated by patients in striped pyjamas, with nurses in neatly starched uniforms patrolling between. Things are more relaxed nowadays with increasingly liberal visiting policies, except perhaps, in the ITU, where the intensity of treatment and fears over infection control have contrived to restrict visiting. However, there is evidence that a more relaxed approach to visiting can reduce anxiety in both relatives and patients. Hunter and colleagues have undertaken a survey of UK ITU’s visiting policies and facilities for relatives.

They managed to get a very reasonable response rate of 76% so we can be confident that their findings are fairly representative of current practice. Interestingly, it would appear that few units have in fact liberalised their visiting policies and disappointingly many units have poor waiting facilities for relatives. The survey contains a wealth of interesting detail about the provision in UK ITU’s for relatives and how they are kept informed of their loved one’s condition.

**Patient safety incidents involving neuromuscular blockade: analysis of the UK National Reporting and Learning (NRLS) data from 2006-2008.**

*Anaesthesia* 2010; 65: 1106-13  
J Arnot-Smith and A Smith

Incident reporting is well recognised by anaesthetists as a powerful tool for learning about and understanding the events that can threaten patient safety. It is rather surprising, therefore, that this is the first attempt at a detailed analysis of the NRLS dataset for a specific type of anaesthetic related incident. It is interesting that Arnot-Smith and Smith have chosen to look at incidents involving neuromuscular blocking agents (NMBA) and not the usual chestnut of airway related events.

Of the nearly 200 000 incidents report in the 3-year period, the authors identified 231 definite NMBA related incidents. The lack of denominator data and the fact that not all relevant incidents are reported means that the true incidence of events is unknown. The three top themes identified were non-availability of drugs, unintentional awareness, and potential drug allergy. The authors make a number of very sensible, practical suggestions for reducing NMBA drug errors, many of which could equally be applied to the administration of other drugs. Take a look and see whether you agree!

Paul Clyburn  
Editor, *Anaesthesia*

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**Two rows by any other name...**

*if you eat sweets.*

**Dentures in**  
France - aperitif*  
Italy - falsetto  
Japan - nashi pear  
Germany - Mönchengladbach (returned in Recovery)

**Replacements in**  
Turkey - Topkapi (care at intubation)  
Mexico - Corona Extra (anaesthetist’s nightmare)  
India - capnogram (avoids dried lentil snacks)  
USA - platitude (refuses to remove partial denture)

**None in**  
Middle East - gum Arabic  
USA - gurney (recipient of gurner’s attention)

**Originals**  
first incisor - consultant surgeon  
second incisor - his registrar  
canine - his dog  
wisdom - his anaesthetist

By Arfur Dent * © Gareth Greenslade
I was at the Post Grad centre bright and early for my ST3 induction. The general feeling around me was along the lines of ‘Great! Another induction!’, but I was immune to such ill-informed opinions - after more than 3 years as a staff grade doctor (SG), I had finally joined the ranks of Specialty Trainees!

The purpose of this piece is to offer a few suggestions to any SGs out there who are keen to return to training. I don’t claim to be an authority on this matter, but I hope these suggestions (which worked for me) will be useful.

To get back into training after x number of years out of it, what needs to be clearly demonstrated in your CV is a continuing commitment to the speciality and to training/personal development; you will need to demonstrate that even when you were not in a training post, you remained committed to progressing.

A good point to start would be to have a chat with the regional advisor/program director/head of school of the rotation your hospital belongs to. As they are intimately involved in the shortlisting and interview process, they will be in a good position to advise you on any items that are missing from your CV/portfolio, and of what else needs to be done to bring it up to scratch. Your hospital may also have a SAS tutor who may be able to help.

Maintain a logbook of all clinical work done. As a NCCG, you will frequently undertake independent lists. A logbook is a good means to demonstrate your immense experience, and ability to work confidently on your own. If you have done a LAT job at some point, make sure you have all the requisite documentation so that that time may count towards training in due course.

Be involved with departmental teaching programs. Not only does this keep you academically up to date, it shows your commitment to teaching and learning. Try to present a couple of topics. In addition, involvement in audit is equally important in the interview process. It is highly desirable to complete the audit loop, hence demonstrating that the initial audit has positively impacted on current practice. You can try to present your audit as a poster at a regional or National meeting, for added value.

