Breathing system obstruction: a continuing issue

GAT report from Cardiff

Treasurer's annual summary
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Editorial

September is a sort of ‘cusp’ month – not quite summer, not quite Autumn, but definitely ‘back to school’ and the new academic year. Dr Dick Birks will hand over the Presidency of the AAGBI to Dr Iain Wilson, and Dr Les Gemmell (Hon Sec) will hand over to Dr Andrew Hartle at this year’s Annual Conference in Harrogate. Dick and Les have done a good job, helping to steer your Association though tricky financial times (see our Hon Treasurer’s report), and taking a firm stand on threats to our professionalism such as the difficulties with SPA time and relations with insurance companies; I wish them all the best for the future and welcome our new President and Hon Sec. We also welcome three new council members, Drs Abhiram Mallick, Samantha Shinde and Sean Tighe who will also take up their posts in September; replacing myself (I remain as a co-opted member of Advisory whilst I am editor of this estimable rag), Drs Ranjit Verma (moving onwards to RCoA Council – congratulations Ranjit) and Andrew Hartle.

I have really enjoyed my time as an AAGBI Council member and leave (as an elected member) with the sense that I have been able to make a difference in the areas in which I have worked; I hope that our new members will be empowered to achieve in their turn.

I was forcefully reminded of the relentless turn of the wheel yesterday; I opened a set of patient’s notes to review an old anaesthetic chart. The chart had been meticulously written in Ed Charlton’s very recognisable hand; it came home to me that he has gone in a way that I had not really felt till then. I think the passing of one of our number, or of those who have made a contribution to our specialty, i is worthy of note, and so I make no apology for including two obituaries in this edition of Anaesthesia News. They celebrate the lives of two very different men, but I think both make interesting reading. I would be prepared to include obituaries in future editions of Anaesthesia News; though in due course (when the current update of our website is complete) I would anticipate that

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The Association of Anaesthetists of Great Britain and Ireland
21 Portland Place, London W1B 1PY
Telephone: 020 7631 1650
Fax: 020 7631 4352
Email: anaenews@aagbi.org
Website: www.aagbi.org

Anaesthesia News
Editor: Val Bythell
Assistant Editors: Kate Mccombe (GAT), Isabeau Walker and Felicity Plaat
Address for all correspondence, advertising or submissions:
E-mail: anaenews@aagbi.org
Website: www.aagbi.org/publications/anaesthesianews
Design: Amanda McCormick
McCormick Creative Ltd,
Telephone: 0845 271 2883
Email: mail@mccormickcreative.co.uk
Printing: C.O.S Printers PTE Ltd – Singapore
Email: terence@cosprinters.com

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Advertisements are accepted in good faith. Readers are reminded that Anaesthesia News cannot be held responsible in any way for the quality or correctness of products or services offered in advertisements.
these would be best placed on our website, with perhaps an edited notice in the print version. I would be interested to hear your views on this.

The front cover of July’s Anaesthesia News generated some adverse comments (see letters); I am working on a better solution, but meanwhile would be delighted to receive any images* from readers for use on the front cover. What do you want our newsletter to look like?

I haven’t received any comment about the paper on which Anaesthesia News is printed – we have changed (from July 2010) to lighter weight paper in order to reduce the carbon cost; we are continuing to look at other ways of reducing our carbon footprint further in future (both at Anaesthesia News and across the Association).

A colleague (it seemed best for this piece to appear anonymously) describes their experience of a near miss due to a blocked circuit on page 8. Blocked breathing circuits have always been a hazard in anaesthesia but I guess the causes have changed over time. In my youth, kinking of rubber tubes and cuff herniation were relatively commonplace, and I have resorted to use of the adage ‘if in doubt take it out’ on numerous occasions for these problems. I particularly recall an unpleasant incident during a carotid endarterectomy. A bit of ‘wheezing’ progressed rapidly to complete airway obstruction. The (very senior) surgeon had just reached a delicate point of the procedure. When I asked him to stop so that I could get at the airway (the head was wrapped in a towel) there was a bit of a frank exchange of views. The cuff of an old-fashioned latex re-inforced tube had herniated over the end of the tube, so the problem resolved rapidly when I deflated the cuff. My dislike of reinforced tubes persists (irrationally) to this day. It may be that the relative infrequency of such events these days has led to a lack of awareness of the problem, and I must say that I had thought (until I read this article) that the fact that so many elements of the breathing system are transparent would mean that a visual inspection would detect ‘foreign bodies’. Perhaps the old adage needs an appendix – ‘if in doubt, take it out and use a self-inflating bag and mask’. That leaves a discussion about what exactly should lead to ‘doubt’ for another day...

Hope to see you in Harrogate!

Val Bythell

*Images need to be free from copyright, to have the appropriate permissions and should be 300dpi at A4 size.
September heralds the approach of the Annual Members’ meeting (to be held at the Annual Congress in Harrogate), and hence the end of my first year in office as Honorary Treasurer. Although the time seems to have just flown past, it has been a fascinating twelve months, complicated by the ongoing recession and unpredictability of the stock market combined with structural changes at the Association. On the gloomy side (it’s always easier to start with the most depressing subjects and progressively “lighten up”) the next few years are not going to be easy. The enormous national debt will affect us all, both personally through salary freezes, rising taxation and the likely reduction in funding of public services, and indirectly through restrictions in the funding of the NHS. It is estimated that the NHS budget deficit will be approximately £20 billion and so we can expect increasing scrutiny, from both the public and politicians, over value for money in the current system, and pressures from our managers for further efficiency savings and improved productivity (dare I mention SPA time?) are inevitable.

On a happier note, however, those of you who have taken time to read the Annual Report and Audited Accounts of the Association and Foundation (http://www.aagbi.org/publications/annualreports.htm) will appreciate that our current financial status is far from catastrophic and we remain on a secure footing. This is due to a variety of factors, not least of which is our ever increasing membership as we continue to expand beyond the 10,000 mark.

2008-09 was a turbulent year in the stock market and we, along with the majority of investors, took a “hit” in terms of our investments. Despite the general downward trend in the stock market it was felt that our investment managers were not performing as well as we would have wished and so we took the carefully considered step of replacing them and we are now delighted to have appointed Williams de Broe to look after our funds. Experts in the investments of charitable organisations, they duly reshaped our portfolios within our agreed policy and both portfolios have subsequently shown an astonishing improvement and significantly outperformed the benchmarks. Nevertheless, despite the encouraging capital growth of our investments, the income generated from savings is poor.

Our journal “Anaesthesia” remains as well read and cited as ever and royalties from advertisements and reprints have seen a sudden rise this year making a substantial contribution to our income. 21 Portland Place has proven to be a popular venue for meetings in central London and the facilities team at the Association have done a tremendous job in marketing our in-house facilities on the days when they are not being utilised by our members. Despite restrictions on study leave and budgets (a concern expressed by all membership groups) the last year has been one of the most successful ever in the AAGBI’s Education Programme and we are grateful to Richard Griffiths and his team for organising such high quality meetings. Of particular note is the popularity of the “Core Topics” series which attracts local support in “taking the meetings to the members” and is regularly oversubscribed. AAGBI meetings are remarkable value for money when compared to those of many comparable organisations and I encourage you all to continue supporting them.

All of these sources of income have allowed us to carry on with our core activities but there is no time to rest on our laurels. Despite the remarkable turnaround with our investments their continuing growth cannot be guaranteed. The recession is likely to persist for some time and it is probable that the United Kingdom may be one of the last of the major economies to recover. The stock market appears misleadingly healthy due to the substantial investment in overseas equities which are flourishing and many of those economies (particularly those of the Pacific rim countries) are already well on their way to recovery. The current weakness of the pound only serves to further accentuate this.

