GAT welfare survey

Dealing with the unexpected: The Cumbrian shootings

New AAGBI president reports
The disappearing needle phenomenon has finally been conquered.

Enhanced needle visualisation at steep angles.

The value of ultrasound guidance during nerve block is well established. But seeing the needle clearly when approaching a deep structure from a steep angle can be very challenging. (See “Study Ranks Needle Visibility Under Ultrasound,” Pain Medicine News, March 2010.)

Now a simple software upgrade clearly enhances needle visualisation while maintaining striking image quality of the target and surrounding anatomy – especially at the steep angles needed on deep procedures.

Advantages of SonoSite’s enhanced needle visualisation:
• No setup time
• No need for expensive additional hardware or special needles
• Simple on/off functionality
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Physicians involved in early evaluations call this a significant step forward in visualising the needle. To see what they have to say, go to www.sonosite.com/needle
As usual, I have spent some time considering the front cover of Anaesthesia News this month. You will see that I have opted for studied neutrality with respect to images relating to anaesthesia, or indeed news. I have made some efforts to obtain suitable images for the front cover which actually relate to ‘real’ anaesthesia, as the ‘pseudoanaesthesia’ images we have used in the past have attracted criticism because they are unrealistic and potentially misleading. The trouble with real anaesthesia is that it tends to be a real mess visually(fig 1), and I’m not sure that I want to project that image. There are also difficulties relating to consent and so on if real people, rather than actors, are used, and lets face it, if we were cut out to be cover girls/boys we might not be stuck doing the day job. I might look vaguely presentable in the mugshot here (though I guess that’s a matter of opinion), but that was taken by a pro, following the careful application of a substantial dose of polyfiller and some sort of effort with a hairbrush. If, as usual, in addition to my routine attempts to ignore my appearance, I have showered, ridden a bike to work then stuffed a ‘J-cloth’ on my head, I think my appearance falls far short of my comfort zone for appearing on the front cover.

Whether or not these are the real reasons, I have not received any photos relating to the workplace or anything else in response to my call for images for the front cover. I’d therefore like to consider a change of tack. Let’s use the front cover as an opportunity to bring out our artistic talents. I see that Anesthesia and Analgesia has a whole section of its website devoted to its front cover artwork – possibly this is a little beyond my initial concept but hey - many of us are keen amateur photographers. Send me your work and I’ll print the best* on the cover.

Continuing the ‘blocked airway’ theme this month a trainee describes his experience of a blocked airway scenario in a simulator (page 9). His experience seems to have been pretty positive. Simulation is undoubtedly a very valuable tool, and should help all of us develop new skills and to hone and maintain skills which are not commonly required in practice. I must confess (whilst being an advocate of its use) to feeling a vague sense of unease about simulation however. Its introduction into medicine is proceeding so fast that there may be a risk that it is not always properly thought through – even the teaching of very simple procedural skills requires a number of complex steps, including validation of the methodology [1]. I think these steps are not always rigorously attended to. Simulation is a very powerful tool, which means that it can go badly wrong if used poorly. Its use in assessment is particularly fraught. Those of us using simulation in training should ensure we are trained to do so.

I was a bit shocked to read the comments of one respondent to the GAT welfare survey (page 15); life really is very stressful for trainees these days. I think the new curriculum is an improvement on the previous version, but the assessment schedule is very complex and the amount of box-ticking is verging on the ridiculous. It is concerning that the respondent feels so threatened by ‘paramedical specialties’ – I assume PAs. I recall that relations between residents and nurse anaesthetists were very poor when I worked with both in the USA; perhaps this needs considering here too.

I am pleased to publish the article on page 11 describing the inauguration of new faculties of pain and intensive care in Sri Lanka. Many colleagues working in the UK are originally from Sri Lanka, and many departments (including my own) benefit enormously from the contribution of Sri Lankan trainees, so it is good to be able to acknowledge these links. Nevertheless, this apparently simple transaction has reminded me how tricky the business of translation can be. I asked the authors for a caption for one of the images accompanying this article, and was told that it depicted the authors, Neil Soni and the ‘chicken of light’. Chicken of light? I couldn’t have invented it. Further enquiries (I asked one of our Sri Lankan trainees) revealed that the object depicted is a very traditional, solid brass oil lamp. The beast on the top is a rooster. The lamp symbolises (as far as I have been able to divine) ‘aspirations, academic striving, and prosperity’. The AAGBI concurs with these sentiments, and we wish the new faculties well in the future.

Last but not least, Dr Graham’s report of her department’s response to the Cumbrian shootings earlier this year is humbling – Dr Graham and her colleagues clearly did an excellent job in a quiet sort of way and we can all be proud of their efforts.

Val Bythell


*The AAGBI and the editor reserve the right to decide whether or not to publish images. Images must be submitted in digital format, be free of copyright (or the owner may retain the copyright whilst giving permission to use the image on the front cover) and be at least 300dpi at A4 size. You may also supply a brief descriptive paragraph to accompany your work.
As my predecessor Dr Richard Birks migrates to a well-earned retirement from the NHS, collecting his tax-free lump sum with a wide grin, Council will sit down in October to a changing NHS landscape.

There are a number of headlines in UK healthcare to consider. Public finances are in disarray and the public spending cutbacks announced by the Coalition are having a very significant impact on the NHS, despite the notional protected budget. The recent White Paper [1] sets out plans to get rid of Primary Care Trusts and Strategic Health Authorities to devolve power and responsibility for commissioning services to local consortia of GP practices supervised by a national NHS Commissioning Board. Interestingly, PCTs were only formed in 2002, reformed in 2006 and are now to be abolished. This change to GP commissioning is very significant. Agreeing contracts for surgical services with a number of consortia instead of a PCT will be time consuming and inefficient. Will GPs take up the commissioning challenge? I hope so, or someone else will. Solving regional specialist services, including trauma, may also be problematic.

Savings are repeatedly emphasised [1]: “The NHS will need to achieve unprecedented efficiency gains, with savings reinvested in front-line services, to meet the current financial challenge and the future costs of demographic and technological change.” Also “The NHS will release up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes.” Although budgets might be protected, in reality NHS demand increases constantly at a rate exceeding that of inflation in many areas, resulting in a shrinking pot of cash. For hospitals with high operating costs life will be challenging - “Prices will be calculated on the basis of the most efficient, high quality services rather than average cost.” The drive towards creating Foundation Trusts continues in England with the proposed shift towards social enterprise as the model of the future, plus the growth of freedoms such as the removal of the private practice cap. The new proposed powers for Monitor are significant – “Monitor will become an economic regulator, to promote effective and efficient providers of health and care, to promote competition, regulate prices and safeguard the continuity of services.” Since the expectation is that all acute Trusts will become FTs or be managed by an FT, the emphasis on financial management and efficiency is paramount. It is anticipated that many more aspects of healthcare will be determined locally, perhaps even pay scales that could be led by healthcare employers rather than imposed by the Government. In future, all individual employers will have the right, as Foundation Trusts have now (though this has seldom been exercised) to determine pay for their own staff.

So – change is the message for the next few years. How will this affect us in anaesthesia? For most anaesthetists, we shall see a continuing emphasis on theatre efficiency and day care. Our contracts will come under financial pressure, especially SPA activity. Movement of surgical contracts to alternative providers will be de-stabilising to hospitals.

Although many of the aspects of the NHS mentioned above apply to England, the financial pressure will be applied across all nations. However the devolved nations and Eire can watch the English changes, as they develop, from the sidelines!

Recently the national ACCEA awards were announced in England and Wales with only 317 awards made this year compared with 601 last year. Congratulations to those who were successful in a year when anaesthesia again did worse than expected. According to the ACCEA website this substantial reduction in awards is a result of “reduced affordability in the light of the fact that fewer consultants have left the Scheme (through retirement or for other reasons) than anticipated, reducing the funds for reinvestment as well as wider financial constraints.” Although the public sector is going through a tough time, the scale of this reduction was unexpected and has substantial implications for the profession.

On the 20th of August Andrew Lansley announced a UK-wide review into “bonus payments” given to NHS consultants at both the national and local level [2]. As we know, reform of the local CEA system is also on a lot of employers’ agendas so it is likely that there are significant proposed changes in the pipeline which could affect pay and pensions for consultants.

Other significant NHS changes are happening almost without being noticed. The AAGBI has worked closely with the NPSA since its inception in 2001 on safety issues in anaesthesia. Along with sweeping changes to all of the Arms Length Bodies, it has been decided to move responsibility for safety to the newly constituted NHS Commissioning Board. We are working to try to protect the new developments in Specialty-Specific Incident Reporting that are currently taking root in an exciting way and must not be lost to the NHS.
For many of us, October will see the usual start to the winter pressures in our hospitals with outlying medical patients causing difficulties in surgery. There are regular reports about the difficulties in filling out-of-hours rotas and the disruption to continuity produced by the EWTD. The report by Sir John Temple [3] recommends that the NHS develops further towards a consultant-based service to ensure that service, EWTD, training and safety can all be maintained. In the current financial climate it is difficult to see how far we shall progress on this, but it is logical and appropriate. In many places it is already starting to happen – in Exeter, the consultants on the general on call rota have worked as first on call without a trainee present after midnight for the last two years.

A lot of discussion takes place about the quality of training and experience gained by our trainees. Although there are undoubted problems in the system, I believe our trainees receive excellent training and I really appreciate the enthusiasm with which they go about their work. In Exeter at present we have 10 new trainees starting out in the specialty – a significant workload for the department due to some of the inflexibility inherent in MMC and MTAS, but the trainees themselves are great. I have at last understood what a DOPS is, and how many boxes need to be ticked!

One of my young relatives recently started anaesthesia training in a hospital near you, and I was pleased to hear of her delight at the friendly reception she received in the department and the high quality, enthusiastic training she is receiving. Her excitement in doing her first spinal reminded me of what a fantastic learning experience starting out in anaesthesia is, although there is more to learn these days! We are known as a specialty of committed trainers and it was great to hear about anaesthetists unknown to me personally doing such a great job!

There are a number of disturbing developments in the area of private practice. Bupa has recently joined AXA PPP in demanding that any consultant who applies to be recognised for reimbursement must agree to bill the insurance company direct, charge only their benefit maxima and not bill patients for shortfalls. With few changes to benefit maxima in the past 15 years, this represents a very restrictive agreement that may ultimately restrict patient choice. It also introduces a fundamental change to the direct clinical and financial relationship that underpins private practice. The AAGBI’s Independent Practice Committee is working with the BMA and the Federation of Independent Practitioner Organisations (FiPO) to challenge these changes. There will undoubtedly be more attempts in the future by Private Medical Insurers to control the private practice market, but the AAGBI will work hard to protect the interests of its members and their patients.

At 21 Portland Place we have had a significant number of changes. Firstly to the newly elected Council members, we welcome Abhiram Mallick, Samantha Shinde and Sean Tighe who will join us to help run the largest membership society in anaesthesia in the UK with over 10,000 members. Thanks and goodbye to the long-serving Ranjit Verna who has moved over to College Council, where he joins other ex-AAGBI Council members Chandra Kumar and David Whitaker.

Our General Manager, Jo Silver, has led a review of staff and we welcome Gemma Campbell (Head of Support Services and Information Management), Nicole Seeff (Marketing and Communications Manager), Chris Steer (Publications and Website Officer) and say farewell to Claire Elliott and Iris Millis.

I am delighted to have been elected to be your President for the next two years – a great privilege, which will involve a lot of work trying to achieve the changes that Council direct, together with the 24 members of staff we employ. I look forward to meeting and hearing from members and working on your behalf.

Iain Wilson
President, AAGBI


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I don’t recall her actual name but I shall call her Miriam.