Having a publication/poster/oral presentation on your CV will be viewed in very good light. It does not have to be a large clinical trial or multicentre study. A case report of an interesting case, response to a published article or a patient satisfaction survey will be suitable.

Passing the Primary FRCA is a minimum requirement for getting an ST3 job. My suggestion would be to not rest at that, but to go for the final FRCA as well. In my view, nothing will demonstrate your desire to progress more than passing this exam.

Work studiously on your application form, highlighting your greater clinical experience compared with your competitors. Be sure to highlight this at the interview as well. Get some interview practice in your department, as it may have been a few years since you were last in such a position. Speak to people who have recently attended an ST3 interview, as they may be able to guide you on ‘hot’ topics. Do some background research on the rotation you are applying for. There are also many courses available to train you for the interview. You will need to work on making your portfolio as presentable and orderly as possible. Study the person specification for the post and ensure that information which might be assessed by reviewing your portfolio is easy to find.

This list is not meant to be exhaustive, but I feel that if you are able to work on some of these suggestions, you will stand a decent chance. All the best!!

Dr Alexander Philip
ST3 Anaesthesia,
Kettering General hospital
The title of the AIM 2010 Trainee Essay Competition is "Creating a pro-active anaesthetic department in challenging financial times."

No more than 1000 words should be submitted to aim@aagbi.org or by post to The Specialist Societies Manager, AIM, 21 Portland Place, London, W1B 1PY

By 29th October 2010

The winner will be invited to present their essay at the 8th AIM Annual Conference on 01 December 2010 @ The Royal college of Anaesthetists, London.

The winner will also receive a prize of £250.00

Undergraduate Elective Funding
Up to £750

All medical students in the UK who have successfully completed two years of clinical medical training are eligible to apply to the Association of Anaesthetists of Great Britain and Ireland for funding towards a medical student elective period.

Preference will be given to those applicants who can show that their intended elective has an anaesthetic, intensive care or pain relief interest.

For further information and an application form please visit our website: www.aagbi.org or email secretariat@aagbi.org or telephone 020 7631 8807

Closing date: 14th January 2011

The Association of Paediatric Anaesthetists of Great Britain and Ireland Annual Scientific Meeting
The Peninsula Meeting, Torquay
GAT refresher Course 18th May 2011
Scientific Meeting 19th – 20th May 2011

GAT Refresher Course
Managing the difficult airway
Anaesthesia outside theatres
Recognising the sick child
IV access: is it mandatory?

Trainee session
Expectations and competencies in paediatric anaesthesia
Free papers and posters:
Trainee Prizes

Additional Symposia:
Cuffed tubes (sponsored by Kimberley Clarke); Research and Publication (sponsored by Pediatric Anesthesia)

Topics include
Transfusion in paediatrics
Preterm anaesthesia
Telemedicine in paediatrics
Paediatric trauma in a war zone

Thursday and Friday Workshops
Ultrasound; airway management; transfer of the sick child

Jackson-Rees Lecturer
Adrian Bosenberg (Seattle, USA)

For information and registration consult the APA website at www.apagbi-asmtorquay2011.co.uk or contact: the APA Event Coordination Team at apa2011@aagbi.org

The Association of Paediatric Anaesthetists of Great Britain and Ireland is a UK Registered Charity 1128113
National Cardiac Arrest Audit

About NCAA

The National Cardiac Arrest Audit (NCAA) is a national audit of in-hospital cardiac arrests, within acute hospitals in the UK and Ireland. It is a joint initiative between Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre). It aims to identify and foster improvements in the prevention, care delivery and outcomes from cardiac arrest.

What data are collected?

The initial scope of NCAA is in-hospital cardiac arrests. Participating hospitals collect a standardised dataset. The initial dataset consists of only 20 fields and covers essential patient characteristic data and short-term outcome following cardiac arrest. Future dataset modules will focus on interventions and longer-term outcomes.

How does it work?

Data are entered onto the NCAA secure, web-based system and are validated at the point of entry and centrally to ensure accuracy of the data.