The AAGBI has always enjoyed an excellent working relationship with our colleagues from the medical equipment and pharmaceutical industries and over the years we have been extremely fortunate to benefit from their sponsorship of our events and involvement with our building. Regrettably they, also, are not immune to the effects of the global economy as their budgets progressively tighten and several have chosen to merge in a quest for greater efficiency. Whilst this relationship between us is likely to continue, the funds available to us will inevitably diminish and we have already seen an effect...
of this in the withdrawal of sponsorship from the GAT Annual Meeting. The last few years have seen a rapid expansion in the number of specialist societies in anaesthesia and we have always been keen to welcome them into the Association and provide them with secretarial support and specialist services when required. The vast majority of members of these societies are also members of the AAGBI so it is only appropriate that we offer them such assistance but it is possible that this expansion may eventually cause us to outgrow our current premises. It is only 8 years since we moved into Portland Place and we have no immediate intention to relocate but we must always look forward and prepare for such eventualities.

Council of the Association is ever aware of the financial pressures on its members, principally the escalating costs of many of the professional organisations, and we strive to keep our annual subscriptions to a minimum. We are therefore delighted that we have managed to freeze our subscription rates for 2010-11. To maintain this, however, we are always looking for new sources of external income for without this the burden falls upon the members. In order to continue with our primary objectives of patient care and safety, education and research, and representation and support of our members we need to maintain our strong financial base. Perhaps surprisingly in the current climate there are many organisations either involved with, or totally unrelated to, medicine who are keen to be associated with us and who would be prepared to pay for this privilege. Some years ago, a large UK motor manufacturer requested permission to promote their cars by taking a stand in the trade exhibition at our Annual Scientific Meeting. At the time it was felt that this was unprofessional and we should only allow companies allied to medicine to exhibit there, so the request was refused. At the same time our sister organisations (such as the ASGBI) were taking a different approach by exhibiting a variety of goods totally unrelated to medical products but which they believed would be of interest to the delegates - high quality designer menswear being one example.

Their alternative approach has now developed into a strategic plan involving ‘corporate patrons’ and ‘commercial and professional partnerships’. Not only is a substantial income generated but there are also associated benefits to the society’s members. For example, a large airline company offers a personalised booking service, 20% discount on published fares and, frequently, a cabin class upgrade. A quality car manufacturer provides a small fleet of cars for the duration of each of the society’s scientific meetings, to be used at the discretion of the society, an extended loan of a chosen model of car for a comprehensive test drive delivered to the member’s door, and should he (or she) choose to purchase it, a guaranteed “best price” agreement. There are also partnerships with a variety of banks, independent financial advisors, insurance companies and solicitors all offering benefits to members.

For some time now the AAGBI has enjoyed a close working relationship with Cavendish Medical Ltd, Independent Financial Advisors, whose articles on financial advice for anaesthetists have occasionally been published in Anaesthesia News. Cavendish also run a ‘Planning for Retirement’ session at our Annual Congresses and have recently provided brief ‘financial advice add-ons’ at the end of some of our seminars. These have all proved to be popular and informative to those who attend them with minimal promotion of the company. The proposal that Cavendish Medical Ltd. be invited to become a ‘Professional Partner’ to the AAGBI, by which they would be offered continuing access to our members, with the aim of offering financial advice, in return for an annual partnership fee, was discussed at some length by Council in early 2010. It was finally decided, however, that it would be irregular to select one particular company out of the multitude specialising in this field as it could be perceived that we were assuring their quality and integrity over and above that of their competitors when we had insufficient evidence to do this, and it was also conceivable that, as a consequence of our financial gain, we would be held responsible for any advice which they might give. To complicate matters further, several Council members had employed Cavendish as their personal financial advisors through their contact at Annual Congress, seminars and in Anaesthesia News and although none had received any additional benefits a conflict of interests clearly existed. One could argue that the best possible recommendation to the Association would be that Council members were delighted with the services provided but not all would see it that way. The upshot of this was that it was agreed that Cavendish should continue providing these services for a trial period but that all financial benefits should be directed to the members rather than the Association itself and all AAGBI members are now entitled to a free “Financial Advice Helpline”, substantial discounts off their standard fees, access to “Financial Planning/Planning for Retirement” seminars along with many other benefits from Cavendish Medical.

Whilst it is always gratifying to provide services for members, we are well aware that we are in a rapidly changing financial climate and we must keep exploring all avenues. We are fortunate in having a large membership base compared with other organisations but there is no doubt that delving into the world of partnerships and sponsorships may reduce the burden on our members. Is this what we are all about? Is it unprofessional for an organisation of professionals to be seeking support from totally unrelated bodies even if substantial additional benefits are available to the members; should we be selective in choosing our patrons and partners or should we just be happy to accept donations from any reputable company that is keen to be associated with us? Council is elected to represent and support the members and is always happy to hear their views and act upon them. If you have any strong views on this matter please contact us at HonTreasurer@aagbi.org or, alternatively, air them in the next issue of Anaesthesia News.

Ian Johnston
The Anaesthetists Agency

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Tel: 01590 675 111
Fax: 01590 675 114

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Difficult Airway Society Annual Meeting
Cheltenham Racecourse
24th - 26th November 2010

Workshops

Wednesday 24th November for 96 delegates will include 4 core topic stations in advanced airway management as well as 2 stations on simulation with non-technical skills and airway scenarios.

Scientific meeting

Thursday 25th and Friday 26th November which will include lectures, free papers presented both as oral and poster presentations and the trade exhibition. We have lectures from experts in the airway from the UK, Europe and USA. Topics will be on the shared airway, medicolegal aspects, obstetric airway catastrophes, education, NAP4 results (major airway complications in the UK), RSI with rocuronium and failed intubation.

Social

Welcome reception on the Wednesday early evening with the opening of the trade exhibition and local beverages with canapes. The Gala dinner at the superb Regency Pittville Pump Room with entertainment and dancing.

CPD

The meeting has been allocated 15 CPD points by the RCoA (5 points per day).

Website

Please look at our Website for more information on the above, how to submit an abstract, on-line registration details, accommodation and also the venue.

www.das2010.co.uk
Breathing system obstruction: a cautionary tale

There is a certain justice about anaesthesia. Omit the basic rules and they will come back to bite you. The speed with which a routine ENT list can turn into a potentially fatal ‘near miss’ critical incident is alarming, and something I hope never to experience in my career again. I have learnt many things from this event, both about anaesthesia and myself.

I had finished my adult list early, and agreed to anaesthetise a child for repair of a small laceration at the end of the list. As usual, the ODA replaced the adult circuits with equipment suitable for an 18kg child. By the time I had checked the equipment in the anaesthetic room, a very tearful child and anxious mother had arrived. I walked into theatre and did a visual check of the paediatric anaesthetic circuit and changed the ventilator settings – I had conducted a full check of everything at the start of the list.

I performed a gas induction – the anxious child was less scared of the ‘green balloon’ than ‘the needle’. I inserted a cannula and a laryngeal mask. The child was easy to ventilate and was now spontaneously breathing with normal tidal volumes.