After 3 days in labour, Miriam’s concerned husband realises that all is not well and takes her to the local health centre using a donkey cart borrowed from a neighbour. With every jolt along the pot-holed, dirt track, she cries out with pain. An hour later, they arrive and the trained midwife diagnoses the problem, recognising that Miriam, despite three normal deliveries in the past, has an obstructed labour and tells them that she needs to go to the district hospital where they will deliver the baby by caesarean section. Realising that the hospital is 70km away along poor roads, Miriam’s husband fears that she will not make it, and even if she does, the cost of medical treatment will be beyond his means. Nonetheless, he sets off and the next day they arrive at the hospital. By now Miriam is much worse, barely conscious, she no longer cries out with pain. The receiving midwife calls the obstetrician from home and fears that Miriam’s has ruptured her uterus. The anaesthetic officer arrives with the obstetrician. She finds that Miriam is tachycardic with a thready pulse, hypotensive and breathing rapidly. Recognising her shock, she skillfully inserts an 18g cannula, the only size available, and runs in a litre of normal saline. Miriam is taken to theatre and the anaesthetic officer induces anaesthesia with ketamine and gives a small dose of pancuronium. The obstetrician delivers the stillborn foetus and repairs the ruptured uterus. Fortunately, blood loss is not too great, as there is no blood available for Miriam. The anaesthetist recovers Miriam in theatre until she judges that she is well enough to return to the post operative ward, a difficult decision as she knows there is only one trained nurse looking after over 20 post operative patients.

Miriam survives; she is lucky. She is fortunate to have been able to get to hospital in time, fortunate to have been cared for by skilled and dedicated obstetrician and anaesthetic officer, and fortunate to have been strong enough to survive the lottery of limited peri-operative care.

Those of you who read the Developing Countries Supplement in Anaesthesia in 2008 will recognise similarities between this account and Lamula’s story [1]. Miriam is not Lamula, but both stories are typical of a tale told over and over throughout the developing world. It is a story resulting from poor infrastructure and inadequate resources, where expenditure on healthcare is a fraction of what we are used to in the UK. For every Miriam or Lamula, there are many patients who do not survive, dying either before they reach hospital, or in hospital because of late presentation or inadequate care.

Of course, there is little we can do about the basic problems of poverty and poor infrastructure but what of the patients who come to harm because of inadequate care when they get to hospital? In most developing countries, medically trained anaesthetists are uncommon, often concentrated in the big cities. The usual anaesthetic providers are anaesthetic nurses or non-medically qualified anaesthetic officers. Some have had an adequate training, others have been trained on the job with little in the way of formal or structured training. Even those that have had a good training often become deskilled because they work in isolation without opportunities to revise and update their knowledge and skills. The one thing we in the West can provide is support for education and training.

On visiting a hospital somewhere in Africa, I was invited into theatre to observe a general anaesthetic for a caesarean section. The woman was lying flat on her back with a black rubber mask strapped to her face being pre-oxygenated. Fifteen minutes later when the obstetrician appeared, the anaesthetic nurse gave her a small dose of thiopental followed by pancuronium 3mg, the only relaxant available. The obstetrician immediately commenced his incision and the baby was out before the anaesthetic nurse was able to intubate the mother. I noticed that the mother was weakly moving her limbs and when I
could see that the halothane vaporiser was switched off, I politely pointed this out to the anaesthetist. She replied that they did not use halothane (or any other volatile agent) because the obstetrician did not want the uterus to relax and promote bleeding as blood transfusion was in limited supply! In addition to the lack of anaesthesia there were lots of departures from what we would recognise as best practice of anaesthesia for caesarean section.

I tell this story not to shock, or denigrate the care the professionals were trying to give, but to illustrate how a little knowledge can be dangerous: the anaesthetic nurse and obstetrician were aware of the relaxant effect of volatile anaesthesia on the pregnant uterus and were afraid that this could increase the chance of major haemorrhage, a condition difficult to control and treat when blood transfusion is a scarce resource. However, their concern was exaggerated and they were blissfully unaware of the harm of excessive catecholamines in an aware mother. In addition, although the anaesthetist understood that lateral tilt is beneficial to the mother, as a nurse she was unable to influence the doctor obstetrician who found lateral tilt an inconvenience. After surgery was completed, I was able to sit down with the anaesthetist and reflect on some of these issues and she quickly grasped how awareness could be decreased without compromising the safety of the mother. This anecdote perhaps illustrates how basic education and training has the potential to improve patient care.

The International Relations Committee (IRC) of the AAGBI aims to improve education and training for anaesthesia providers in developing countries. The committee awards regular travel grants to members going overseas for educational purposes and this year we have awarded grants to members travelling to Benin, Togo, Nepal, India, Ukraine, and Peru. The main problem with many of these initiatives is that they tend to be isolated and sporadic. There is a need for more collaborative projects, particularly involving other specialties: surgeons, obstetricians and midwives to name but a few. The IRC is ideally placed to coordinate such collaboration and although these are in the early stage of development, I hope to report on the fruits of these efforts in the not too distant future.

The IRC is an active partner, alongside the WHO and World Federation of Societies of Anaesthesiologists (WFSA), in the Global Oximetry (GO) project, which seeks to introduce robust, affordable pulse oximeters into operating theatres throughout the developing world. But having a pulse oximeter is not the whole solution: it is important to be able to know how to use it, be able to interpret the saturation values and know how to treat the hypoxaemia it detects. Hence, the GO project includes a training programme so that users understand the use of pulse oximeters, together with the causes and appropriate management of hypoxaemia.

Educational resources are in short supply in many developing countries: textbooks are expensive, libraries are non existent or poorly stocked, and internet connections are slow and intermittent. The IRC has negotiated special discounted prices for anaesthetic books, with editors forgoing royalties. This allows effective use of the generous donations by members to the Overseas Anaesthetic Fund (OAF) for the book donation programme. Books are distributed with the help of Teaching-Aids at Low-cost (TALC) to anaesthetic practitioners in developing countries. In the last 12 months, approximately 2500 books, including Safe Anaesthesia and the Oxford Handbook of Anaesthesia, have been distributed to countries, mainly in sub-saharan Africa. Feedback from recipients is very positive and now many anaesthetists in these countries have access to some of the textbooks they require.

For several years, OAF has also supported the training of physician anaesthetists in Uganda. Potential anaesthetists are discouraged from entering the profession in Uganda because postgraduate training is unpaid and the trainees have to fund their own course fees. We are working in collaboration with the University of California San Francisco Global Partners in Anaesthesia and Surgery (GPAS) to support anaesthesia training in Uganda through educational links and support for salary and fees. The programme has recently expanded from two trainees to eleven, with more trainees applying to start anaesthesia training next year. The first AAGBI funded fellow, Dr Arthur Kwizera, obtained his MMed in anaesthesia this year and is already introducing improvements to anaesthetic services in his country.

One of the problems with providing education and training is the potential for offending local sensitivities. It is crucial that, despite good intentions, we are not perceived to drop in for short periods, criticise local practice and institutions, and preach on techniques that are not practical within local resources. Far better to support and encourage local institutions to develop education and training themselves, which can then be locally sustained. Commitment and continued support, either by visits or by modern means of communication, are important aspects to this.

One recent exciting development (the brainchild of Drs Kate Grady and Iain Wilson) is the SAFE anaesthesia course. This is a revision course for overseas anaesthetic practitioners who usually work in relative isolation without regular CPD. It comprises small group interactive stations covering basic practical obstetric anaesthesia. The course is designed to be introduced to a region where local facilitators are taught how to use the course material and can then adopt and roll it out throughout the region. In this way there is local ownership of the teaching material, which can be modified to suit local conditions and preferences. In addition to being backed by the AAGBI, it will have support from the WHO. The plan is to pilot the course in a couple of regions towards the end of this year.

The new coalition government has announced that it will protect its overseas aid programme from the severe cuts being made to other areas of public spending. This is brave, particularly as the decision has many critics. It underlines the belief that such aid is important to the development of many countries and should be maintained despite austerity at home. In its small way, the AAGBI believes it can contribute to improving anaesthetic quality and safety in countries with fewer resources than our own, but it is essential that our efforts are delivered in a way that delivers maximum benefit.

Dr Paul Clyburn
Chair, IRC

References
1. J. Tumwebaze. Lamula’s story Anaesthesia 2007;62S1:4
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Anaesthesia in Developing Countries

Courses will again be held in 2 centres this year:
Royal Society of Medicine: November 5th 2010 (all day meeting)
Kampala: 27th Mar – 1st Apr 2011 (residential course)

The RSM one-day primer course in November will focus on “Bridging the Gap” – the different requirements for anaesthesia in a developing country, including hands-on technical demonstrations and workshops. Register at: www.rsm.ac.uk/anaesthesia

The Uganda 5-day course in March 2011 will complement and amplify this in a clinical/conference setting, with additional teaching on draw-over and ketamine techniques, oxygen concentrators, logistics and supply, obstetric and paediatric challenges, blood safety and training issues. Registration fee (£800/£860) includes airport transfers, accommodation and all meals. (Flights are not included).

For further information and registration for the Uganda course, contact:
Mrs. Pat Millard, Nuffield Department of Anaesthesia, John Radcliffe Hospital, Oxford OX3 9DU. Tel: 01865 221590.
Email: Pat.Millard@nda.ox.ac.uk
Web: www.nda.ox.ac.uk or www.oxfordanaeschool.org.uk

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The case was a 5 year old boy listed for an open appendicectomy. I first met him with his mother in the anaesthetic room where they were waiting for me to administer the ‘sleeping medicine’. Not ideal. Mum was quite anxious, as you would expect. George, her son didn’t say a lot. But his monitoring was on and his blood pressure, heart rate and saturations all looked good. Someone had also kindly cannulated him and so having done our pre-op ‘time-out’ procedure, we were ready to go.

I enquired as to when the Consultant on-call would be arriving to help with the anaesthetic and was told that he would be delayed in a meeting for 20 minutes and could I just get on with it as time was limited. Clearly, I wasn’t keen but did as I was told. Reluctantly, I ran through the plan with Kate and Todd, the ODP’s who were with me for the case. Kate was very experienced and Todd was a student ODP. Kate was allowing Todd to assist with the anaesthetic, a situation I wasn’t best keen on but one which she assured me would be fine. Todd had performed well in all his previous assessments. So there we were with the plan for a RSI with Thiopentone and Suxamethonium, ETT, Atracurium and Morphine.

Pre-oxygenation went fine. George remained still and his Mum continued to be anxious. Asking all manner of questions from how much it would hurt to when she would be able to take George home. I fielded her enquiries as best as I could but sensed a growing uneasiness about her. Was she about to completely lose it? I was so focused on George however and was running through my RSI algorithm in my head so didn’t pay her too much attention.

The 3 minutes were up, saturations were 100% and I gave the thiopentone and suxamethonium, once George’s Mum had left the anaesthetic room. George responded appropriately. Much to my relief his Mum left without any incident, a little tearful but nothing more. I could have sworn she was going to lose it, I was wrong. I passed the laryngoscope and was met with a beautiful grade 1 view. Relief. I passed the uncuffed tube to 17cm, and reached for the circuit tubing which Todd was holding, very tightly. He was a shade more nervous than me. He then turned a shade greener than me, paled, moaned slightly and collapsed to the floor. He was still conscious but being very unhelpful. Saturations still 100%. Kate managed to get a chair for Todd to sit on. I asked him politely to stay put, despite his protestations about how keen to help he was, whilst I connected George to the bag to ventilate him. Saturations 100%. I squeezed the bag and it didn’t move. It was rock hard! Saturations 98%.

At this point, I think it’s fair to say, my ‘autopilot’ took over. The situation was a 5 year old boy, intubated but unable to ventilate. So where to start? Well calling for help, 100% Oxygen and ‘A’ seemed like a good place. I had seen the tube go in but I couldn’t ventilate, so had I seen the tube go in? Saturations 95%. I set about systematically checking the patient, the tube and the ventilator. I tried in vain to squeeze the bag again. Nothing. Saturations 93%. We are told in our training that “If in doubt, take it out”, so I did. Cricoid pressure was maintained, the patient was turned on to the left lateral position and a size 2.5 LMA inserted instead. Saturations 91%, alarms starting to sound on the ventilator. The patient was reconnected to the ventilator and I tried squeezing the bag for a third time. Still nothing. Where was my help I thought, where were the surgeons? But there were more pressing matters to attend to. Saturations 89%.