Hospitals signed up

Since NCAA commenced in September 2009, a total of 67 hospitals have signed up to participate with many more expressing their intention. A list of these hospitals is available to download from the ICNARC website (www.icnarc.org - follow the quick link ‘National Cardiac Arrest Audit’).

If your hospital would like more information about the audit, then please contact the NCAA Team at ncaa@icnarc.org.

NCAA Participants Meeting

The First NCAA Participants Meeting was held on 28 June 2010 in London. Those attending were given the opportunity to contribute to informal and interactive discussions around the initial scope of NCAA, the current dataset and the content of NCAA Reports. To facilitate discussions around the development of NCAA Reports, some early NCAA analyses were shared with those attending. Two members of the NCAA Steering Group; Jerry Nolan (NCAA Steering Group Chair) and Sarah Mitchell (Director, Resuscitation Council (UK)) also attended the meeting as well as the NCAA Team from ICNARC. Evaluation Forms and post-event feedback indicated that delegates found it to be a useful and informative meeting.

The Second NCAA Participants Meeting was held on Monday 4 October 2010 in Central London.

Official NCAA Launch

An evening reception, to mark the official launch of NCAA, was held on Monday 4 October 2010 in Central London.

Current focus and new developments

The NCAA Team is currently focusing on data validation and the development of NCAA Report. The validation report will inform hospitals about the completeness and validity of their NCAA data with a view to improving the quality of NCAA data. NCAA Activity Reports and Comparative Reports are also in development.

Keen to join NCAA?

If your hospital is keen to join, then please contact the NCAA Team for a NCAA Recruitment Pack at/on: ncaa@icnarc.org

020 7554 9779

Supported by:
Dear Editor

An unusual ‘apple core’ lesion!

With World Cup fever at its peak, we came across a gentleman who had found a rather unique way of flying the flag for our country.

This picture was taken during a routine colonoscopy; after the operator’s initial surprise we realised that this was an undigested branding sticker from an apple rather than a colonic mucosal tattoo!

Thankfully this was the only “core lesion” seen during the examination.

Dr TM Astles, Specialty Registrar in Anaesthesia
Dr S Singaravelu, Consultant Anaesthetist
Mr JA Anderson, Consultant Surgeon
Wirral University Teaching Hospital NHS Foundation Trust, Upton, Wirral, CH49 5PE

Dear Editor

I read with interest the piece by Michael Ward entitled ‘The early days of anaesthetic nurses’ (Anaesthesia News)

I would like to point out that no mention is made of the Newcastle School of Anaesthetic Nursing. This was, in fact, the second anaesthetic nursing school. It preceded Cardiff by quite a time because it was started by Dr EA Pask shortly after his appointment as Reader in Newcastle in 1948/9 and was flourishing when I first arrived in Newcastle in July 1950. It was led by Sister Joyce Evans and Sister Ursula Woodley - in charge of about three permanent Staff Nurses and about six others in training.

Dr John Inkster
Consultant anaesthetist (retired), Newcastle

Dear Editor

On a recent visit to India, I visited a local hospital to visit a convalescing relative. In the main foyer of the reception area was displayed a painting depicting the biblical creation of woman, using the rib of Adam. Underneath the painting read the caption ‘God, the first surgeon’.

This set me thinking, surely for this first ever operation, there must have been an anaesthetist present? Sure enough, I got the answer from the book of Genesis (chapter 2 verse 21). ‘And the Lord God caused a deep sleep to fall upon Adam, and he slept: and he took one of his ribs, and closed up the flesh instead thereof’. So, there you have it. The origins of our speciality are indeed divine. I am sure our surgical colleagues will be reassured to learn that our speciality is as old as theirs!!.

Dr Alexander Philip, Princess Alexandra Hospital, Harlow

Dear Editor

Having often heard suggestions that surgical and anaesthetic opinions and priorities do not necessarily always overlap, we have recently undertaken a survey which highlights this point very aptly.