We transferred the child into theatre, bringing the Ayres T-piece with us from the anaesthetic room. I connected the child to the anaesthetic machine in theatre via the circle system. Spontaneous ventilation continued with a normal capnograph and good tidal volumes. The wound was cleaned and draped. There was an increase in respiratory rate during cleaning which prompted me to give a small dose of fentanyl. As the opioid took effect, the respiratory drive fell and I gently assisted ventilation. It was at this point that I felt something unusual, an increased resistance to ventilation. I changed to the Ayre’s-T and again attempted positive pressure ventilation which proved impossible. The situation immediately felt strange, the usual tachycardia and pattern of obstructed ventilation with laryngospasm were absent. There had been no obvious change in a previously well positioned laryngeal mask. I removed the laryngeal mask and attempted face mask ventilation using the same circuit – still no CO₂ trace nor chest movement. My working diagnosis at this point was laryngospasm. I knew something was wrong, this wasn’t anything I’d dealt with before. The possibility of a blocked circuit crossed my mind. I could not explain how a previously patent anaesthetic circuit had become completely blocked without disconnection from the patient and in the absence of anything visibly blocking the tubing. I called for help and moved down the laryngospasm algorithm in my head. Still no chest movement nor CO₂ trace. I intubated the patient and a second consultant paediatric anaesthetist arrived.

Over the next three quarters of an hour, severe bronchospasm, pneumothorax, mediastinal mass were all suspected. Emergency drugs were administered and a needle thoracocentesis performed to try and resolve the situation. We asked the ODA to change the whole anaesthetic circuit. I became fixated on making a diagnosis, not dealing with the clinical scenario in the most sensible way. I had a strong desire to return to the anaesthetic room where things had previously been normal. I could not rationalize this and when I spoke it seemed to be lost in the chaos of the situation. I was about to go and talk to the child’s parents when it was decided that rigid bronchoscopy should be performed. Prior to this, someone suggested connecting an Ambubag directly to the ET tube - finally the chest moved up and down. Everyone watched as a small disc of cellophane wrapper floated out of the anaesthetic circuit (now disconnected and lying on the child’s chest). The cellophane had acted as a flap valve inside the clear spirometry sensor tubing, and had remained present despite repeated disconnections and reconnections. Unknown to us, every part of the circuit had become completely blocked.

Of the circuit, the paediatric spirometry sensor tubing had been pushed through the cellophane wrapper thus coring out a disc of clear plastic.

It has been widely documented that anaesthetic breathing circuits can become obstructed by foreign bodies (1,2,3,4). Our patient made a full immediate recovery. In some cases the patient was not so fortunate.

Basic rule of anaesthesia - always check the patency of all circuits prior to the start of anaesthesia. A visual check is not enough when an adult circuit is substituted with a paediatric one in the middle of a list. ‘Specific checks should be carried out for each new patient during a session on any alteration or addition to a breathing system’ (5).

Another basic rule of anaesthesia - if ventilation is difficult use an alternative method of ventilation eg. the Ambubag. ‘Ensure that it is directly connected to the ET tube, removing all parts of the existing circuit’ (6).

I have also learnt that the support of colleagues is invaluable, not only during the immediate crisis, but in the subsequent weeks and months that follow the event.

2. Ward M.M., Collins S. J. Another case of obstruction to an anaesthetic circuit. Br J Anaesthesia 2003; 91; 452
4. Chacon A.C., Kuczkowski K.M., Sanchez RA. Unusual case of breathing circuit obstruction; plastic packaging revisited. Anaesthesiology 2004 100(3); 753
5. AAGBI. Checking anaesthetic equipment (2004)
NPSA bans jokes in the operating theatre

The AAGBI have been in top-level negotiations over a proposal to ban all jokes from the operating theatre.

“This is no laughing matter” explained NPSA spokesman Terry Cereus. “We have good evidence from orthopaedic theatres that staff are being victimized and finding it difficult to concentrate during complex surgery.”

AAGBI has learned from contacts in the Incident Reporting Centre that a number of incidents appear to have been generated from a hospital in the South East of the country. Reports have also been made to the NPSA by the Royal College of Orthopaedic Surgeons (RCOS) explaining that humour involving orthopaedic surgeons and surgery had gone too far, and was causing a loss of confidence in the profession.

Senior examiner Mr Harry Thickster explained “Recently one of our excellent trainees undertaking the exit exam in knee and hip specialist surgery caused great confusion to the examiners by claiming that the heart was in fact a pump to deliver cefuroxime to the bones. Apparently he had learned this fact in all seriousness from one of the anaesthesia trainees. This kind of thing could result in great confusion.”

The RCOS are also very concerned that operating theatre humour is causing victimization of their consultants and risking sterilization protocols. An example quoted by the NPSA concerned a senior surgeon who announced in theatre that he had been able to do a jigsaw marked 5-6 years during the weekend. Apparently sniggering from the SHO in anaesthesia had been unacceptable, and the scrub nurse had barely been able to maintain sterility due to shaking so much. “An initial delight in an academic achievement suitable for the ACCEA CVQ was turned to derision by a few cynical theatre staff”.

The NPSA sees no alternative to a ban on all humour in the operating theatre, otherwise it is only a matter of time before a staff member sues the financially-depleted NHS. “This will also increase safety for patients as staff will no longer be smiling but concentrating hard. The NHS is not about enjoyment after all.”

The AAGBI have made representation to the NPSA about the importance of humour in the workplace but without any success. A frustrated spokesman explained “This is all very well, but who are we going to get to help zero the cerebral function monitor on ICU?”

The program is dedicated to upper limb regional anaesthesia with an emphasis on small group practical, hands-on ultrasound training and experience for those looking to further improve knowledge and confidence in performing regional blockade. DVD included.

Course Organisers: Dr Adrian Searle, Dr Zahid Sheikh
CME approved 5 points
Course Fee: £150

Application forms and more information from:
Course secretary Mrs. Shirley Goddard
Shirley.Goddard@derbyhospitals.nhs.uk
Tel. 01332 787195
Royal Derby Hospital, Anaesthetic Office, Uttoxeter Road, Derby DE22 3NE
The early days of anaesthetic nurses...

Having retired from clinical anaesthesia after 37 years at the ‘coal face’ it is good to reflect on how the provision of anaesthesia has changed over time.

I started anaesthetic training as a Senior House Officer at King’s College Hospital in London in 1970. The theatres had been designed many decades before, and I recollect that each theatre had a very small room that was used as the induction room. It was just possible to accommodate a theatre trolley, a patient, an anaesthetist, an assistant or student (but rarely both). The ‘anaesthetic helper’ was always a nurse. What training did this anaesthetic nurse receive? Usually none, occasionally a few hours if she was required to help in cardiac theatre.

I once asked how the anaesthetic nurse was chosen from the ranks of the theatre staff, and was told that the anaesthetic nurse was generally the least experienced student nurse in the theatre team, as she couldn’t do anything anywhere else. Her assigned duties were the traditional nursing duties of being kind to the patient, receiving handover from the ward nurse, acting as a chaperone if required, fetching and carrying and generally assisting the anaesthetist, and clearing up the mess made by the doctor after the patient had gone into the theatre proper.

I soon learnt that before the patient arrived at the start of a list it was worth quizzesing the anaesthetic nurse as to her previous knowledge and experience, as otherwise a request for a ‘catheter mount’ could be met with a very blank look at a vital stage of induction. Drawing up drugs was very properly NOT part of the helper’s role, but holding the controlled drug (CD) cupboard key was, even though technically illegal, as it required a state registered nurse to sign the register and be responsible for the safety of the CDs. The system, ad hoc as it appears, worked well provided everything ran smoothly. If something unexpected happened, such as an unexpected difficult airway, then it went pear-shaped very quickly. For that reason, if the anaesthetist was uncertain of the patient, the door to the theatre was often left open, or at least ajar, so that a cry for help would be heard and Theatre Sister could despatch another more experienced individual to run in and sort us out! Monitoring was not used routinely, and oximetry was not available at all, so many shades of blue to black could be seen in even the best run anaesthetic rooms.