At this point I was still focussed on the patient’s airway. I hadn’t resolved ‘A’ and so didn’t want to move on down my algorithm. But something about the feel of the bag when I squeezed it didn’t seem right. I asked Kate for an ‘Ambubag’ and connected this to the LMA with 100% oxygen. Saturations 85%. I squeezed and the chest rose beautifully. I squeezed again and I knew I was ventilating. The sense of relief was overwhelming as the saturations rose with each breath. I had made the decision to wake the patient in the left lateral position with cricoid pressure maintained, wait for my help to arrive and proceed once I had figured out the cause for the lack of ventilation. Just as the situation started to stabilise, the on-call Consultant arrived. I explained what had happened with the help of Kate and a rather sheepish looking Todd. The patient was now completely stable and I was able to wake him, remove the LMA and transfer him to recovery without any further
incident. I also suggested we should inform the surgeons and George’s mother as to what had happened.

“Shall we stop there then?”

The scenario had finished. Relief.

Fortunately, this hadn’t been a real case. It was one of the scenarios in the Simulation Centre on a course run at the Royal Devon and Exeter Hospital last year.

George was ‘Sim-Man’, George’s mother and Todd were both Consultant tutors and Kate is really one of the hospital ODP’s.

In my scenario, the equipment had become occluded by a piece of rubber from the capnography connection by Todd during his somewhat theatrical ‘faint’. This had completely blocked the ability to ventilate the patient and hence accounted for the feel of the bag.

The point of this scenario is to expose the candidate to a ‘can’t ventilate’ situation and to teach a systematic and quick approach to managing the situation. 1. Check the patient, 2. check the tube and 3. check the ventilator. It also allows the candidate to appreciate the difference in feel of the bag when the occlusion is due to the airway and when it is due to an actual physical occlusion.

This can make the difference between changing the source of ventilation, a quick and easy thing to do to localise the cause of the obstruction and following a ‘can’t ventilate’ algorithm to the stage of an unnecessary and unsuccessful needle or surgical cricothyroidotomy. This scenario has helped my practice and taught me to think ‘outside the box’ when faced with an airway problem.

The clinical scenarios are made as realistic as possible. In addition to Consultant tutors, theatre staff are able to assist on the courses. The environment of the Exeter Simulation Centre is set up like an operating theatre with bed, ventilator and Sim-Man all connected by way of a one-way mirror and cameras to a control room. It enables the tutors to alter Sim-Man’s physiological parameters in response to the actions of the anaesthetist. It is indeed life-like and is very believable to those of us who have been involved in our training here. I feel the time spent in the Simulation Centre allows us to practice these ‘nightmare’ scenarios in as safe an environment as possible but also allows us to experience the same emotions as I’m sure one would feel if the real thing happened. This aspect of training is difficult to replicate outside the virtual world and one can certainly learn much from one’s behaviour and actions using this tool. I know I did.

Simon Marshall CT2 Anaesthetics
Royal Devon and Exeter Hospital

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**THE STATE OF THE ART MEETING 2010**

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CPD accreditation: 10 points pending
At a ceremony held on the 17th July 2010, the Faculties of Pain and of Critical Care Medicine were formally inaugurated by the lighting of a ceremonial oil lamp (Fig 1).

This was a momentous occasion in the history of the College of Anaesthesiologists of Sri Lanka. The College itself was formed in 1971 with the following objectives:

• To achieve and maintain the highest standards of Anaesthesiology in the country
• To promote and advise on postgraduate education in Anaesthesiology
• To advance the knowledge of and to promote research in Anaesthesiology
• To promote fellowship among those engaged in the practice of, or research in Anaesthesiology

In this inaugural ceremony the newly-created Faculties of Pain and of Critical Care Medicine declared the same objectives for their specialities.

The evolution of these two specialities has been largely under the auspices of the College of Anaesthesiologists of Sri Lanka but with the increasing numbers of members who were interested in specialising in either critical care medicine or pain medicine it was felt that the time had come to establish a Faculty of Critical Care Medicine and a Faculty of Pain Medicine. Accordingly, the constitution of the College was amended in January this year to allow the establishment of the faculties and election to the faculty committees was held soon afterwards. At their first meeting each faculty committee elected a Head of the Faculty and also decided to co-opt representatives to the committee from other disciplines. The committee of the Faculty of Critical Care Medicine has a representative from each of the Colleges of Surgeons, Physicians, Radiologists, Haematologists and Microbiologists. The committee of the Faculty of Pain Medicine has representatives from the College of Obstetricians & Gynaecologists, the Association of Neurologists, Association of Neurosurgeons and the Sri Lanka Chapter of the International Society for the Study of Pain.

The Faculties have been active since their inception and the Faculty of Critical Care Medicine has organised two workshops in conjunction with the Haematologists and the Microbiologists.
The history of the two specialities in Sri Lanka is outlined below.

There is certainly anecdotal evidence of the use of the iron lung to ventilate patients in the General Hospitals in both Colombo and Kandy in the late 1950s. However the establishment of the first intensive care unit in the Sri Lanka seems to have been beset with problems. ATS Paul, a cardio-thoracic surgeon, wrote that his requests for an ICU next to the OT complex was ‘opposed both by surgeons and anaesthetists’[1]. An article published in 1967 [2] set out the case for the need to establish an ICU in General Hospital, Colombo. The reasons given were:

1. High incidence of tetanus and to a lesser extent paralytic polio and infective polineuritis
2. Contemplated establishment of a Cardio-Pulmonary bypass unit
3. Recent inauguration of an accident service and establishment of a central post-operative observation room
4. In keeping with modern trends as prevalent in major hospitals throughout the world.

Persistence resulted in Sri Lanka’s first ICU being set up at the General Hospital, Colombo in 1968 with Dr Thistle Jayawardene, Consultant Anaesthetist of the Cardio Thoracic Unit, in charge. In the mid 1970s in Jaffna both medical and surgical patients were ventilated in the thoracic unit using an East Radcliffe ventilator. It took a further 12 years before a second ICU was opened at the Teaching Hospital, Peradeniya in 1980. Since then there has been an exponential growth in ICUs there are now nearly 75 adult ICUs on the island.

The history of Pain in Sri lanka is longer. The first reference in the local literature was in 1915 when RL Spittell who was the Professor of Medicine wrote on ‘Sciatica and its treatment with special reference to epidural injection’[5].

Chronic pain got a mention in 1940 when PB Fernando who was the Professor of Medicine wrote on ‘Sciatica and its treatment with special reference to epidural injection’[5].

The first pain clinic was established at the General Hospital, Colombo in the 1980s. Another clinic was subsequently opened at the Cancer Hospital, Maharagama.

The inauguration of these two Faculties is a major milestone in the development of both Pain and Critical Care Medicine in Sri Lanka. It is hoped and expected that the Faculties will help to achieve and maintain the highest standards, will promote and advise on postgraduate education, and will both advance knowledge and promote research and engender fellowship among those engaged in the practice of, or research in these specialities both at home and overseas.

Dr Jayantha Jayasuriya,
President of the College of Anaesthesiologists of Sri Lanka
Dr Kumudu Mendis,
Head of the Faculty of Critical Care Medicine
and Dr Rohini Ranwela, Head of the Faculty of Pain Medicine

Fig 1 Jayantha Jayasuriya President, Dr Kumudu Mendis and Dr Rohini Ranwela, Heads of the new faculties and Dr Neil Soni lighting the lamp to dispel darkness and illuminate learning.

References
South West Regional Anaesthesia Course

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SAS Audit and Research Prize

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

An audit project should have been approved by the Trust. A research project should have been approved by the local ethical committee and Trust.

Applicants should submit a summary of their audit or research of no more than 1000 words, 3 figures and 3 tables. It should be presented in the style of the journal Anaesthesia.

The winning entrant will have an opportunity to present their work at a national scientific meeting held by AAGBI. Other entrants may be asked to display a poster at the same meeting (as judged by the Research Committee of the AAGBI).

Please email entries along with full contact details of the author to secretariat@aagbi.org
If you have any additional enquiries, please contact 020 7631 8807.

CLOSING DATE FOR ENTRIES: FRIDAY 14 JANUARY 2011

Anaesthesia for Thoracic Aortic Surgery Symposium

October 21st 2010
Postgraduate Medical Education Centre
University Hospital Birmingham
NHS Foundation Trust

5 CME points approved by RCoA

Topics and faculty include:

Current practice for Neuro and spinal protection Dr. M Wilkes
Review of anaesthetic techniques Dr. H Singh
Surgical techniques and review Prof. R.S. Bonser
Stenting in aortic surgery – case studies Mr. S. Rooney
Pre and perioperative Aortic Imaging Dr. R Steeds
Management in ITU Dr. T Oelofse
Pain relief following aortic surgery Dr. S Desai

Programme

10.00-10.30 Registration and coffee
10.30 – 11.15 Lecture 1 Anaesthetic techniques
11.15 – 12.00 Lecture 2 Aortic Imaging
12.00 – 12.45 Lecture 3 Cardiac Surgery
12.45 – 13.00 Discussion
13.00 – 14.00 Lunch
14.00 – 14.30 Lecture 4 Neuro and spinal protection
14.30 – 15.00 Lecture 5 Cardiac Surgery - Stenting
15.00 – 15.30 Lecture 6 ITU management
15.30 – 16.00 Lecture 7 Pain relief

Contact Dr Debbie Turfrey for details and application forms on 07967 360645 or deborah.turfrey@uhb.nhs.uk
£90.00 (max 30 delegates)

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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
Stress is a loosely applied term but essentially represents an imbalance between what is asked of us and what we perceive we are able to achieve. Our ability to cope with increasing demands decreases as our stress levels increase and situations which were previously manageable, can suddenly become problematic. Recently Dr Nick Denny, Consultant Anaesthetist and former AAGBI council member described how he suddenly ‘realised that I could not carry on and do the list’ - a task he had performed all his consultant career [2].

Yet, stress is part of everyday living and helps us to perform optimally. Certainly the adrenaline surge as you enter your FRCA viva helps to achieve peak performance, often to levels that surprise us. What is of concern however, is excessive, prolonged stress. This can lead to the development of a more serious problem, such as burnout, depression, an anxiety disorder, and drug or alcohol dependence [3].

“Feeling ignored, disempowered or not in control is one of the most negative experiences for a human being and a common experience in hospitals” - Dr Iain Wilson President AAGBI.

On a personnel level, when an individual experiences excessive stress, he or she can suffer from insomnia, altered eating habits, find themselves smoking or drinking too much or avoiding friends and family. Mentally, they may become more indecisive, find it hard to concentrate, have muddled thinking, loss of memory and feelings of inadequacy and low self-esteem.

An excessively stressed doctor may, clearly, not perform to the best of their ability. A case-control study found that the introduction of a stress management course to 22 hospitals created a reduction in the rate of malpractice claims when compared with the control [1].

In 2008 the welfare committee asked a random sample of AAGBI members about stresses and strains they face at work. This demonstrated that 23% of the anaesthetists who responded felt ‘burned out’ (defined as emotional exhaustion, depersonalization, and decreased sense of personnel accomplishment owing to work stress) and 1 in 6 experienced significant problems with depression and sleeping.

Anaesthetists who took part in the survey talked about the difficulty of constantly changing shift patterns, poor management, lack of appreciation and heavy workloads. 25% of the respondents were trainees and the findings within this subgroup lead the GAT committee to undertake its own “Your Welfare” survey looking at stress levels and stressful triggers amongst trainee anaesthetists.