Undertaken at University College London Hospital, we surveyed the opinions of fifty anaesthetists and fifty surgeons, (20 consultants, 20 senior trainees (ST3) and 10 junior trainees (CT1-2)), by asking them the above question ‘What makes a good anaesthetist?’ Each respondent listed the top 5 attributes that they thought suitable, and on collation of the results, the following was seen:

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Anaesthetists’ opinions</th>
<th>Surgeons’ opinions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Keeping calm under pressure (12.4%)</td>
<td>Communication (8.8%)</td>
<td></td>
</tr>
<tr>
<td>2. Clinical knowledge (12.0%)</td>
<td>Keeping calm under pressure (8.4%)</td>
<td></td>
</tr>
<tr>
<td>3. Clinical judgement (11.6%)</td>
<td>Efficient at running lists (7.2%)</td>
<td></td>
</tr>
<tr>
<td>4. Communication (10.0%)</td>
<td>Speed – quick at performing procedures (6.8%)</td>
<td></td>
</tr>
<tr>
<td>5. Attention to detail (8.8%)</td>
<td>Clinical knowledge (6.4%)</td>
<td></td>
</tr>
<tr>
<td>6. Knowing your limits (8.0%)</td>
<td>Technical skills (5.2%)</td>
<td></td>
</tr>
<tr>
<td>7. Teamwork (7.6%)</td>
<td>Teamwork (4.8%)</td>
<td></td>
</tr>
<tr>
<td>8. Technical skills (5.2%)</td>
<td>Approachable (4.8%)</td>
<td></td>
</tr>
<tr>
<td>9. Keeps up to date with research (2.8%)</td>
<td>Reliable (4.4%)</td>
<td></td>
</tr>
<tr>
<td>10. Other -20 further attributes (21.6%)</td>
<td>Other –21 further attributes (43.2%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 1- Attributes suggested by Anaesthetists and Surgeons. (Percentage of votes)

Discussion:

With some 29 different attributes listed in our respondents’ top five responses, this survey clearly highlights the huge range and divided opinion amongst anaesthetists and surgeons of every grade, as to what indeed does make someone a good anaesthetist.

Whilst some harmony was evident between specialities, for example both anaesthetists and surgeons agreed that ‘communication’, ‘keeping calm under pressure’ and ‘clinical knowledge’ were important attributes to possess, disparities were also evident – anaesthetists believing ‘clinical judgement’ and ‘attention to detail’ were of great significance, whilst surgeons placed more emphasis on ‘speed – quick at performing procedures’ and ‘efficient at running lists’.

These distinctions perhaps represent the ‘cultural’ differences between the two specialties - disparities which are sustained by the different stresses and pressures exerted upon each on a day-to-day basis. Amongst surgeons, the pressure to operate to high standards in order to minimise morbidity and mortality, whilst maximising theatre throughput, finishing theatre lists on time, and reducing waiting lists, are just some of the many factors which could readily influence these ‘cultural’ differences and thus account for the choices made in this survey. Anaesthetists on the other hand, whose job amongst other things entails the precise management of human physiology and thus ‘attention to detail’, though necessary to facilitate the surgeons, are not held directly responsible for the lists and henceforth may decide that these are not necessarily the most important attributes.

In an attempt to answer the seemingly simple question ‘What makes a good anaesthetist?’, it is evident from the divided opinions that perhaps the answer is not as readily obvious as previously thought. Whether or not the results we obtained are representative of other hospitals or different specialities remains to be answered, however there is no doubt that the debate is set to continue.

Dr Hamish McKay, ST6 Anaesthetics, North West Deanery
Dr Bhskar Saha, Consultant Anaesthetist, Royal Oldham Hospital
When you meet a pro.....