Checking the anaesthetic equipment was not part of the anaesthetic nurse’s routine. The anaesthetic machines (one in theatre and one in the anaesthetic room) were checked by the anaesthetist without fail at the start of the list; all were cylinder machines as we had no piped oxygen, so that meant four cylinders on all machines to be checked. We used a Bosun oxygen failure alarm that depended on the cylinder pressures opposing each other, so that if the oxygen pressure went down it opened the system to air and blew the nitrous oxide across a whistle giving an audible alarm.

Checking equipment also included all the laryngoscopes and red rubber endotracheal tubes (ETTs) which might be required for the list, and that included testing the cuffs that were likely to show wear after a few autoclavings. In order to complete all these checks it was necessary to arrive in theatre at least thirty minutes before the first patient was called for. One advantage was that the patients for the list were seen at the latest the night before so that patients cases were admitted at least one day prior to surgery to allow for investigations and clerking by the House Surgeon. In fact it was the norm at King’s in the ‘70s for the House Surgeon to call the anaesthetist to tell him about the patients on the next day’s list so the anaesthetist could prioritise his preoperative visits to see the sicker or older patients first.

When I began my anaesthetic training in 1970, glass syringes, which had certainly been the standard when I was a student five years earlier, had now been phased out in favour of disposable plastic ones. The drugs were drawn up before induction; thiopentone or less commonly methohexitone, an analgesic, generally pethidine or morphine, and any relaxant deemed suitable, suxamethonium for intubation followed by tubocurare or gallamine for maintenance. A suitable range of ETTs was also prepared as were two laryngoscopes as the bulbs were very prone to failure. The ‘Liverpool technique’ had taken hold at Kings then and most paralysed patients received no additional volatile agent.

If endotracheal intubation was not deemed necessary, a Guedel airway was inserted and spontaneous breathing was
maintained with halothane, trilene or later methoxyflurane, via a Mapleson A circuit with the expiratory valve next to the patient end and often close to the anaesthetist’s face, if he was to hold the mask throughout. Often if the anaesthetist was feeling brave or lucky, a Clausen’s or Connell’s harness was used.

Having checked the equipment, the first patient would be sent for and would arrive on a trolley from the ward. The only essential for a trolley to be used as a theatre trolley was an ability to tip. Some tipped more efficiently than others and it was a sensible thing to check that it tipped head down. On one occasion, the trolley had recently been serviced and an elderly somewhat obese gentleman was nearly launched over my head onto the floor!

After receiving the handover of the patient from the ward nurse, the anaesthetic helper and anaesthetist would prepare for induction, apply the limited monitoring then in use, insert a cannula (disposable ‘butterfly’ needles were just being introduced) and induction could begin. The anaesthetic room at King’s was regarded as being out of bounds to surgeons until they were invited, a habit which regretfully did not follow me after I moved away from KCH.

Once the patient was settled they were taken into the theatre and surgery commenced. When completed the patient’s relaxation was reversed, the ETT removed and the patient taken to the recovery section of theatre. This sounds quite grand, but the recovery was actually the exit corridor from theatre to the main hospital with a cylinder of oxygen mounted on the wall that was used infrequently in the early 70s, but increased throughout my time at King’s. A student nurse would be assigned the recovery role and would stay with the patient until they were awake and ready to be transferred back to their ward. The anaesthetist remained, as now, fully responsible for the patient until consciousness and reflexes returned but rarely stayed in close proximity as he was required to get back to the anaesthetic room to prepare for the next case. He would be likely to check the patient personally to discharge them when the next case was settled on the table.

The list would continue until completed, but most of the lists were half-day lists only so could accommodate one major plus a couple each of intermediate and minor cases in the three and a half hour slot. The surgeon and his assistant would take coffee in a purpose built doctors changing room, where fresh brewed coffee was served in a pot together with biscuits. The anaesthetist could join him if there was time or an assistant/trainee was present, but often took coffee whilst watching the next case from outside the theatre door. Lunch in the form of a plate of sandwiches was sent up from the theatre stores, but was often got at by the surgeons before the anaesthetist had his share. A well-trained anaesthetist would ask his helper to grab a few sandwiches and hide them in a cupboard in the anaesthetic room if the list ran late.

That was the pattern in King’s College Hospital and was likely to be representative of practice in the UK at that time, but things were beginning to change. Professor Sir Robert Macintosh had introduced the concept of ‘anaesthetic nurses’ when setting up his Nuffield Department in Oxford in 1937 and insisted that two nurses be attached to the Department. As a result, the Oxford department ran courses for anaesthetic nurses from early after the Second World War, emphasising their role as assistants to the anaesthetist (rather than the American model of nurse anesthetists). However, as my account above has shown, this had not widely caught on. Professor Mushin ran Anaesthetic Nurse courses from the late sixties in Cardiff. In the mid 70s, an Anaesthetic Sister was appointed at Kings who had completed the Cardiff course and then had further training in Europe, and by 1979 a second Sister with an ITU background was appointed. These two pioneer nurses at King’s, with encouragement from Professor Leo Strunin, then set up a course that was approved, eventually, by the English Nursing Board as “Post Basic Course 182 – Anaesthetic Nursing”. But that, as they say, is another story.

Dr M Ward
Consultant anaesthetist (ret’d)
Oxford
Kilimanjaro Christian Medical Centre (KCMC) is a large teaching hospital set in the South Eastern foothills of Mount Kilimanjaro, serving a population of 6 million people. Its creation in 1971 was funded by the Church, who continue to run it today. KCMC has 400 inpatient beds, employs over 1000 staff and has 400 students at any one time. The medical school, one of 3 in Tanzania, trains around 100 medical students per year. KCMC also provides an outreach service to many parts of the country by both air and road. This service treats over 10,000 patients and performs over 500 operations per year.

Astonishingly, there are only 20 consultant anaesthetists in Tanzania, a country with a population of 41 million. In contrast, the UK, with a population of around 60 million has over 5000 full time consultants (RCoA 2008). As a result, anaesthesia in Tanzania is largely provided by nurse anaesthetists and anaesthetic medical officer's (AMO's) who undergo 1 and 3 years of training, respectively.

KCMC has an anaesthetic department consisting of 1 Consultant, 6 AMO's and 8 Nurse Anaesthetists. They staff 10 theatres, covering most major specialties and also provide 24-hour emergency cover. There are 2 intensive care units (ITU) - a small medical ITU (2 beds) and a larger surgical unit (12 beds). Both have extremely limited resources when compared with European ITU's in terms of equipment, training, support services and staff. Despite this, they still manage to accept patients from all specialties and all age groups.

Labour ward has around 300 deliveries a month, with a caesarian section (LSCS) rate of approximately 33%. There are no options for pain relief during labour. On occasion, failure to cope with labour pain is an indication for LSCS. LSCS are performed (where possible) under spinal anaesthetic using 5% lignocaine with no opiates. Indications for general anaesthetics (GA) are similar to ours, and the GA technique is administered as per a protocol which is used throughout the hospital. No opiates are used periopeatively. Post-operative analgesia comprises paracetamol after the first 24 hours, and pethidine intra-muscularly when available. Morphine is not freely available.