We emailed all of our trainee members twice with an online anonymous questionnaire. We received 860 replies giving a 29% response rate.

Graph 1- Demographics. We had equal numbers of male and female respondents and more senior trainees replying which probably reflects the demographics of the AAGBI membership.

We asked ‘To date, what do you find to be the most stressful part of training.’ Throughout all grades the primary and final exams are the biggest trigger.

Graph 2- Stressful trigger in CT1/2

Most Stressful part of your training to date-CT1/2?
We identified daily habits that may indicate detrimental levels of stress and asked members whether they had suffered from these in the last 3 months on a daily, weekly or monthly basis. These habits included trouble getting out of bed, irritability, eating too much or too little, trouble concentrating, anxiety, sleep disturbance, feeling they had let people down, having little or no interest in previously enjoyable activities, feeling down depressed or useless, having feelings of self doubt and waking in the middle of the night.

The graph below illustrates the number of respondents suffering these symptoms on a daily basis. The number who reported these symptoms on a weekly basis more than doubled for some symptoms.

The comment below illustrates a common theme that was highlighted throughout the study and highlights how the multiple demands put upon us can appear excessive and stressful.

“No single factor on its own is that stressful. However when you are trying to revise for the Final, have a busy and antisocial rota, work with para-medical specialties who consistently undermine your knowledge and confidence, have to prepare journal club presentations repeatedly as no one else is available, whilst also running around trying to get certain quota of DOPS, mini-CEX, CBD and module reports despite being left solo on lists, for which you are chasing these competencies and at the same time buffing paperwork for an ARCP then it gets a little too much.”

The way ahead

Raising awareness and acceptance of our stressful work is one small step towards reducing stress. There are many things we can do to decrease our stress levels and these steps can be relatively small and simple ones. It is important to implement changes early and in this way you could see the following as primary prevention to avoid the ill affects of stress. Here are some suggestions from the GAT committee:

Regular trainee meetings (in the hospital or out). We recommend that trainees meet on a regular basis to improve communication about common problems and to boost morale. With the current shift patterns, it is becoming increasingly hard to meet fellow colleagues during a normal working day. In this way, for example the impact of a poorly designed rota could be highlighted as a common problem and then addressed.

Mentoring or buddy scheme. As we continue on our career paths we acquire a wealth of knowledge, professionalism and clinical experience that can be used to guide and support other trainees in a similar position. The simplest scheme would be to match a novice anaesthetist with a trainee in the same hospital who has obtained their FRCA.

Peer support. Any concerns or worries we have can be alleviated by discovering the problem is a shared one. This form of support is particularly useful for certain groups of trainees. For example having an email group whereby Less Than Full Time trainees can contact each other about issues relating to their training or exam support study groups.

Discussion sessions regarding difficult patients/cases/scenarios, which offer open and constructive discussion of the management of these situations, are to be encouraged. In the right environment they are an invaluable learning tool for those, directly and indirectly involved.

Work on your ‘work life balance’ and set aside some protected time for your personal enjoyment and hobbies. It is easy to unintentionally become consumed with our working lives and to let previously enjoyed hobbies pass us by.
Be realistic. By nature we are all highly competitive and we find it hard to say ‘no’. Throughout the survey trainees talked about the difficulty not with one element of training, but with juggling all the demands made of us. Learn what your limits are, stick to them and learn how to politely decline.

These measures could help to alleviate the pressures of our training. To help us further there are other avenues that may be available. All trusts should offer counseling through their Occupational Health Department. Our survey found that 42/860 had sought help from their Occupational Health department for work related difficulties.

There are courses available in Management and Leadership, (GAT run a Management course), assertiveness training, conflict resolution, time management and life coaching. When we asked in our survey if any trainees had received any formal training in these key areas less than 10% responded ‘yes’. As Dr Firth Cozens points out “Stress is here to stay and the sooner we accept that tackling it is a normal part of management, and an essential part of patient safety, the sooner lives of doctors and patients will improve.” [5].

Finally, in this survey the last question we asked our members was “What should GAT be doing?”. Whilst I am sure we can all relate to the trainee who wrote “Persuade the College that exams are not really necessary!” or to the one who wished “I didn’t have to do night shifts” some ‘evils’ are necessary to ensure patient safety and the maintenance of high anaesthetic standards.

Whilst we do not have the ability to increase our pay or make the FRCA easier (where is that fairy godmother when you need her?) there are many issues and concerns raised that we can approach.

TRAINING TIME

“Get training extended - there just isn’t enough time to do everything and also have a life!”

The implementation of the EWTD and its impact on training time has not gone unnoticed. Concerns regarding the ability to produce competent Consultants within an ever-decreasing time frame have been raised.

The recent Medical Education England report “Review of the Impact of the European Working Time Directive on the Quality of Training” to which GAT provided written evidence addresses exactly that. However, it does not call for an increase in training time or hours. It feels the 15,000 hours of training on offer during the seven year training programme are adequate if ‘every training opportunity is utilised’. It goes on to state that in order to enhance training opportunities, consultants will have to be more directly involved with 24/7 care and work more flexibly [6].

“Shifts means fewer hours (which is good) but greater proportion of on-call, so less support and training plus more anti-social hours. Bad for family life and quality of training. I’m sure you’ll hear this from everyone”

PAPERWORK

“Push for a reduction of the endless paper exercises and meaningless assessments in our training.”

We all groan at an upcoming ARCP (RITA for those SpRs still out there) and the endless paperwork that goes with it. Yet, despite the burden on our assessors and us, the new curriculum requires more form filling.

The need to prove that we are competent begins during training and continues until retirement. As a consultant we will have yearly appraisals and five yearly revalidation. The threat to SPAs also means that we will have to be able to justify our allocated time and again diary keeping will be essential. Be pro-active and stay on top of the paperwork throughout the year as it can be overwhelming if all the paperwork has to be completed the week before your ARCP.

“The multiple layers of assessments, dops, cex and cbds is confusing and distracts from the primary aim of developing safe competent practitioners. Additional paperwork just seems to add pressure to ever decreasing training time.”

PEER SUPPORT

“look into schemes which could be organised locally for trainees to support trainees.”

We believe that the best form of support during our training is right on our doorstep, your fellow colleagues. Often just speaking to your peers can alleviate any concerns or worries

WORKING MUMS

“Clearer guidance on on-call commitment whilst pregnant.”

The GAT committee has a LTFT trainee representative who is available via email to answer any queries susanlwilliams@doctors.net.uk . Our new website will have web pages dedicated to LTFT training and will hopefully address many of the existing uncertainties.

We have also published articles in Anaesthesia News informing our members of many of these issues. In January 2007 an article on LTFT training was published, followed in October 2008 by an article entitled ‘The Pregnant Anaesthetist’ and more recently an article addressing the issues of returning to work after maternity leave in February 2010. These are all available online via www.aagbi.org/publications/anaesthesianews.htm . The AAGBI will also be producing a glossy giving advice and guidance for those working mums within Anaesthesia.

“About to return after maternity leave - and there doesn’t seem to be any guidance for those who have been out of practice for several months - is this right?”

SUPPORT

“Provide an anonymous helpline for advice and support?”

The welfare committee was established in
2005 and advertises in both the main AAGBI publications (Anaesthesia and Anaesthesia News) and at the two main annual meetings (Annual Congress and WSM London). In times of distress or difficulty you can call the BMA Counseling and Doctors for Doctors advisory service on 08459 200 169.

“Recognise that drug addiction is an ILLNESS and an occupational hazard affecting a significant number of anaesthetists. Promote the idea that people should be rehabilitated rather than punished if they are unfortunate enough to find themselves in this position. Raise awareness of the organisations that exist to help addicted doctors.”

The Welfare Committee has co-opted Dr Ruth Mayall onto its committee. She works closely with the “Sick Doctors Trust” which aims to help addicted doctors and provides an invaluable contribution to the workings of the committee. They have a helpline 0370 444 5163 and they offer confidential advice and help.

The GAT committee works very hard at a national level to ensure that your views are taken forward and represented. Your responses to our surveys help us to ensure your voice is heard so please continue to keep us informed. If there are any concerns or issues you wish to make us aware of please get in touch gat@aagbi.org

Dr Susan Williams, GAT

References


2. Dr Nick Denny. On the edge of a black hole. Anaesthesia News June 2010 p20-21


Core Topics 2011

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

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

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

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

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

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Core Topics Date

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For bookings & further information: www.aagbi.org/events/act.htm
Prevention of Acute Kidney Injury and Protection of Renal Function in the Intensive Care Unit 1

Acute Kidney Injury (AKI) is a serious medical condition with significant morbidity and mortality. Various studies indicate that AKI is independently associated with an increase in both morbidity and mortality. The causes of AKI are manifold. Minimising renal injury confers a benefit to patients. Despite advances in techniques and technologies in renal replacement therapy, mortality associated with AKI has remained largely unchanged over the past decade.

AKI refers to a sudden decline in kidney function, causing disturbances in fluid, electrolyte and acid base balance because of a loss in small solute clearance and decreased GFR2

More than 35 definitions of AKI currently exist in the literature. Initiatives have been taken to define AKI. (RIFLE criteria (Risk, Injury, Failure, Loss, End stage) by ADQI (Acute Dialysis Quality Initiative) and AKIN (Acute Kidney Injury Network) criteria by AKIN).

Both the RIFLE and AKIN criteria were developed to facilitate clinical investigation and comparison across study population.

Critical Care Nephrology Working Group of the European Society of Intensive Care Medicine (ESICM) with international collaboration reviewed the literature for studies between 1966 and 2009, using the potential protective agents in adult patients at risk for acute renal failure/kidney injury with the aim of giving recommendations and suggestions. Studies are graded according to the international Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) group system.

Here are the recommendations /suggestions for the prevention of AKI, focusing on the role of potential preventive maneuvers including volume expansion, diuretics, use of inotropes, vasopressors/vasodilators, hormonal interventions, nutrition, and extracorporeal techniques.

1. Volume expansion:
   Controlled fluid resuscitation is recommended in true or suspected volume depletion (Grade 1C).
   The working group recommend avoiding 10% HES 250/0.5 (Grade 1B); high molecular weight preparations of HES and dextran in sepsis.
   Prophylactic volume expansion using isotonic crystalloids is recommended in patients at risk of contrast nephropathy (1B) and use of isotonic sodium bicarbonate (1.4%, 150 mEq/L) for emergency procedures such as emergency coronary procedures (emergency percutaneous coronary intervention) are recommended.
   Volume expansion is suggested to prevent AKI due to Amphotericin B, antivirals and drugs causing crystal nephropathy such as indinavir, acyclovir, and sulfadiazine (2C).

2. Diuretics:
   Loop diuretics are not recommended for prevention or amelioration of AKI (1B)

3. Vasopressors and Inotropes:
   All efforts should be made to maintain a MAP of >60-65 mm Hg (grade 1C) but at the same time target pressure should be individualised where possible.
   In sepsis or SIRS norepinephrine or dopamine is recommended as the first choice vasopressor. However low dose dopamine is not recommended.

4. Vasodilators:
   Should be used cautiously. Vasodilators are recommended when volume status is corrected. Clinical condition of the patient and concomitant interventions are considered before starting the vasodilator therapy. Hypotension is avoided.
   Fenoldopam is recommended in cardiovascular surgery patients at risk of AKI (grade 2B) but not for prophylaxis of contrast nephropathy (grade 1A) whereas theophylline may be used for contrast nephropathy (grade 2C) especially in acute interventions such as in critically ill septic patients.
   Natriuretic peptides are not recommended in critically ill patients (grade 2B) but may be considered during cardiovascular surgery.

5. Hormonal manipulation and activated protein C:
   Routine use of tight glycemic control (1A), thyroxine (2C), erythropoietin (2C), activated protein C (2C) or steroids (2C) are not recommended to prevent AKI.