As the night on-call Intensive Care doctor, most of us have been called to the Accident and Emergency (A&E) to see postictal patients, drowned in diazepam - I can never really fathom why diazepam is so much more popular than the shorter-acting midazolam or lorazepam with our physician colleagues. Returning to the postictal patient with a Glasgow Coma Score (GCS) of 3, most of us are inclined to observe them in the recovery position for a “bit longer” and hope for them to improve to a GCS of 9 and to save the last precious bed on the Intensive Care Unit (ITU) for the lucky draw between the patient with pneumonia with borderline arterial blood gases and the postoperative laparotomy patient who has been requiring metaraminol boluses in the recovery room. But what do you do when you get called to the A&E to review a teenager with a known history of epilepsy, who has been having seizures for a few hours, has never really gained consciousness between seizures, and who has scored no more than GCS 3 since presentation. The answer is simple, the teenage girl is in status epilepticus, and therefore you secure her airway, get on top of the seizures and arrange a CT scan. But when I was warned by the medical registrar that he was reasonably confident these were “pseudoseizures” based on the examination findings and previous notes, being a mortal creature, I proceeded to examine the patient with a biased mind. The patient was on the trolley, still as a board, and did not flinch as the house officer obtained a blood sample. After a few minutes the pattern of vigorous shaking of right upper and lower limb was repeated in my presence. I was told that the seizures occurred every time a doctor or a nurse visited the bed space. With no access to EEG or a super-intelligent person who could interpret an EEG, we were left with pseudoseizure diagnostic techniques we had anecdotally inherited from our seniors. So we tried the deep pain stimulus and then the famous drop-the-arm-on-the-face technique. Neither produced a clear response, nor did the intermittent swallow reflex. We then tried the jaw thrust starting with the head titled to right side and on releasing the head fell back really slowly when released from the left side. There was momentary (or was it imaginary) eye-opening during fundoscopy, again not solid enough to confirm that the patient was faking the seizures. We had to confirm the diagnosis so as not to mismanage the case which would be a serious mistake. We took the liberty of more time since all vital signs and investigations were normal. My threat of saying out loud, as if I were talking to a 90 year old patient, “If she does not wake up in the next 15 minutes, I will have to put her to sleep and put a tube down her throat and put her on the breathing machine” had no effect, but we did glance from behind the curtain to discover the patient nodding when the mother was trying to talk to her in our absence. We were running out of time, both clinically and A&E stay breach time, so our wise senior medical registrar was summoned. She cleverly declared, with all the doctors in the bed space, “If the patient has true seizures, the arm will stay unsupported in the air, when lifted above the head”. Lo and behold, the arm did stay unsupported without falling for nearly 30 seconds. A good lesson learnt indeed! Oh and also the litre of intravenous fluid administered previously did the trick as soon the patient was transferred to a medical ward, where she blurted out “loo” before falling unconscious again!

Dr Vidhi Patle, Specialty Doctor, Watford

*Editor’s note. ‘Dissociative seizure’ seems to be the current term for this disorder, which may affect as many as 20% of those diagnosed as epileptic. A useful article (including features suggestive of this diagnosis) can be found as follows:


BLOCKED CIRCUITS ARE STILL A PROBLEM

An article in September’s Anaesthesia News made harrowing reading; “one quick last case” almost turned into a disaster. The anaesthetist in question was trying to help, making full use of spare theatre time (which should make managers happy), being flexible, and trying to avoid distressing delay in getting a child to theatre for minor emergency surgery. This case led almost directly to the MHRA’s Medical Device Alert (MDA) on the early use of an alternative means of ventilation if unexpected difficulty arises [1].

This Device Alert led to a number of critical comments from AAGBI members about “teaching granny to suck eggs”, but sometimes we need reminding of what we already know. I was saddened to learn from the MHRA that within six weeks of the release of the MDA there was another case when the early use of a self-inflating bag might have averted disaster. Maybe our egg-sucking skills do need revision?

Should difficult airway courses become more didactic (rather like ALS, ATLS etc.), and mandatory? The Royal College “matrix” of core CPD for revalidation may be one route to achieve this. Incident reporting and patient confidentiality often make it difficult to share all the details of a particular case. The author of September’s case is to be commended for being brave enough to share their experience. It is their hope, and mine, that no-one ever has to learn this lesson again, except perhaps in a simulator!


Andrew Hartle
Hon Sec, AAGBI
NOTTINGHAM ASM 2010

The Neuroanaesthesia Society of Great Britain and Ireland developed from the Neuroanaesthesia Travelling Club which first met in Scotland in 1965. In keeping with that tradition, the Annual Scientific Meeting (ASM) is hosted by a different department each year, with Nottingham playing host to the 185 delegates in May. Held over 2 days, the first morning of the meeting is an update session. The theme this year was the effect of neuro-intensive care in trauma management, with talks on cervical spine injuries, management of brain perfusion and systemic complications of trauma. Carl Waldman gave his perspective on what can be achieved in a general ITU for these patients.