After several visits to KCMC as observers, we were invited to set up an anaesthetic workshop. Given the problems faced by the department with regards to limited selection and availability of analgesics, lack of epidurals, perceived problems with post operative pain, and lack of exposure and education on regional techniques, it was jointly decided that regional anaesthesia and analgesia would be a useful area to focus the workshop on. We felt that simple, safe and effective techniques which require no specialised equipment would be particularly useful. Examples of such included TAP blocks, fascia iliaca blocks, ankle, femoral and axillary blocks.

Preparation for the workshop required regular contact with Dr Andrew Hellar, Consultant Anaesthetist and Head of Department at KCMC, and Adam Chagula, the Senior AMO. Abbott kindly donated Chirocaine, books, CD’s, theatre hats, pens and posters. A nerve stimulator was donated by the Anaesthetic Department of Worthing Hospital, and they also allowed us the use of their transdermal teaching ‘pen’ to allow delegates to learn nerve mapping for the duration of the workshop. The workshop was to run over a 3-day period, with the first 2 days covering regional anaesthesia and the third day covering a few basic intensive care topics. It was open to anyone interested, but targeted mostly towards anaesthetic providers from KCMC and neighbouring cities.

We conducted a pre-workshop questionnaire. The audience consisted of KCMC AMO’s and Nurse Anaesthetists, Dr Heller and trainee anaesthetic providers of varying levels of experience. Also in attendance were consultant anaesthetists from Kenya and Dar Es Salaam.
The questionnaire confirmed our perceived problems with post-operative pain management, and interestingly highlighted that, at present, responsibility for postoperative analgesia lay chiefly with the surgeons.

We faced many challenges along the way - some with obvious solutions, some not. Below is a summary of the different obstacles we faced, how we tackled them, and some suggestions for the future.

**Challenges**

**Difficulties Communicating with Tanzania**

Internet connections are unreliable and unpredictable in Tanzania, thus email was sometimes unreliable and slow. Postal services are also unreliable with no available tracking facilities for parcels and letters within Tanzania.

**Potential Solution:** Perseverance, establishing communication links far in advance of intended workshop

**Transporting Goods**

Teaching materials, equipment and donated goods amounted to an extra 28kg of luggage. Despite prior arrangement with the airline, we had to personally pay a substantial fee in excess baggage costs.

Previous experience had taught us that a letter of introduction from KCMC was required for Customs to avoid confiscation of all educational equipment on arrival in Tanzania. This still didn’t prevent our equipment spending 24hrs somewhere in Tanzanian airspace after our arrival, as has happened on all previous trips to Tanzania!

**Potential Solution:** ‘Pilots without Borders’ are an international service providing free air transport for medical equipment and supplies destined for the developing world. They have established contacts with the customs officers. We are hoping to use their services in the future.

**Printing and Photocopying Facilities**

Photocopying and printing facilities are either non-existent or expensive. Computer access is not freely available to all staff. Delegates were very keen to have paper handouts of all lectures, but given the financial constraints and difficulties in printing, this was not possible. We provided a few memory sticks with all the lectures, as well as an old laptop, however the delegates felt that they would probably still not be able to gain access to the material.

**Potential Solution:** Take out a portable printer, secure charitable funds for printing expenses.

**Timekeeping**

Due to delegates’ work commitments, and occasional misunderstandings, lecture start times were sometimes delayed.

**Potential Solutions:** Be prepared to wait! Remain flexible and advertise widely with posters and handouts, detailing intended program.

**Power Failures**

We experienced regular power cuts. This was particularly challenging as many of our lectures involved the use of powerpoint for demonstrating anatomical pictures and photographs, as well as video footage of various blocks. We used 3 laptops around the classroom and the chalkboard during such times. Also, lack of daylight during such times resulted in a premature finish.

**Potential Solution:** Change of venue to classroom supplied by backup hospital generator. Be prepared for such occurrences. Use of posters and paper handouts.

**Wide Audience**

The wide variety of experience in our audience from fully trained consultants to medical students to brand new trainee nurse anaesthetists, made pitching at an appropriate level challenging.

**Potential Solution:** Narrowing target audience, division of workshop into simpler topics and more advanced topics, correct advertisement of appropriate lectures. Greater awareness, on our part, as to target audience. Longer workshop / lectures.

**Teaching Styles**

We found our audience was used to didactic teaching styles, and were, thus, initially wary of participating in interactive teaching methods. With time, trust and enthusiastic teaching the delegates began to interact with us.

**Potential Solutions:** Smaller group teaching, more practical sessions, handouts prior to lectures to enable delegates to read up on topics, and, thus, gain confidence in the topic before the workshop.

**Language Barriers**

English, although both spoken and read to a high standard by all of the audience, remains a second, third or, sometimes, fourth language for Tanzanians. Our accents and the speed with which we spoke sometimes proved difficult for the audience to understand.

**Potential Solution:** Handouts, speak slower, repeat important concepts, practical sessions, encourage audience participation, small group teaching.
The Challenges in Setting up a Regional Anaesthesia Workshop in Tanzania

Access To Theatres

Lack of theatre scrubs, reluctance to delay lists and big groups made practical sessions in theatre difficult.

Potential Solutions: Provide our own theatre scrubs. Consider using the urology workshop setup, which incorporates a live video linkage from theatre to classroom, to demonstrate blocks. Support from the surgeons and theatre staff would be essential.

Work Commitments

Service commitments of KCMC Anaesthetic providers during working hours made it difficult for them all to attend all of the workshop.

Potential Solution: Consider changing the timing of the lectures to evenings or weekends to allow those providing the anaesthetic service in KCMC to attend. Practical demonstrations would need to be done during daytime hours, but could, potentially, be videotaped and replayed when convenient.

Despite the hurdles we found it a very rewarding experience. Judging by our post-workshop questionnaire, many delegates found it helpful and 100% said they enjoyed it. It has opened our eyes to how lucky we are in the UK. Even in these times of recession, we still have access to such advanced equipment, drugs and training.

Plans are afoot to return in 2011. It has been suggested that we invite the Society of Tanzanian Anaesthetists who have not held such a meeting for many years. We would be delighted if they wish to contribute to the program. In a post-workshop questionnaire the delegates suggested topics and improvements to consider in the future (see below).

We would like to thank Dr Andrew Hellar, Adam Chagula and the staff at KCMC for their support. Also, a big thankyou to Abbott for their kind donations.

Emma Glasgow

Suggestions for Future Workshop Topics

Suggestions for Improvement
MEDICAL COMPLICATIONS IN PREGNANCY
3 - 5 November 2010
at The Royal College of Physicians,
London NW1 4LE

This annual course, now in its 16th year, is highly relevant for all consultants and trainees caring for pregnant women with medical disorders. It provides the theoretical element of the RCOG ATSM in Maternal Medicine.

Full programme, availability of places and secure on-line registration:
www.symposia.org.uk

The Symposium Office, Imperial College London
Tel: (0)20 7594 2150; email: sympreg@imperial.ac.uk

Genesis Research Trust, Registered Charity No. 292518 Science for the health of women & babies.
This year, the 2010 GAT Annual Scientific Meeting returned to the flourishing Welsh capital city of Cardiff, famous for its castle, university and of course, rugby.

This year’s excellent scientific and social programme was organised by the team of Professor Judith Hall, Drs Sarah Harries, Paul Clyburn and Caroline Evans, the latter being the trainee representative co-opted onto the GAT committee whilst carrying out this onerous task. We would like to thank them sincerely for their hard work, both before and during the conference.

The meeting itself, attended by 280 delegates was held in Cardiff City Hall, an imposing building, which was both beautiful and impressive, and lent an air of gravity to events.