6. Metabolic interventions:
   Adequate nutritional support through the enteral route is suggested (2C).
   N-acetylcysteine is not recommended as prophylactic agent against contrast induced nephropathy in critically ill patients (2B).
   Routine use of selenium is not recommended (1B)

7. Extracorporeal therapies:
   Periprocedural CVVH is suggested to limit contrast nephropathy after coronary interventions in high risk patients with advanced chronic renal insufficiency (2C).

AKI results from multiple insults. Early diagnosis and prevention reduce the overall ICU morbidity and mortality. Maintenance of renal perfusion by volume expansion, inotropes, vasoconstrictors and or vasodilators and avoidance of nephrotoxins are important strategies to prevent AKI.

References:

Dr. Nageswaran Narayanan
Consultant Anaesthetist, Dublin
Incomplete Adherence to the ASA difficult airway algorithm is unchanged after a high fidelity simulation session


The objectives of this study were to observe how consultant anaesthetists manage a simulated ‘can’t intubate, can’t ventilate’ scenario, and the effect of a one hour debrief on performance. The investigators postulated that following the debrief, participants would adhere more closely to the ASA difficult airway algorithm.

38 anaesthetists were recruited into the study. After a ‘warm up’ scenario with the fully monitored high fidelity simulator, the participant was called to help a ‘junior anaesthetist’ who had anaesthetised and paralysed a patient and was subsequently unable to manage the airway. The scenario was such that the only way to re-establish ventilation was to perform a cricothyroidotomy, as the mannequin’s tongue became oedematous and the vocal cords adducted. The debrief was then carried out, when the ASA guidelines were reviewed and further instruction on the performance of cricothyroidotomy given. Following this, the same scenario was repeated again. Performance in the two scenarios was compared by measuring the time to perform cricothyroidotomy, the time to re-establish ventilation and also the number of major deviations from the ASA algorithm that occurred. Major deviations included more than two attempts at laryngoscopy, bypassing the use of the laryngeal mask and attempting to use the fibreoptic bronchoscope.

It was found that there was no difference in the number of major deviations from the ASA algorithm - in fact, the actual number of deviations increased second time around but did not reach statistical significance! However, during the second session, the time to secure the airway and re-establish ventilation was reduced.

What exactly constitutes a ‘major deviation’ from the published guidelines is debatable, especially as the ASA algorithm does not seem to mention the number of attempts at laryngoscopy (although DAS suggests no more than four). It is also disappointing that exactly the same scenario was repeated twice - I imagine that as soon as the candidates heard the word ‘cricothyroidotomy kit’ they reached for the cricothyroidotomy and beat it twice - I imagine that as soon as the candidates heard the word ‘cricothyroidotomy kit’ they reached for the cricothyroidotomy kit and beat it twice. The investigators postulated that following the debrief, participants would adhere more closely to the ASA difficult airway algorithm.

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What exactly constitutes a ‘major deviation’ from the published guidelines is debatable, especially as the ASA algorithm does not seem to mention the number of attempts at laryngoscopy (although DAS suggests no more than four). It is also disappointing that exactly the same scenario was repeated twice - I imagine that as soon as the candidates realised, they reached for the cricothyroidotomy kit and beat it hastily back to the relative safety of the coffee room.

In spite of these drawbacks, the article did raise three questions in my mind:

1. Should senior anaesthetists adhere rigidly to what, after all, are simply guidelines? Is it not to be expected that they will draw on their own previous experience and choose to use equipment and techniques with which they are most familiar in an intensely stressful situation such as this?

2. Alternatively, are these same anaesthetists not the very ones who should rigidly adhere to the guidelines, as they may be more likely to have an overinflated sense of their own abilities and put patients at risk as a result?

3. If the answer to Question 2 is yes......then can we be taught?

Dr F McHardy, Consultant Anaesthetist, Glasgow

Early postoperative subcutaneous tissue oxygen predicts surgical site infection

Raghavendra Govinda, Yusuke Kasuya, Endrit Bala, Ramatia Mahboobi, Jagan Devarajan, Daniel I. Sessler and Ozan Akça

Anesthesia and Analgesia. ANE.0b013e3181e80a94; published ahead of print July 2, 2010, doi:10.1213/ANE.0b013e3181e80a94

Infections at the site of surgery are a potentially devastating complication of surgery due to physical and financial costs of treating them (1,2). Although signs and symptoms may not appear for up to a week post surgery, the infection itself becomes established during a short period of perhaps only a few hours (3, 4). As neutrophils utilise the oxidative burst to defend against infection, oxygen tension levels in tissue may be useful in determining likelihood of surgical site infection. Do interventions to improve tissue oxygenation therefore reduce the morbidity and mortality associated with SSIs? Near red infraspecterotscopy (NIRS) can be used to measure this non-invasively.

This study (carried out by the outcomes research group, previously responsible for influential research in this field) tested whether tissue oxygen measurements made post operatively correlated with the development of SSIs. 116 patients undergoing colorectal surgery, laparoscopic or open, were recruited. They were 18-80 yrs old and ASA 1-3. Exclusion criteria were applied and treatment guidelines followed protocols of the two participating institutions. Antibiotics were administered, core temperature was maintained at 36°C, hair was removed from the site and chlorhexidine/alcohol prep was used. Post-op patients were given supplemental oxygen to maintain an SpO2 of >95% and the tissue measurements were made 15mins after weaning from supplemental oxygen.

Two surveillance systems were employed to evaluate SSI risk:

SENIC – Study on the Efficacy of Nosocomial Infection Control
NINSS – National Nosocomial Infection Surveillance System

Thus the operative time, blood loss, fluid management, physiological variables, urine output and transfusion details were recorded. Tissue oxygenation was measured 75 minutes post surgery and on the 1st postoperative day. The probe measured to a depth of 5-8mm of tissue at 3 sites - the wound site, the thenar eminence and the forearm. An independent investigator who was unaware of the STO2 measurements reviewed the wounds daily. SSI was diagnosed using definitions from the Centers for Disease Control and Prevention.

Of 116 recruited patients 20% developed SSI, 14% if diverticulitis cases were excluded. All of these patients had superficial wound infections, 3 developed deep incisional infection and 4 peritoneal infections. The risk scores and physical variables were all similar across the cohort, as were the surgical and anaesthetic variables. Those who developed SSIs did however have a larger BMI (p=0.106). 35-38% of patients could not be weaned from supplemental oxygen after 1hr therefore some of the tissue measurements were taken with supplemental oxygen still in place. At 75mins the STO2 at the surgical incision did not differ significantly in those who developed SSI’s and those who did not yet there was a statistical difference at the arm measurement site, with lower STO2 in those who developed SSIs (p=0.033). The thenar eminence measurements were not statistically significant. Pain scores were higher in those who developed SSI and this was statistically significant (p=0.048) Those that developed SSI’s also had a lower SpO2 on the 1st postoperative day (P=0.001). This was considered to be the only statistically independent factor contributing to SSI.

The results show that patients who develop SSI have lower STO2 at 75mins, measured at the upper arm at only 75mins post operatively. A simple and non invasive measurement of tissue oxygenation may be useful in peri-operative care, in identifying those patients at risk. Early detection in patients at high risk might allow early intervention to maximise tissue oxygenation and possibly reduce infection rate. However further work is required to demonstrate whether such intervention would result in a clinical benefit.

References


Catherine Budge ST anaesthesia, Northern Deanery
Study Days

The Learning in Pain Series Study Days continue to achieve good attendances. Upcoming study days include ‘The Problems of Long-term Opioid Use’ due to be repeated in November and ‘Back Pain’ in December. Further details of these can be found on our web page.

www.britishpainsociety.org/meet_bps_study_days.htm

Membership

The number of people joining the British Pain Society continues to increase. The membership currently stands at 1482 and is represented by 721 anaesthetists, 272 nurses, 100 psychologists and 81 physiotherapists with other disciplines accounting for 308 members. Other disciplines include occupational therapists, rheumatologists, neurologists, pharmacists, general practitioners and basic scientists, thus demonstrating a truly multidisciplinary group as required for the management of pain.

Special Interest Groups

The British Pain Society has a number of special interest groups which reflects the diversity of our members’ interests. The SIGs often lead on publications, specialist advice and study days relating to their areas of interest. We have recently approved a new special interest group (Primary Care) which brings our total number up to ten groups.

Publications

The British Pain Society aims to produce up to date and relevant guidance on pain and related matters. Our publications are based upon best available evidence and expert opinion and can be downloaded from our web site free of charge. We have published two publications for health care professionals this year:

- Opioids for persistent pain: Good practice (2010)
- Cancer Pain Management (2010)

And a further four publications for patients:

- Managing cancer pain - Information for patients (2010)
- Managing your pain effectively using “Over the Counter” (OTC) Medicines (2010)
- Understanding and managing pain (2010)
- Opioids for persistent pain: information for patients (2010)

All of our publications can be found on our web site www.britishpainsociety.org/pub_home.htm

We like to think of ourselves as an active society with lots to offer our membership and this is a flavour of the work that has been ongoing so far this year.
Report from the front line: Cumbria 2010

“What are you doing?” grunted my husband as I tossed yet another piece of crumpled paper onto the pile accumulating in the vicinity of the waste paper basket.

“I’ve been asked to write an article for Anaesthesia News” I replied “and it’s not going well.”

“What about?”

“Our experience on the day of the shootings.”

Silence, and a slightly quizzical look.

“What is there to say? You just did your jobs didn’t you?”

“Exactly. That’s my problem.”

At this point, I would advise anyone expecting tales of high drama to turn the page to avoid further disappointment. I have no stories of lives being saved using pieces of equipment hurriedly fashioned from a string of paperclips and an empty toilet roll holder. Nobody even threw the theatre doors open dramatically and pushed in a patient whilst shouting. ER style “4 units of packed cells, stat!” In fact I don’t recall anyone shouting anything at all. What follows is merely a story of ordinary anaesthetists doing ordinary things, albeit in somewhat extraordinary circumstances.

Wednesday 2nd June started like any other day. In fact it started particularly well for me, as it was half term, I was off work and the sun was shining. When the phone rang and I heard our departmental secretary’s voice I wasn’t unduly worried as she often calls me when I’m off to keep me updated with “the crack.” (That’s gossip to the non-Cumbrian!) But there was a touch of anxiety in her voice as she told me that there’d been a shooting. Nobody was exactly sure what was happening, but I might be needed. I still wasn’t that worried. This is West Cumbria. Shootings are rare, and if they do occur, the likely explanation is that someone has had a mishap whilst out potting rabbits. Besides which, we’ve had more than our fair share of pain recently, with severe flooding affecting the area in November and the Keswick School Bus crash in May. It really didn’t enter my mind that something else serious could be unfolding. But it was. A second phone call came 10 minutes later and before I knew it I was abandoning my slightly bewildered children with a colleague’s wife and driving into work. I locked my car doors whilst driving, though with hindsight, I have no idea what good I thought that would do!

By the time I arrived a lot had already happened. Elective lists had been stopped or were drawing to a close and the on call team had decanted to the Emergency Department. I took on the role of departmental co-ordinator, first visiting ITU and all the theatres to determine what resources were immediately available, in terms of staff and space. All available staff were allocated roles – some to the emergency department, some to ITU, and equally importantly, staff clearly identified to respond to the ongoing unrelated work of the hospital. The two dischargeable patients on ITU were “packaged” in preparation for a speedy discharge and additional bed spaces prepared. Theatres were rapidly cleaned and set up in preparation to receive injured people either requiring surgery or stabilisation prior to transfer. People worked quickly, quietly and efficiently at their tasks. Over the course of the next few hours, members of the anaesthetic department were directly involved with four seriously injured patients. Two required intubation and stabilisation prior to transfer to other hospitals, another was admitted to our own ITU and the fourth spent a substantial time in theatre but was well enough to return to the general surgical ward post operatively. In addition we provided support to the “walking wounded” assessment area as well, of course, as caring for our existing ITU patients, attending other emergencies and covering labour ward. So not that much different from a normal day really!