The guest lecture by Prof Nicolas Bruder from Marseille concentrated on thromboprophylaxis in Neurosurgical Patients. Many guidelines make an exception of these patients from standard VTE prophylaxis because of the potentially devastating complications of bleeding into the CNS. This is despite an incidence of 2.3-6% of symptomatic DVT with all the ensuing medical complications. He concluded that Intermittent Pneumatic Compression devices should be used routinely with LMWH given postoperatively to those with malignancy, paresis or prolonged surgery, even though this will result in an increase in postoperative haemorrhage(1). Talks on simulation and research completed this session.

The traditional Annual Dinner was held in the splendid surroundings of the 80 year old Nottingham Council House. Being a small specialty this is a great social function.

The main event of the second day is the free paper session. Harvey Granat, one of the founding members of the travelling club, bequeathed a prize for the best free paper presented by a trainee. This year it was won by Chris Bourdeaux who showed that 8.4% sodium bicarbonate decreased raised intracranial pressure to acceptable levels for 6 hours following traumatic brain injury(2). The abstracts of the free papers and posters are published in the Journal of Neurosurgical Anesthesiology.
Prof Cor Kalkman from Utrecht set the theme of the final session speaking on “How can anaesthetists contribute to good peri-operative outcomes for neurosurgical patients?” This led on to a lively debate on “Anaesthetists have nothing further to offer to the safety of neurosurgical patients” which we are glad to report was defeated.

NEWCASTLE ASM 5th/6th May 2011

Next year's NASGBI ASM is in the vibrant city of Newcastle at the Sage Gateshead. This building is part of a project to regenerate the area’s river frontage and is adjacent to the Stirling Prize winning Gateshead Millenium Bridge and Tyne Bridge. The scientific programme looks very exciting too, with sessions on:

- Muscle disorders
- Home ventilation
- Genetics and Ageing
- Head injury, NCC and Brain death
- Neuroradiology

The ongoing support from our industry sponsors helps ensure high quality international speakers while limiting delegate fees. The programme, links for booking accommodation and registration forms will be available on our website www.nasgbi.org.uk by early January 2011.

SURVEYS

John Andrzejowski has done a great job organising the surveys for NASGBI. After an initial review and changes by John, the surveys are then sent to 2 other reviewers before the final version is entered onto the ‘Survey galaxy’ website. Free text boxes are minimised, incorporating as many skipping rules as possible so that unnecessary answers are avoided by respondents. This has ensured that all the surveys are relevant, of a high standard and can be completed in a short a time as possible allowing for greater numbers of respondents. Mail merging by Busola and Zoe at the AAGBI also avoids email servers rejecting mail as spam. Thanks should also go to the Consultants who have been involved in the peer reviewing. This year we have conducted eight surveys of which the first three were presented at the annual meeting.

- Throat pack use in neurosurgery
- Anaesthesia for interventional radiology
- Anaesthesia for sitting craniotomy
- ALS for patients in head pins
- Airway anaesthesia in patients with unstable necks
- Central line use in Neuroanaesthesia

Further surveys pending are on NSAID use and Antibiotic prophylaxis. So if you have any ideas get in touch with John via the NASGBI website.

TRAVELLING FELLOWSHIPS

NASGBI budgets for up to two £750 Travelling Fellowships annually to support visits to either gain or impart skills, knowledge or experience in neuroanaesthesia or neuro-intensive care. Those applying must have been members of the society for at least 1 year and may not use the award solely to attend a meeting. The society will be looking for the potential that practice will change as a result of the visit and the applicant is expected to present their findings at the annual meeting. In the past visits to Lund (to see how their head injury management protocol works) and Seattle (to observe their Transcranial Doppler service) have been supported. Details are on the NASGBI website.