Following a welcome address by Dr Richard Birks, the President of the AAGBI, the first session concerning airway management proved both interesting and thought provoking. Dr Steve Morris highlighted that in today’s working environment, the number of ‘day-time’ intubations continues to fall, with only 18% of tracheal intubations occurring in designated ‘training periods’, the rest being conducted by trainees ‘out of hours’. It has been estimated that it takes 10,000 hours of practice to become an expert at something, as we move through the learning stages from unconscious incompetence, to conscious incompetence, to conscious competence before finally arriving at unconscious competence. He emphasised that ‘experts are made, not born’ and that effortful study is required if we are to become masters of our art.

Following this, Dr Aled Evans delivered an interesting and original take on factors well recognised to make intubation more difficult and re-emphasised the importance of having a plan B (and C…!) for difficult intubations.

The final lecture in this session, by Dr Tony Wilkes, discussed research into airway management and devices and encouraged all of us to think about becoming involved in this endeavour, and not assume it is out-with our capabilities.

During the lunch break, there was the opportunity to watch Dr Claire Williams being tortured by Dr Stuart Davies, Chair of AiM, and Dr John Hall, Consultant in Cardiff, during a mock consultant interview. This interactive session was extremely useful, allowing us insight into how certain styles of rhetoric and presentation may prove more successful than others during our own interviews, no matter what level of job we may be applying for.

Two afternoon sessions ran in parallel: the first concerning obstetric anaesthesia, where consultants from Cardiff delivered three lectures. The first detailed pre-eclampsia and its up-to-date management, in the next the assessment and management of mothers with cardiac disease was explored, and finally, some of the more challenging haematological aspects of pregnancy were discussed.

The parallel session was concerned with Critical Care Medicine, and lectures on surviving sepsis, new concepts in the management of ARDS and patient safety and critical illness delivered by speakers.
heralding from Wales, (Drs Parry Jones, Shah and Smithies). Both sessions were extremely well received.

Returning from the parallel sessions, the final effort of the day was concerned with peri-operative optimisation and considered age-old dilemmas such as, ‘should our patients be kept wet or dry’, considered against the background of available evidence.

That evening the introductory social was held at a bar in the regenerated Cardiff Bay area, where a buffet dinner provided the necessary carb-loading to allow enjoyment of the ‘social refreshments’ on offer (to use the words of the RCOA!). After dinner, there was dancing to allow us to work off the aforementioned indulgences.

Thursday dawned bright and sunny again and the first session was delivered by a team of pain specialists. Dr Knot reminded us that chronic pain, post surgery, is a problem that can be pre-empted before the patient even arrives in theatre, and with a combination of psychological support and multimodal analgesia, this problem can be significantly reduced. She pointed us towards the website http://www.postoppain.org/, an incredibly useful resource, giving advice on pain relief for many operations.

Following a lecture on pain management in children, Dr Tracy delivered an absolutely fascinating lecture on her research, using functional MRI, into neuronal responses to pain and the effects chronic pain has on those neuronal pathways.

The midmorning session was taken up with presentations shortlisted for the Registrar’s Prize; congratulations to Dr Johnson, whose presentation into his research on ‘Mitochondrial uncoupling proteins and energetics in human heart and skeletal muscle’ was very impressive and won him first place in the competition. In second place came Dr Neeta Tailor followed, in third, by Dr Maria Roberts. The judges commended all the finalists for the high standard of their work.

The GAT ASM followed lunch, and saw Dr Felicity Howard give her annual report before handing over the Chair of the Committee to Dr Rob Broomhead. After four years of dedicated hard work, Felicity leaves GAT to throw herself into her consultant job in Cardiff. We thank her sincerely for all her hard work in promoting the interests of the trainees and of AAGBI, and for being such a measured and inspiring Chair over the last year. We wish her good luck for all her future endeavours. As Rob takes over, we wish him luck too, in what is undoubtedly a challenging and uncertain time for training, and the NHS as a whole.

The AGM included a welfare session during which Dr Susan Williams presented the results of the GAT welfare survey, which will be published in Anaesthesia News in the coming months. This survey highlighted the stress experienced by trainees often seemingly caused by the necessity to gather endless, and often duplicated paperwork necessary now to prove competency, in addition to the other more traditional strains, such as the Fellowship exams. Dr Dickson from Leeds gave us incredibly useful advice on when and how to say ‘No’ to demands placed upon us, and Dr Hartle stepped in to cover a last minute absence, presenting a lecture on the processes that occur when an anaesthetist’s practice is under investigation.

Following this, the winner of this year’s Anaesthesia History Prize, Dr Aditi Modi, author of, ‘Survival of the slickest: a history of anaesthetic training’, raised the bar as she delivered an incredibly eloquent presentation, during which she did not consult her notes once!
Finally then, was the Pinkerton Lecture, this year delivered by the charismatic orator Dr Patricia Oakley of Practices Made Perfect Ltd, a consultant who advises the government on work force planning. She gave us an insight into why this is such a difficult task, and discussed many of the challenges faced in this area, such as the increasing number of women in the medical workforce, and the problems of keeping highly intelligent doctors engaged and interested in their jobs over their 30 year consultant life-span.

That night followed the black tie Annual Dinner in City Hall. An excellent meal preceded a live band, and the hardcore continued to dance until the wee-small hours.

The final day of GAT 2010 began with a sobering yet inspiring session where speakers who have worked with the Overseas Anaesthesia Fund and the charity organisations Mothers of Africa and Mercy Ships related their experiences of delivering anaesthesia in the developing world. We learned that in Benin, there are 11 anaesthetists for a country of 11 million, where as there are 140 anaesthetists in Cardiff alone and that each day in Africa enough women to fill a Boeing 747 die in childbirth. These, and other shocking statistics put many of our concerns about our working environment into stark perspective and were profoundly thought provoking for the audience.

The final session was concerned with pre-hospital medicine and Prof Porter from Birmingham explained the proposed training scheme for this embryonic specialty. Following this was a fascinating insight into the demands placed on the retrieval anaesthetists in New South Wales, Australia. Dr Lewis showed pictures of several dramatic rescues from ravines, mountains and raging rivers, making the average ED in the UK look a pretty dull place in which to work! Finally Dr Fitzgerald talked about his experiences as doctor in the world of boxing, looking particularly at the unique brain injuries that boxers suffer.

The meeting this year had an interesting and extremely diverse range of topics and in addition to the main lectures a series of workshops ran throughout the first two days. These explored the paediatric airway, lung isolation techniques, echo/PICCO/LiDCO/oesophageal doppler and new airway kit for 2010. Feedback from candidates at all stages of training was very positive.

There was the opportunity for candidates to display poster presentations and this year 97 posters could be seen. The 2010 Audit prize was awarded to Drs Cross and McLaughlan for their audit ‘Improving fluid prescription in trauma patients’. Second prize went to Drs Bindal, Tulloch and Kannan and third to Drs Chamber and Vedwan. The RSM Poster Prize was awarded to Dr Myers for her ‘Audit of the timing of antibiotic administration in patients meeting SIRS criteria’.

GAT 2010 was brought to its conclusion by Dr Richard Birks, who thanked the local committee for organising such an enjoyable meeting. It only remains then, for me to thank the staff at 21, Portland Place, who work so hard, not just during the conference, but all year to ensure the GAT ASM runs smoothly – without them, chaos would certainly ensue - thank you.

Next year’s conference will be in Leeds; we look forward to seeing you there!

Dr Kate McCombe
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<td>Primary FRCA OSCE/Orals Course</td>
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For Information on all MSA Courses
msoa.org.uk
Anaesthesia News welcomes submissions and correspondence.