The first thing that I am immensely proud of is the stupendous response from our department. There aren’t a lot of us – 9 consultants and 9 Specialty Doctors – but virtually everyone appeared or phoned in. The only people who didn’t were those who were actually out of the county. Staff came in off annual leave, post on call and days off. I even had a call from a recently retired colleague from our neighbouring hospital offering to help. The response from the ITU and theatre nursing staff was similar. In fact we had too many people so we were able to construct a “reserve list” of people who would be available to come in later and the next day if needed. That proved to have been a wise move. The incident itself did not keep us busy into the small hours, but two trips to CT, a laparotomy on an ITU patient and a crash call to labour ward did, and stretched our already tired team. By this time we were back to our normal on
call team of one Specialty Doctor and one Consultant and they were very grateful for the support of colleagues who came in to help.

Although the message to “stand down” came from the Emergency Department at around 15.30, our last transfer team wasn’t back in the hospital until around 4 hours after that. We were kept busy with other work that had been displaced by the incident and our colleagues in Carlisle and Newcastle who received those patients for many hours. We learned first hand that a major incident doesn’t stop “normal” emergencies happening and that the effects spread beyond the initial receiving hospital and far beyond the “stand down”. The staff who dealt with the other problems were just as valuable to the team as those who cared for with the gunman’s victims.

The other single biggest asset was the flexibility of our staff. The West Cumberland Hospital is one of the most geographically isolated DGHs in England. Our nearest hospital is an hour away by road, and our tertiary referral centres are well over 2 hours away. We are used to dealing with whatever comes through the door, at least in the initial phase and we’re equally used to long distance transfers. As a small, isolated department we must be self-sufficient and mutually supportive. We all have our particular strengths and interests of course, but in essence we are generalists who work well as a team. These qualities have been working with those patients for many hours. We learned first hand that a major incident doesn’t stop “normal” emergencies happening and that the effects spread beyond the initial receiving hospital and far beyond the “stand down”. The staff who dealt with the other problems were just as valuable to the team as those who cared for with the gunman’s victims.

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Our nursing staff are much the same. One of the defining moments of the day for me was speaking to an anaesthetic nurse as he cleared a theatre at the end of an elective case.

“When you’ve done that” I said, “I want you to prepare this theatre for....”

I paused for a moment and thought. For what? I had no idea!

“...for anything.” I continued.

“OK” he replied, without batting an eyelid, and got on with doing exactly that.

Likewise, we commandeered two endoscopy rooms adjacent to ITU, as potential additional ITU capacity and within a very short period of time these rooms were ready. No arguments, no fuss. On reflection, this was partly a result of our Pandemic Flu Planning. We spent a lot of time and effort on that, and it’s been tempting at times to think that that was all wasted. But it wasn’t! When we realised that we may have to rapidly expand our Critical Care capacity there was no new thinking required. We had a plan, and we followed it. So don’t let the dust gather too deeply on your Flu Plans – you never know when they may be needed!

We had problems of course. The biggest source of difficulty was communication. The initial call out apparently didn’t follow the correct procedure. That said, everyone we needed was there! Information from outside the hospital was difficult to come by and communication between the Emergency Department and theatres/ITU could probably have been better. But in all honesty, whilst it may have raised my circulating catecholamines, I don’t think this compromised patient care to any significant degree. We were actually preparing for more injured people than we ultimately received, as tragically most of the victims did not survive to reach hospital.

Communication difficulties with the outside world did undoubtedly add to staff anxiety. Just about everyone had concerns about their own loved ones. Lack of opportunity to call friends and family was exacerbated by intermittent failure of the mobile phone networks. One of the unsung heroes of the day was our departmental secretary, who did sterling work tracking down our missing relatives whilst we worked. The relief that some staff members experienced once spouses and children had been contacted was almost tangible and definitely contributed significantly to their ability to work effectively.

The emotional impact on staff cannot be overstated. It’s a cliché, and one that has been used extensively in the press coverage of this incident, but West Cumbria is a close knit community, and even those of us who are only Cumbrian by adoption rather than birth have been deeply affected. In contrast with other incidents I’ve been involved with elsewhere, I found myself at least as worried about who I might be called upon to treat as what. When a major incident occurs in a large city, the probability of being faced with a victim that you actually know is extremely small, but here it is different. Fortunately it didn’t happen to me, though many staff have connections to those who were killed and injured. In addition, suddenly finding ourselves in the glare of the national press was not pleasant. It will be a long time before everything is really “normal” again here.

So, two months on, how do I feel? I have very mixed emotions. I’m sad. Sad, that this wonderful place that I am lucky enough to call home has been rocked by such tragedy. Like many, I still can’t quite believe it in fact.

I’m also immensely grateful. Grateful that nobody close to me was harmed and grateful to all the people, within our own hospitals, in other Trusts and other agencies who have supported us.

And I’m proud. Proud that we coped. Proud of my colleagues who rolled up their sleeves and just got on with the job. And proud to be part of a department, Trust and community that have conducted themselves with dignity through a period of great stress.

But I will close with a question. I strongly believe that our department handled the situation as well as it did because we are so flexible. We will admit to being jacks of all trades and masters of none, but we believe it is what hospitals like ours need. Super specialism undoubtedly has significant advantages in large hospitals in major conurbations. But living and working here is different and we need different skills. Will the anaesthetists of the future have those skills? I’m not sure. I believe our colleagues in paediatrics are looking at developing specific training for remote and rural care. Do we need the same? Is it time for a new sub specialty? Maybe we could call it “generalism”?

Dr F Graham, Clinical Director
Anaesthetic Department
West Cumberland Hospital
Should routine pre-operative testing be abandoned?

A.A. Klein and J.E. Arrowsmith

Klein and Arrowsmith's editorial in this month's Anaesthesia provides a reasoned and thought provoking argument against the culture of routine pre-operative testing.

They present a number of arguments including the problems that may arise when performing multiple screening tests, the risk of replacing good clinical history taking and examination with unnecessary tests, the problem of what to do about an unexpected abnormal result and the poor predictive value of tests (such as haemoglobin concentration, ECG and chest radiographs) when screening for disease.

They also discuss evidence from large studies suggesting that routine pre-operative testing did not reduce peri-operative adverse events and moreover, that history taking and clinical examination are superior in this respect. Finally they examine the economic implications of pre-operative testing in the day-case setting and perhaps before all surgery is thought routine pre-operative testing in the face of the increasing drive to perform surgery in the day-case setting.

Their closing statement suggesting we abandon routine pre-operative testing in the day-case setting and perhaps before all surgery is thought provoking, well argued and a call to avoid replacing good medicine with protocol-driven tests. We should all give careful consideration to this editorial.

Minimum local analgesic concentration of ropivacaine for intra-operative caudal analgesia in pre-school and school age children


This study adds to previous work looking at the minimum local anaesthetic concentrations (MLAC) required to produce effective caudal blockade. The authors used a Dixon's up-and-down method in school-age and pre-school age children, undergoing hypospadius repair under general anaesthesia, to determine the MLAC for ropivacaine. They found a MLAC of 0.107% (95% CI 0.089-0.122%) in pre-school age children and 0.143% (95% CI 0.132-0.157%) in school-age children. This represents a 34% higher requirement in the school-age children.

They discuss their results in relation to previous work showing an increase in local anaesthetic dose requirement with increasing age and also the increased requirement in female patients compared to male patients. They discuss the weakness of comparing these types of studies that have been carried out under general anaesthesia and the effect that anaesthesia and pre-medication will have on the results. These weaknesses aside, this study adds useful information to our knowledge regarding the pharmacodynamic properties of caudally administered local anaesthetic.

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 wellbeing@aagbi.org and you will be put in contact with an appropriate advisor.

*The doctor advisor scheme is not a 24 hour service
Evidence and guidelines symposium on Interventional Pain Procedures and 10th Hands-on Cadaver Workshop 3-5 December 2010

VENUE: University Hospital of South Manchester
DATE: Friday 5th November 2010
TIME: 10am – 4pm
COST: £50.00 including lunch and refreshments

This will be a hands-on practical day to let you understand the principles of basic, safe obstetric anaesthesia – it will include:

- Lectures
- Simulators
- Small group discussions/problem based learning

Additional details and application:
Dr Fiona Dodd
Department Anaesthesia
University Hospital South Manchester
Wythenshawe, Manchester M23 9LT
Email: Fiona.Dodd@UHSM.nhs.uk

Feedback from last course:
'Excellent course' 'Good practical sessions' 'Well structured course' 'Small group practicals surprisingly unintimidating' 'Best course I have been on!'

Evidence and guidelines symposium fee:
£250 including beverages and lunch.

Hands-on cadaver workshop and symposium fee:
£1350 including beverages and lunch.

Cheques payable to The Interventional Pain Institute

Trade exhibition of great interest to pain interventionists.

Hands-on workshop is limited to 49 attendees on a first-come/first-served basis.

Apply to:
Dr M H Ather, Consultant in Pain Management,
Queens Hospital, Rom Valley Way, Romford, Essex, RM7 0AG.
Tel & Fax: 01277 228 587
E-mail: muhammadather1@aol.com

Topics to be covered in cadaver workstations include:
- Stellate ganglion RF, Trigeminal P/RF, Sphenopalatine P/RF, Cervical facet injections & RF, Lumbar DRG blocks & P/RF, Splanchnic RF, Lumbar sympathetic RF, Sacro-Iliac injections & RF, Thoracic facet injections & RF, Thoracic sympathetic RF, Racz Catheter, Discography, Disc Biacuplasty, Disc Decompression, Vertebro & Kyphoplasty.

(Additional procedures may also be covered)

Evidence and guidelines symposium
3 DECEMBER 2010
Bloomsbury Hotel • 16-22 Great Russell Street
London WC1B 3NN

Hands-on Cadaver Workshop
4 & 5 DECEMBER 2010
Rockefeller Building • University College
London WC1E 6BT

Faculty of experienced interventionists from Europe, UK and USA

6-7 Cadaver workstations with maximum of 7 attendees per workstation on both days

Suitable preparation for FIPP diploma exam

Evidence and guidelines symposium fee:
£250 including beverages & lunch.

The hands-on cadaver workshop and symposium fee:
£1350 including beverages & lunch.

Cheques payable to The Interventional Pain Institute Trade Exhibition of great interest to Pain Interventionists.

The hands-on workshop is limited to 49 attendees on a first-come/first-served basis.

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Dr M H Ather, Consultant in Pain Management,
Queens Hospital, Rom Valley Way, Romford, Essex, RM7 0AG.
Tel & Fax: 01277 228 587
E-mail: muhammadather1@aol.com

Fee £300 - includes lunches, refreshments and course dinner. Early application recommended.
Dear Editor

I was interested to read Dr Isaacs’ letter concerning the incident with the defective angle piece connector (Anaesthesia News July 2010). As a trainee I have been taught that the final step of the anaesthetic machine check is carried out during preoxygenation of the patient. This routine process allows conclusive detection of any problems with oxygen delivery to each patient. As it is carried out for every patient, it enables us to assess the integrity of the single use, disposable items of the breathing circuit, which would otherwise pass unnoticed. Seeing the bag move freely with preoxygenation of each individual patient would ensure a patent, leak-free breathing circuit in each case. If this had been performed with the patient highlighted above, it may have allowed discovery of the faulty angle piece connector prior to the patient being anaesthetised.

As the AAGBI is revising the checklist for anaesthetic equipment¹, we would suggest that it be considered that a process is added in which the disposable elements of the circuit are checked for each case as this may prevent further such difficulties with deficient components.