LINKMEN

We now have a robust group of 38 NASGBI Linkmen in all of the neurosurgical adult and paediatric hospitals in UK and Ireland. After the AGM, we have amended the Linkmen’s terms and conditions which can be found on the website. This year instead of having a Linkmen’s meeting, we held a Linkmen’s lunch. This proved highly successful as we managed to put faces to names (and email addresses!). We shall be repeating this in Newcastle. We would like to thank the Linkmen for all their hard work in gathering and disseminating information and energies spent in overcoming their Trust firewalls!

..AND OTHER THINGS

- Don’t forget that NASGBI is a nominating Society for ACCEA awards.
- Huge steps are being taken with e-learning for Health. The intermediate section includes sub specialties including Neuroanaesthesia. Arun Gupta has been appointed Editor, assisted by Derek Duane (Cambridge) and Chris Kearns (Oxford). Many members of NASGBI will be co authoring sections. In parallel there is also a Neurosciences e-learning project ‘e-brain’. Arun Gupta has also been asked to edit the Neuroanaesthesia and Neurocritical care sections, allowing both projects to use the same material. It is hoped that the e-learning material will be accessible for the ASM in Newcastle 2011.
- Mike Nathanson is developing firm links with the APA and working on ‘Safe and Sustainable Paediatric Neurosurgical Services in England’.
- NASGBI remains firmly committed to supporting research via the NIAA and working with other specialties at the Joint Neurosciences Council.

So we look forward to seeing you in Newcastle in 2011 or at any meeting with a neuro slant to it! Please contact any of the NASGBI Council via Busola or Zoe at the AAGBI and trainees especially, keep applying for the prizes and travel grants.

2. Bourdeaux C, Brown J. 8.4% Sodium Bicarbonate reduces raised intracranial pressure after traumatic brain injury. Critical Care 2010: 14(Suppl 1);290
At-a-Glance Monitoring: Covert Observations of Anesthesiologists in the Operating Room.

(Anesth Analg 2010; 111:653-8)

Are we in danger of information overload? Do we have too many wave, trend, numeric, visual and auditory monitoring values during our routine anaesthetics to be able to interpret them all? Could the presentation of this information be improved to allow more rapid response and reduce error?

This pilot study from Canada attempts to begin to address this issue. In true “Big Brother” style; 10 anaesthetists and 2 medical students were covertly videoed administrating a “normal anaesthetic” either during solo or dual provider cases. The videoing was performed at a single site, in a single operating theatre. Full consent was obtained from the anaesthetists involved and the cameras were mounted in full view, several months prior to the initiation of the study to allow “acclimation” to their presence.

The authors analysed video from three 10-minute ‘snapshot’ periods of the anaesthetic; early, mid and late maintenance. These segments of video were then analysed for certain behaviours in a video suite.

Their results indicated that the anaesthetic provider looked at the monitor for less than 5% of the time and for durations of on average around 1.5 seconds. This remained consistent across the 3 stages of the anaesthetic. Less surprising perhaps, was the finding that during early maintenance the majority of activity was seen ‘filling in charts’, and during mid maintenance the majority of time was spent reading ‘other reading material.’ The grade of anaesthetist or whether or not the case was a solo or dual case had very little effect on these observations.

This study reinforced previous work in this area that highlighted the anaesthetic behaviour of frequent, regular but brief glances at the monitor. As our displays fill up with ever more sophisticated information this behaviour has changed little. Can we take it all in? Or are we just glancing at the piece of information most relevant to the patient and us each time?

Perhaps more importantly, this study concluded that covert operating room observation is both “feasible and practical.” As video cameras appear more and more ubiquitously within our working environment surveillance footage could be made available far more commonly as a research or audit tool. This could provide new insights into our day-to-day work but, in addition, may also have great ethical implications as to how we practice in the future.

Dr R Whittle, ST6, Wansbeck

Rescue Therapies for Acute Hypoxemic Respiratory Failure

Liu et al. Anesthesia and Analgesia, September 2010; 111(3): 693-702

Management of acute lung injury (ALI) and acute respiratory distress syndrome (ARDS) is important to anaesthetists as it is both commonly encountered and associated with a high mortality to our patients. The recent H1N1 influenza pandemic has renewed interests in so called ‘rescue therapies’ and this review article from San Francisco outlines the latest evidence behind each.