Articles and letters should be submitted, together with any declaration of interest, to the Editor at anaenews@aagbi.org as an email attachment in Microsoft Word English (UK). If this is not possible, please telephone 020 7631 8817. We regret that we are not able to accept submissions on paper.

Digital images, figures or photos should be at least 300dpi in resolution. Preferable file formats are JPEG or PDF. Please do not send original artworks or photographs unless you have discussed this with the Editor or other staff. Please note that the explicit, written permission of patients or third parties is required prior to submission of such images. Many images are subject to copyright; please state whether images are free of copyright or not. If not, please indicate who holds the copyright, and whether permission to reproduce the images has been sought/grant.

The full name(s) of all authors, and their position, grade and hospital must be included together with a contact address, telephone number and email address.

Articles should not normally exceed 1500 words (including any references, further reading, tables, figures or graphs). Each table, figure or graph should have a title or legend. It is the author’s responsibility to obtain written permission for the use of any copyrighted material; please state whether this has been obtained if submitting copyrighted material.

Please insert references as numbers within square brackets [ ], and write out references in numbered order at the end of the text.

The Editor of Anaesthesia News reserves the right to edit articles for reasons of space or clarity.

Authors will be notified if their article has been accepted for publication, however please note that due to the volume of correspondence received, letters will not normally be acknowledged. Authors may have the chance to review their article in proof prior to printing, but we regret that this is not always possible.

For further information please contact 020 7631 8817 or email: anaenews@aagbi.org.

Help for Doctors with difficulties

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help (www.bma.org.uk/doctorsfordoctors).

To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor*.

A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

If for any reason this does not address your problem, call the AAGBI during office hours on 0207 631 1650 or email secretariat@aagbi.org and you will be put in contact with an appropriate advisor.

*The doctor advisor scheme is not a 24 hour service
Obituary
Dr. Michael Slazenger

Dr Michael Slazenger died aged 69 in April of this year from injuries sustained following a flying accident. He had retired from his post as Consultant Anaesthetist to St Michael’s Hospital Dun Laoghaire, where he had worked from 1979 to 2005. He was also the owner, chairman and chief executive of Powerscourt Estates Ltd, a 4,000 acre estate in Co.Wicklow purchased by his father Ralph in 1961 after he had sold the famous family firm, one of the oldest sportswear manufacturers in the world, to Dunlop.

His father had inherited the Slazenger sports company that was the source of their great wealth. Founded by his grandfather, also called Ralph, & great-uncle Issac in Manchester in 1880, the company manufactured the famous ‘guttie’ golf ball in 1891 and became the leading tennis ball supplier at the turn of the century. Michael’s father oversaw the expansion of the company worldwide due to astute sponsorship of major sporting personalities. They signed up Fred Perry just before his 3 Wimbledon titles & added Ken Rosewall later as they strengthened their business in Australia.

Michael was born in England in 1941, the eldest of five children and spent his early years in Buckinghamshire where the family farmed. In 1953 his father moved to Ireland and bought Durrow Abbey House where they lived for eight years until the family company was sold. With the proceeds of the sale his father bought Powerscourt, one of Ireland’s finest estates situated about twelve miles south of Dublin in the foothills of the Wicklow mountains and adjoining the pretty estate village of Enniskerry. Powerscourt House, a vast Palladian structure built around an old castle, contains one of the finest eighteenth century interiors in Ireland. The house is approached by a mile-long drive lined by over 2,000 beech trees and surrounded by a world-famous terraced garden of some fifty acres. Gutted by fire in 1974 it was Michael Slazenger who was instrumental in its subsequent rebuilding.

Educated at Harrow School he studied medicine at Trinity College, Dublin, qualifying in the mid ‘60s. His intern year was spent at Sir Patrick Duns Hospital in Dublin. Following a spell demonstrating in anatomy at Trinity – where I was one of his willing victims – he embarked on a career in anaesthesia. His junior and registrar years were spent in Ireland and he obtained his final fellowship in 1976. From 1976 to 1979 he worked in London in the anaesthetic research department of The Royal College of Surgeons in Lincoln’s Inn Fields under professors Jimmy Payne and John Bushmann. The computer they worked with filled the entire room. As well as his research he undertook clinical work at the ‘3 Ps’ – St Philip’s, St Paul’s and St Peter’s hospitals as well as the Shaftsbes and the Royal London Hospitals.

He was appointed to St Vincent’s Hospital, Dublin and St Michael’s Hospital, Dun Laoghaire as a consultant in 1979 and during the ‘80’s was elected a member of the board of the Faculty of Anaesthetists in Ireland and was a final fellowship examiner for many years. He also represented the Faculty on the Electro-Technical Council of Ireland. He was a man who loved gadgets and was one of the first consultants in Ireland to have a personal computer. He produced a version of T.C.I. for maintenance anaesthesia in the early eighties but alas he did not develop the idea.

He resigned his post at St Vincent’s hospital in 1984 but continued in practise at St Michael’s - a move which allowed him time to devote a proportion of his energies to developing and promoting the Powerscourt estate. This was a major undertaking. Originally a very large farm with a prize-winning herd of Aberdeen Angus cattle and a very large garden open to the public requiring considerable upkeep Michael undertook some major developments. An 18-hole championship-level golf course was developed; the main house was re-roofed and restored and a restaurant, shops and other facilities created; a second golf course was added; the Ritz-Carlton hotel was built with wonderful views overlooking the gardens and a smart housing complex close to the village of Enniskerry was developed. His energy and enthusiasm at the helm caressed and massaged the whole estate into the 21st century in robust financial health and without government grants – no mean feat.

His father was passionate about flying and created an airfield at Powerscourt soon after the family arrived. Michael shared his father’s passion, learning to fly at the age of 12. All his life he kept at least one plane on the airstrip at the estate - as a friend said of him ‘Michael needed to fly, it was hard-wired into his personality’. He was generous with lifts to various anaesthesia meetings in the UK, and some of his colleagues will remember crossing the Irish Sea with apprehension in such small planes! He glided for Ireland at international events in his earlier years.

He loved to ski and latterly enjoyed golf, being president of the Powerscourt Golf Club at the time of his death.

A huge crowd packed St. Patrick’s Church in Enniskerry, built in the 1840s together with the catholic church on the other side of the village by the estate, for his funeral. He was buried in the graveyard of the old church in the estate grounds. Our thoughts and wishes go to Noreen, his wife and constant companion since his days in Trinity and his children and grandchildren.

Dr. Carlos McDowell, Consultant Anaesthetist, Lourdes Hospital, Drogheda.

Mr. Michael Dover Family Friend of the senior Slazenger Family.
Sir Cecil Clothier died on May 9th 2010 aged 90. He had already served with distinction on active service in the army in the Second World War for seven years, and been an highly successful and respected advocate and judge for nearly thirty years, before he was appointed to be the first lawyer to hold the joint offices of Parliamentary Commissioner for Administration (Parliamentary Ombudsman) and Health Service Commissioner for England, Wales and Scotland (Health Ombudsman). Previously the Ombudsmen had been high-ranking civil servants. Sir Cecil held these appointments from 1979 to 1984. During this period he coincidentally began a special relationship with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) at a critical stage in its development. His interest and support for the AAGBI continued for the rest of his life, and he became an Honorary Member of the AAGBI in 1987.

Sir Cecil's association with the AAGBI began when he delivered the eponymous annual John Snow Memorial Lecture at the Anglo-American Meeting held at the Royal Festival Hall in 1980. His lecture on “The price of excellence” was by common consensus one of the most memorable John Snow Lectures ever given. Colleagues from the USA, used to mainly didactic scientific lectures at their conferences, also expressed their appreciation of the erudite and scholarly presentation spiced with humour and a sympathetic appraisal of human nature.