Samanthi De Silva
CT1 Anaesthetics, Kent Surrey Sussex Deanery
Mark G Way, Consultant Anaesthetist,
Royal Surrey County Hospital NHS Foundation Trust


Dear Editor

I was most amused to read the “Anaesthetic Anthem” from Drs Humford and Goodwin in the July edition of Anaesthesia News (1). I thought I would share my firm opinion that many singer/songwriters were in fact former anaesthetists reflecting on their previous careers:

Clearly Bono was lamenting his nights on the delivery suite when he wrote the opening lines to the legendary Joshua Tree album:
I want to run, I want to hide
I want to tear down the walls that hold me inside (2)

Roger Waters, losing faith in medicine altogether during a multiple tendon and digital nerve repair, thinking he was doing Time, will have written:
Ticking away, the moments that make up a dull day (3)

Finally Al Simon and his ODP Betty were clearly decades ahead of the WHO checklist when they decided to do their own introductions (before he changed his name to Paul):
I can call you Betty,
And Betty when you call me,
You can call me Al. (4)

Sunjay Bhadresha, Consultant Anaesthetist
Northampton General Hospital


Dear Editor

I would like to thank Dr Hilton for an excellent summary of obstetric anaesthesia courses [1]. I find myself in a very similar position; a final year SpR with an interest in obstetric anaesthesia but a slightly less generous study budget of £400. I too wanted to make good use of my time and money but found it difficult to find a central point of information of courses available on a relevant topic.

I think the author is correct to draw attention to non-anaesthetic courses as these go beyond the usual anaesthetic topics. I have found it very enlightening to gain some insight into the thought processes and approaches other members of the obstetric team employ. In particular I would like to highlight the following courses.

NLS-Newborn Life Support
Aimed at paediatricians, midwives and anaesthetists involved in the care of neonates. We may all think we are master of the airway and would have no difficulty in dealing with an apnoeic newborn but the ventilatory and resuscitative strategy taught on this course was unlike any other I had encountered. I will feel slightly more comfortable on the labour ward. See www.resus.org.uk for details.

Maternal Medicine
Similar to the Medical Complications Pregnancy course described by the author this course was run by and held at the Royal College of Obstetrics and Gynaecology (RCOG) in May of this year. This involved talks on a variety of medical conditions and workshops based around clinical cases. The course was held over 2 days and was a slightly cheaper alternative to the 3 day Symposium course. As a further note I have found the RCOG website a useful resource for courses, books and clinical guidelines.

Royal Society of Medicine
The RSM holds meetings on a variety of topics via its different sections. In December there will be a joint meeting of the Anaesthesia and Obstetrics & Gynaecology sections. See www.rsm.ac.uk/academ/ogb03.php for details.

In addition we should remember the education programme offered by the AAGBI. An update day in obstetric anaesthesia was held in February of this year and there is an obstetric session at this year's Annual Congress in Harrogate (www.aagbi.org/events/congress.htm).

Yours sincerely,

Dr Claire Williams, SpR5 Anaesthesia, Norfolk & Norwich University Hospital

Just over six months ago, the Emergency Laparotomy Network was launched. It is run by a steering group consisting of Dave Murray (Middlesbrough), Carol Peden (Bath), Adam Pichel and Simon Varley (Manchester) and Dave Saunders (Newcastle). This article aims to provide an update of our activities so far, and hopefully to tempt you to join the Network. At the time of writing, there are almost 100 members signed up from hospitals around the UK. It is evident from the speed with which people signed up that this is a real issue in which people are keen to get involved. I would like to thank the AAGBI for providing us with the space to promote the network within Anaesthesia News and at their Annual Congress. There is always a flurry of new members after such publicity.

The Network’s broad aims are to bring together clinicians from relevant specialties and help achieve a consensus of opinion on best practice in order to improve outcome. Whilst we ultimately hope to develop guidelines on best practice that can be disseminated via the network, this will take time. We need a starting point: a multicentre audit. This will provide a baseline from which to measure subsequent changes to practice. It may also highlight Trusts where best practice has been implemented such that it results in improved outcomes.

The development of this audit that has been our prime concern since the Network’s launch. Network members have been active in developing the audit dataset. Around 50 people attended an open meeting at the Age Anaesthesia annual meeting in Leicester in May, where the dataset was discussed. Many of you have provided suggestions about which data to collect. There is a huge amount of data that could be collected and it was necessary to draw the line somewhere. There is a balance to be struck so that we collect enough data to provide meaningful results, without being so user-intensive that it puts people off participating.

We have gone for the “less is more” approach. We propose to start collecting limited data on a wide range of operations, and refine this as necessary. We feel it is important to include as many Trusts as possible. A very detailed dataset is likely to need considerably more enthusiasm in order to obtain complete data. At present the real need is to simply and define the size and extent of the problem.

The dataset we have agreed to collect is summarised in Box 1. The majority of the data can be completed in theatre, with limited follow-up at a later date to capture discharge/mortality. This should facilitate a higher completion rate. This is intended to be a minimum dataset, in order to broadly establish a baseline amongst as many Trusts as possible. It may well need to be supplemented with additional data in order to address local issues. However if everyone can include the minimum dataset, then it will help greatly by ensuring consistent data collection across sites.

A data collection form is available to download from the Network website. The audit will include anyone having an emergency laparotomy over the age of 18 years. The duration of data collection will depend on how quickly we accumulate cases, which will depend on the number of Trusts that sign up. Our plans are to analyse results after 3 months, and see where things stand. A further period of data collection may be required. It should also be possible to go back and gather 1 year outcome figures which will provide useful information on long term outcome.

Whist it might be possible to obtain outcome data from large databases such as HES (Hospital Episode Statistics www.hesonline.nhs.uk), there are problems with this approach. Data base studies of patient outcomes are rendered very difficult by the multiplicity of operations, under different codes, that can be performed under the umbrella term of “emergency laparotomy”. This approach would not provide much of the “story” behind the cases such as when patients were admitted, when they were booked for theatre, which staff were present in theatre, and post-operative critical care requirements. Obtaining this sort of data will be crucial in providing insight into who has the worst outcome, flag up areas where our attention might be better directed, and the financial cost of caring for these patients. Knowing the admitting speciality will tell us where we need to direct attention in order to identify these patients earlier. Knowing the surgical sub-speciality of the operating surgeon is important. There may be times when patients may receive a Hartmann’s procedure rather than a definitive anastomosis in an emergency situation purely because the operating surgeon is not a colorectal specialist. This then necessitates additional surgery that might have been avoided had different surgeons been available.

One of the areas that have deliberately
been left out for now is collecting data on peri-operative management. Our natural instinct as anaesthetists is to want to know how many patients received an epidural, or received invasive monitoring. However, exactly what do you learn by knowing that for instance 50% received an epidural. Was it the correct 50%? If patients with invasive monitoring were more likely to die, one might assume that they were sicker. However this then requires some ability to measure “sickness”. Drawing meaningful conclusions from this sort of information is very difficult without access to the decision making behind the case management. For this reason, we have omitted it for now.

Subsequent work is likely to require collection of pre-operative Early Warning Scores (eg on admission and highest in the 24hrs prior to surgery) and POSSUM data. This will allow some analysis of acute pre-operative morbidity and standardisation of mortality rates. It will require a significant increase in time taken for data collection. If individual units do wish to collect this now, we would be interested in supporting this, and using your experiences for subsequent audits.

By the time you read this, various Trusts should have started collecting data. (We started on 13th September). However it is not too late to sign up to data collection. In return for your data, the Network will be able to provide denominator data from a multicentre audit that will allow you to compare your own outcome to others. The only caveat to add when making direct comparisons is that the length of stay and mortality data is unadjusted for risk.

If you wish to join the Network and get involved in the audit

• Visit us at http://www.networks.nhs.uk/laparotomy and sign up to the Emergency Laparotomy Network
• Download the data collection forms and definitions
• Start collecting data!

Dr Dave Murray, Consultant Anaesthetist,
James Cook University Hospital, Middlesbrough.
dave.murray@stees.nhs.uk

Mr Clive Bray retired in August from his post as Director of Device Technology and Safety at the MHRA, and he was presented with a carriage clock by Barema and small gifts from the AAGBI at 21, Portland Place on 20th July 2010.

Clive has been a stalwart of the Safety Committee and also in the field of Standards work. The AAGBI recognises Clive’s contribution to patient safety and wishes him a long and happy retirement.

Copy to follow
THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

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

Closing date: 14th January 2011
The World Federation of Societies of Anaesthesiologists (WFSA) was founded in 1955 in The Netherlands. When it was initiated, there were 28 founding Member National Societies and today this has extended to over 120. There have been a series of World Congresses of Anaesthesiologists (WCA) held in the name of WFSA since then and these are listed in Table 1. In recent years, other groups have held ‘alternative’ World Congresses, often focusing on specific sub-specialties, but there is only one WFSA sponsored WCA. This happens every four years in a different area of the world. Each WCA is organized by a national member society which imparts its own local flavour to the proceedings but there are a specific set of targets that need to be achieved by each Congress. Many people have discussed what defines a ‘good Congress’. Such debate is outside the scope of this article and there can be no doubt that the perception of a Congress depends very much on one’s own circumstances.

There are four main components of a WCA; firstly the delegates who spend their money to attend; secondly the trade exhibitors who invest large sums of money to support the meeting; thirdly the WFSA which has a series of constitutional obligations to meet and fourthly the local Conference Organizing Committee (COC). All of this activity is facilitated by the Professional Congress Organizer (PCO) who in this case is ChoiceLive from the UK (they also ran the Cape Town Congress of 2008).

I believe there are many different types of delegates but the majority attends the WCA to learn new aspects of their professional activity; this may be in terms of activities that take place in their own geographical region which are often highlighted by presentations from the WFSA Regional Sections. Others will be looking for new initiatives which may appear in programmes facilitated by specialist groups, like obstetrics or paediatrics, while others will be searching for answers relating to their professional development and organizational requirements. Many young (and old!) delegates will be presenting their own research or a distillation of their experience either at oral sessions but more commonly at poster sessions. Others will be looking to attend the plethora of workshops which are presented at the WCA.

One of the most important aspects of any WCA is the ability of delegates to meet others from different backgrounds and environments. The exchange of ideas and experiences that takes place within scientific sessions, but also over breakfasts, lunches and evening social gatherings, often leads to lasting friendships and facilitation of professional improvements in less affluent areas of the world.

<table>
<thead>
<tr>
<th>WCA</th>
<th>YEAR</th>
<th>CITY</th>
<th>HOST SOCIETY</th>
<th>REGION</th>
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<tr>
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<td>1955</td>
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<td>2nd</td>
<td>1960</td>
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<td>1964</td>
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<td>4th</td>
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<td>5th</td>
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<td>6th</td>
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<td>2004</td>
<td>Paris</td>
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<td>2008</td>
<td>Cape Town</td>
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<td>15th</td>
<td>2012</td>
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<td>2016</td>
<td>Hong Kong</td>
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<td>17th</td>
<td>2020</td>
<td>To be decided</td>
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TABLE 1. World Congress of Anaesthesiologists
The trade exhibition is a vital aspect of any WCA. It permits the industrial companies operating in our sector to demonstrate their latest innovations and allows them to access anaesthesiologists from all over the world. They provide a huge funding boost to the meeting and their attendance, with the associated financial support, should never be taken for granted. Most delegates recognise the benefits of attending the trade exhibition to familiarise themselves with the latest innovations and, increasingly, they are also attending the growing number of ‘scientific presentations’ that occur within the exhibition.

The WFSA has to undertake a series of administrative duties within the time frame of the WCA. All of the activities of the WFSA are governed by the General Assemblies (GAs) to which every member society, which has paid its annual membership fees, sends representatives in proportion to their number of announced member anaesthesiologists. These representatives accept the reports of the myriad of permanent and sub-specialty committees of WFSA and determine the future activity of the organization, often at the instigation of the elected Executive Committee and Officers. In addition the GA confirms the appointments of all members of all committees and, for the first time in Buenos Aires, will actively elect those standing for the Executive Committee and Officer posts. All WFSA committees have the opportunity to meet at the WCA and plan their activity for the next 4 years.