The article firstly reminds us of the ARDSNet trial[1], which showed a mortality benefit in ventilating such patients with lower tidal volumes (6ml/kg compared to 12ml/kg) resulting in widespread adoption of this as the current standard of care. It then outlines the lesser resource-dependent (but still labour intensive) strategies for hypoxaemia of prone positioning and recruitment manoeuvres, which have been shown to transiently improve oxygenation without demonstrating mortality benefit.

More resource-dependent strategies such as the use of extracorporeal life support, inhaled selective pulmonary vasodilators or high frequency oscillatory ventilation have received widespread research interest and, particularly in light of H1N1, increasing clinical interest. Their use, however, has failed to become universally established due to doubts over effect on overall patient outcome coupled to their cost implication. Liu discusses the CESAR trial[2] from Leicester acknowledging its importance specifically to ECMO and recognises that the OSCILLATE trial[3] from Canada should add to the debate with regard to HFOV. No mention, however, is made of the ongoing OSCAR trial[4], here in the UK.

In summary this article provides a useful starting point for both trainees and consultants in examining the current literature of a core topic in Intensive Care.

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Spinal anaesthesia for day case surgery

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Since lignocaine has lost favour as a spinal anaesthetic agent due to high incidence of Transient Neurological Symptoms (TNS), there is a space in the anaesthetic armamentarium for a similar short acting agent. Prilocaine is one such agent, and this interesting double blinded randomised controlled trial conducted in Switzerland compares the quality and duration of subarachnoid block with 2% hyperbaric prilocaine and 0.5% hyperbaric bupivacaine for day case surgery.

Why this study
The unavailability of a short acting agent has caused anaesthetists to hesitate using spinal anaesthesia for short day case procedures. Lignocaine is no longer recommended for spinal use due to high incidence of TNS. Prilocaine has a similar duration of action as lignocaine but without the high incidence of TNS, making it a good choice for day case spinals.

Study methodology
88 patients between 18-75 years of age and ASA grade II or below, scheduled for elective lower extremity surgery of maximum 45 min duration were included in the study. Double blinded randomised allocation of patients into the Prilocaine group (3mls of 2% hyperbaric prilocaine) or the Bupivacaine group (3mls of 0.5% hyperbaric bupivacaine) was carried out. A 25g spinal needle was used to site the spinal in all the patients at L3-L4 interspace in the sitting position.

Extent of block, vital parameters and mental state were recorded after 2, 5, 10, 15, 20, 25 and 30 mts after injection as well as every 30 mins for 6 hours. Sensory level was tested with cold spray, motor function by the modified Bromage score and pain intensity using the numerical analogue scale (0-10)

Results
The success and onset time of maximum sensory block was comparable in both groups. Bupivacaine lead to a significantly higher sensory block (T6 vs. T8). Regression of spinal occurred significantly earlier and faster in the prilocaine group, with these patients relocated from recovery to the day ward on an average 59mts earlier and discharged home 99mts earlier. There were no significant differences between the groups regarding the incidence of side effects, complications, pain scores in the theatre, recovery, day surgical ward and at home and the use of NSAIDS or opioids.

Summary
Under the study conditions, 2% hyperbaric prilocaine proves to be superior over 0.5% hyperbaric bupivacaine for outpatient interventions due to shorter effect profile with otherwise identical block quality.

Current role of prilocaine
Prilocaine has duration of action similar to lignocaine and a lower incidence of TNS in clinical trials. Hence it is being increasingly considered where short duration of spinal anaesthesia is needed. However, data comparing these anaesthetic agents with respect to their potential to induce major neurologic injury are lacking. Available data demonstrate that intrathecal prilocaine and lidocaine produce similar functional impairment and morphologic damage. Substitution of prilocaine for lidocaine is therefore unlikely to reduce the risk of persistent or permanent neurologic injury. In addition, the present findings of equivalent neurologic injury with prilocaine and lidocaine are inconsistent with the available clinical data that suggest a lower incidence of TNS with prilocaine. This discrepancy may indicate that neurologic injury (e.g., cauda equina syndrome) and TNS are not mediated by the same mechanism. Prilocaine is not licensed for intrathecal use in the US or UK, but is used in other parts of the world.

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