The COC, besides wishing to run a memorable meeting, wants to provide for the delegates that attend a flavour of their country and culture. As the 2012 Congress President Alfredo Cattaneo writes:

“By going to the 15th WCA you will really have the world of anaesthesia at your fingertips. Our Scientific Program for the 15th WCA will try to globalize the level of knowledge and practice of anaesthesia through:

- Reporting progress and knowledge in anaesthesia
- Promoting the best anaesthetic practice
- Improving your skill in workshops
- Promoting safe practice in anaesthesia
- Encouraging organisation of anaesthesiologists.

The Scientific Program will cover the latest scientific knowledge in different areas of Anaesthesiology, Perioperative Medicine, Intensive Care, Emergency Medicine and Pain Management. Topics will include research, organization, economy and education. The preliminary programme will be available shortly. It will be comprehensive and diverse, representing the needs of our colleagues from all around the world. You will surely be able to find the best level of lectures not just at the cutting edge of the science of anaesthesiology, but also the ‘ABC’ of the safe practice of our specialty, for those delegates looking for this information. We hope to have only electronic poster sessions to save delegates having to transport bulky posters. Workshops will have a special priority in this WCA, with simulations and the latest technology designed to improve our access to new skills. Our aim is to improve the skill and knowledge level of all of our colleagues coming to Buenos Aires.

Be sure that there will be a lot of science, but there will be also a lot of fun! We are developing a wide variety of social and cultural programmes – there will be tango lessons, parties, and the ever present possibility of tasting our famous cuisine including fantastic barbeques which will be surely enjoyed by you all. I am confident you will feel very comfortable living with our Argentinean culture and it will provide you with a unique opportunity to make new friends in the world of the anaesthesia.

Buenos Aires is Argentina’s capital city, with easy access from almost anywhere in the world. It’s breadth of attractions make it an excellent city for hosting the World Congress. These attractions include shows, theatres, sports, museums, art shows, antiquarians, shopping, and of course, as I mentioned before, our gastronomy. Before, and/or after the WCA you can also enjoy the many interesting tourist possibilities that Argentina can bring you such as:

- Iguazú Falls, one of the wonders of nature
- Perito Moreno Glacier, a fantastic place to visit
- Patagonia, a very different landscape
- Mendoza’s wineries and wines
- Mar del Plata, very nice beaches
- Córdoba, beautiful and peaceful hills
- Litoral, with the fantastic Paraná River

There are so many places you will surely feel that this WCA is a unique opportunity to mix science and leisure. It will be an unforgettable experience. It will be a great pleasure for us to meet you in Buenos Aires!”

I am sure you will all agree he ‘paints’ a very attractive picture.

Of course our PCO, ChoiceLive, is eager to facilitate your attendance at the BuenosAiresWCA and has the following advice for those who want to attend: The website www.wca2102.com is the ‘definitive source’ for all information relating to the congress and your attendance. You will be able to register, book workshops, book accommodation (designed to suit all budgets) and select any tourist activities all ‘on line’. The website will have full details of the scientific programme, posters, social programmes, exhibitors, sponsors and much more. Hopefully it will answer any of your questions relating to the congress, but, if you do still need further information or help then just ‘contact us’. The information on the website is being constantly updated and if you want to be sure you don’t miss any important deadlines (such as poster submission dates, closing of early registration) then make sure you register your interest on the website and we will send you timely reminders.

A few final comments. The WCA needs to be a financial as well as a scientific success so that the WFSA can continue to run its extensive programme of educational, publication and safety activity all around the world. The membership dues of the member societies do not fund this activity which comes almost entirely from the surpluses generated by the WCA. This in part determines the registration fees charged for the delegates. We hope you will attend the WCA in Buenos Aires. It will be a scientific, social and cultural triumph and, if you are not there, then for years in the future you will hear from those who were that phrase “Ah but you should have been there in 2012 in Buenos Aires; that was a truly great meeting.” Oh and start taking your Tango lessons soon!

25-30 March 2012 is the date for the next World Congress of Anaesthesiologists in Buenos Aires, Argentina; start planning NOW.
The Healthcare Debate – A Trans-Atlantic Viewpoint

I have just returned from a year working as an anesthesiologist at the University of California Davis Medical Centre, Sacramento, California. This was an OOPE that I had arranged for my penultimate year of SpR training.

There are many differences between the US and the UK and their healthcare system was something I thought it would be valuable to experience. I got a little bit more than I bargained for but this article is a summary of what I learned whilst over there.

Little appears to have summoned more anger and strength of feeling in American domestic politics in recent history. US healthcare makes quite a target for criticism. It is the most expensive in the world, costing around 15% of GDP - compare France and Germany with 11%, Japan and the UK with 8% [1], 62% of personal bankruptcies in the US are due to medical debt [2]. Around 45 million Americans are uninsured and around 9 million of these are children [3] and these are often people who do not qualify for government provided healthcare (Medicare or Medicaid), are not provided with health insurance by their employer or who cannot afford or choose not to purchase private health care. It is thought that 18,000 unnecessary deaths each year are due to lack of health insurance [4].

A typical family insurance policy can easily cost in excess of $10,000 per year and one colleague’s healthy 25-year-old daughter was paying $500 per month. We met teachers and hairdressers who simply chose to go without health insurance because they felt it was too expensive and this was a risk worth taking.

When it can be afforded, insurance can frequently exclude pre-existing and chronic conditions.

Many of those without insurance were much less likely to seek primary care and receive follow up for chronic conditions or injuries as well as being more likely to attend the Emergency Room.

Consequently, it was apparent that the average patient in the publicly funded university system was generally sicker than those seen in the private sector or in the UK. In fact, my logbook data for the year showed that the median ASA grade of the patients I anaesthetised was one point higher than back at home.

Despite the spending, US healthcare fails to deliver healthcare which is good as that of many other developed countries. The 2000 WHO world rankings put France in the number 1 slot, the UK in 18th and the USA in 37th – one position above Slovenia [5]. Other sources provide similar information that demonstrates that US healthcare is not necessarily the best in the world [6].

It is also argued that in a system where health care is primarily provided by a private sector whose main objective is, quite understandably, profit, there is little incentive to reduce costs. Insurance companies and lobbyists are also a powerful force in US politics. Costs continue to escalate, in part due to rising medico-legal expenses and over-investigation – which are inexorably linked.

Of course, statistics can be used to show a variety of results but there is no doubt that US healthcare is, like ours, far from perfect. So why then is there so much anger about change to “Obama-care”?

Extending health coverage will undoubtedly raise costs for US citizens and at a time of economic recession, that is never going to be popular. Opponents of healthcare reform also point out that socialised healthcare will lead to massive cost overruns and significant rationing of healthcare. Weaker aspects of British healthcare, such as cancer survival rates, the availability of certain chemotherapeutic drugs and patient choice of physician and healthcare institution are held up as further disadvantages of reform. Other opponents point out that health care is not a right and is not part of the US constitution.
Many of these points have some founding. Then again, as already mentioned, US healthcare leads the world for spending without coming close for outcomes. And the insurance issue suggests that denial of healthcare already exists in the US for a significant section of the population in a far more serious way than in any other industrialised nation.

So what was my impression of the US healthcare system? I was acutely aware of all the problems described above. UC Davis Medical Centre plays a role similar to that of the NHS in that it is a provider of last resort. It deals with many insured patients but also provides care for uninsured patients and those requiring specialised tertiary care, with an annual budget of just over $1 billion. Patients receive high quality care but are often sicker than those we tend to see in the UK. Many patients seemed to have received very little primary care and HbA1c levels of 12-13 percent were not uncommon along with morbid obesity, substance abuse and other chronic problems.

We had to experience it from both sides. My 1-year-old daughter was diagnosed with a “silent” congenitally dislocated hip whilst we were out there. Major surgery and prolonged immobilisation in a spica cast whilst living 5200 miles from home and family and friends made for an intense winter.

But I was in a respectable job with a fantastic employer-subsidised health insurance policy that provided for my family. My daughter’s surgery was carried out less than five weeks after we made an appointment to see her paediatrician. The care she received was first class. The surgery was successful, her epidural worked well, the nursing care was great and everyday someone from the catering department made a personal phone call to help with personalising a menu for the day. Everybody involved in her care was fantastic.

We were treated extremely well – no shortage of information, help or courtesy. Appointments came through without delays and waiting times for subsequent trips to theatre and outpatient appointments were virtually non-existent. There were no multi-patient bays, a telephone for free local calls was at each bedside and there was absolutely no stress in finding somewhere to park. In the end, we couldn’t fault our experience.

Of course the waiting time for such surgery in the UK wouldn’t necessarily be that long for a child, but it was impressive nonetheless.

Our financial contribution to this treatment consisted of $350 per month in insurance premiums (with a further heavy subsidy from the University of California) and just over $500 in co-payments over the course of her treatment. Not bad considering the total bill came in at just over $150,000!

I think I would summarise as follows: healthcare in America can be absolutely amazing, providing you can access it. Americans are generally courteous and professional and have a “can-do” attitude that was very refreshing. We were fortunate to be able to afford good quality accessible health care without worry or financial stress. This is not possible for many Americans.

I felt fairly critical of many aspects of the system – and the US society at times - but our treatment made me realise that things are not always so black and white. There were many aspects of their “patient pathway” that we could learn a lot from.

However, there is also much to be extremely proud of in our National Health Service despite its many faults. It is said that the way a country looks after its vulnerable people is a good measure of how civilised it is.

With this in mind, I would say we are very civilised indeed...

Further Reading:

References:
1. WHO World Health Statistics 2009

Dr Niraj Niranjani, SpR Anaesthesia, Royal Devon and Exeter Hospital
The new NHS Nutrition Czar Professor Findlay McSporran is set to revolutionise the diet of patients in hospitals. “Since the NHS only receives around 85p to provide three meals a day in hospital, clearly there are cost and nutrition pressures”.

The solution to NHS nutrition came to Findlay during one of his regular visits to see his grandmother in Fife. “I suddenly realised one morning that the solution was in front of me – porridge! Nutritious, complex carbohydrate with balanced salt and water content. No chewing required and even able to be prepared for tube feeding. Even at lunch and supper I found the sliced porridge and oatcakes very tasty”.

Following a full NHS safety review by the NPSA, NICE and the newly formed Health and Safety Special Health Authority, porridge was found to be safe for patients unless placed in tracheostomy tubes or given into the circulation through central venous lines. It was felt that with careful labelling and training the risks from this could be minimised. The NHS will initially change all meals to porridge, targeting nutrition throughout 24 hours – Scottish porridge in the morning (Carbs, Water and Salt); International porridge at lunch (Complex, including sugar and milk = fats and protein) and a choice of either or both, cold and sliced for dinner. The diet will be supplemented by freely available oatcakes with special rough oatmeal (fibre).

Findlay explained that a key member of his working party on “Porridge Saves the NHS” was Dr Ivan O’Brain who quickly realised that the solid nature of porridge meant that patients could eat right up until they went to theatre as it would be impossible to regurgitate porridge which has always been know to have special gastric lining properties. “That man is a genius” reported Findlay.

“By following my dear Granny’s recipe, NHS patients will receive 3 warm nutritious meals a day, cooking practice will be simplified and all at a truly Scottish price” joked Findlay.

The British Society for Nutritional Support was broadly supportive of this new initiative but their spokesman Dr Fuler Wynde explained that nutrition was a highly complex issue, and the concept that the Czar’s grandmother could have something useful to say was quaint, but rather outdated in comparison with his PhD. Dr McSporran was quick to point out those with any particular nutritional deficiencies would be treated with nutritional intensive care - two helpings of porridge.

“I think you’ll find any Scotsman who has had his oats is always a contented lad. A double helping is simply a bonus” said Findlay.