There was a great deal of wisdom in this lecture, which detailed how the pursuit of excellence can sometimes result in problems. This can only be fully appreciated by perusing the original text[1]. The talk was also prophetic, so far as later developments in the National Health Service (NHS) have been concerned. He praised the optimism with which the NHS was introduced, however, he also pointed to the moral dilemma that had arisen because of the excellence of the developments in medical therapy that had given rise to patient dependence, and that the price of such excellence was “an enhanced expectation that is often quite unreasonable and therefore doomed to disappointment”.

The AAGBI launched an appeal for funding for the purchase of premises in Bedford Square in 1984 and Sir Cecil consented to be its Chairman. The Appeal was outstandingly successful. The target was £600,000; in fact over £700,000 was raised (the equivalent of over £1,500,000 in 2010) before the appeal was closed in October 1986. The house was was officially opened by HRH Princess Margaret in July 1987. The AAGBI owes a debt of gratitude to Sir Cecil and for his continuing support thereafter.

Cecil Montacute Clothier was born in Liverpool on 28th August 1919, the second son of a successful dental practitioner. Cecil had his first vicarious contact with anaesthesia during exploratory visits to the surgery when it was not in use; during these he observed “the sinister looking” anaesthetic apparatus that was regularly used by a neighbouring medical general practitioner to give anaesthetics for his father. From his description this must have been a “Walton” No.1 intermittent flow nitrous oxide and oxygen machine. It is often said that the name “Walton” was invented during a game of golf at the well-known club of that name, which is situated a few miles from Liverpool and, to which many doctors and dentists from Liverpool, including Cecil’s father, belonged. However, the question of who might have designed and named the apparatus remains a mystery.

He married Elizabeth Bush in 1943 and they had two daughters and a son. Elizabeth died in 1984. In 1992 he married Diana Stevenson (née Durant). She survives him together with his own children and the three stepsons from his second marriage.

T.B.Boulton

References


A full version of this obituary is available via the AAGBI website.
Clinical Excellence Awards 2011
AAGBI support for higher award applicants

Time to act!

The AAGBI is recognised by the Advisory Committee for Clinical Excellence Awards (ACCEA) as one of the professional organisations that can nominate anaesthetists, intensivists and pain physicians for national Clinical Excellence Awards (Bronze, Silver, Gold and Platinum levels), and can also support applications for higher awards in Scotland and Northern Ireland. The AAGBI has established an objective assessment and ranking process in accordance with strict ACCEA guidelines. The AAGBI will convene a group that will assess and rank the submissions for each award level. The group will include senior national award holders, local award holders and lay representation. The ranked list of nominations will be formally submitted to the ACCEA or equivalent body for applicants from Scotland or Northern Ireland. Any anaesthetist wishing support from the AAGBI should follow the instructions and timetables below.

England and Wales

ACCEA - Clinical Excellence Awards

The 2011 National Clinical Excellence Awards round for England and Wales will close this year at 5pm on Friday 10th December 2010. If you would like your application to be considered for support by the AAGBI, please email your completed and carefully checked application form to president@aagbi.org by 5pm on Friday 15th October 2010. Please note that the application and nomination process is conducted in line with regulations described in the ACCEA website (http://www.advisorybodies.doh.gov.uk/accea) - we recommend that you read the relevant guides published on the website before submitting an application form.

Scotland

SACDA - Scottish Advisory Committee on Distinction Awards.

At the time of going to print, the deadline dates for the 2011 SACDA round have not yet been published. If you would like your application to be considered for support by the AAGBI in accordance with the relevant guidelines as will be published on the SACDA website, please email your completed and carefully checked application form to president@aagbi.org by 5pm on Friday 17th December 2010.

Northern Ireland

Northern Ireland Clinical Excellence Committee (NICEAC) Higher Awards Scheme

The timetable on the website www.dhsspsni.gov.uk gave a deadline for CV application forms of 9th July 2010. Following this closing date the NICEAC secretariat will themselves seek citations from the relevant Royal Colleges or Specialty Associations and the AAGBI will respond to any such requests by the NICEAC secretariat by the closing date of 8th October 2010.

General notes

All CVQs will be considered, but those contributing to the work of the AAGBI may be ranked higher.

Please be aware that your employing hospital or regional committee may have earlier deadline dates for the submission of your application form – we cannot emphasise too strongly the need to read and follow application instructions closely as published on the ACCEA website.

For those seeking guidance for future years, the AAGBI will continue to run ACCEA workshops, the next being at Annual Congress Harrogate (22nd - 24th September 2010).
The main purpose of this article is to inform readers about this updated resource, which has been redeveloped over the last year. It is also an opportunity to share some of the lessons learned with others who may be interested in pursuing similar projects.

The South East School of Anaesthesia (SESA) has had a website for trainees for many years thanks to the hard work of Dr Adrian Pearce who single handedly managed the website until the beginning of 2009. The South East School of Anaesthesia would like to thank Dr Pearce for his hard work in setting up the website and maintaining it for all of those years.

Training in anaesthesia has changed dramatically over the last couple of years, as indeed the whole of medical training has. As a consequence, nearly the entire content of the SESA website required updating to reflect these changes and provide trainees with the new information.

The project to update the website was announced in January 2009 at a SESA Study day and a small team comprising myself, Kyne Woodsford and Libbie Hoskins took on the challenge to have a new website published by August 2009. It was a daunting prospect as an enormous amount of information needed to be processed and none of us actually had any website development experience. The key features required for the website were that it should be accessible and user-friendly, that it should avoid becoming out of date by redirecting users to original source information, and that it should be easily updated by SESA staff without needing web-design knowledge. The need to keep costs to a minimum and avoid ongoing charges was also important and made the whole project more challenging.

As there were three people working on this project, a solution was needed to allow each of us to contribute to the organising of all the information collected. One method was simply to create a Word document that could be emailed between us, permitting suggestions on the layout and content. This however would have been too time consuming. Kyne came up with the solution by introducing us to ‘Google Docs[2]’.

Google Docs is an on-line package of office applications much like Microsoft Office. Advantages of Google Docs are that it is free and allows information to be stored, shared and edited on-line. Access to the documents is controlled by an invitation process.

Individual Google Docs were created to represent each web page of the SESA website. Once all the Google Docs were completed, a ‘dummy’ website was created to allow us to view the organisation of the site from our different locations and create all the relevant ‘Links’ before going live.

There are many different programmes available on the Internet to help create websites. At a very basic level there are programmes that allow text to be entered into a template as though writing onto a Word document, called ‘wysiwyg’ (what you see is what you get) web builders. They automatically generate the coding required for your work to be
viewed on the Internet. The programme we chose (Rapidweaver[3]) enabled this ‘wysiwyg’ function but also permitted the scope to learn some programming to address the specific requirements of the SESA website. Learning the relevant programming was achieved by viewing free on-line video tutorials and searching on-line forums for the answers to specific tasks.

Whilst creating a static website is relatively easy, our intention was to enable new content to be updated immediately to the website by the individuals who had first hand access to this information. Many of us do not possess web development experience or the time to learn and initially the solution lay again with Google Docs. Each Google Doc can published to the Internet as mini-website at the push of a button. It was possible to programme each page of the SESA website to mirror the text on each Google Doc. Any changes made to a Google Doc would automatically show up on the website.

Google Docs ran into some problems about a month or so down the line. For some inexplicable reason the SESA website pages stopped mirroring the Google Docs and presented the viewer with an error message. As the website was due to be presented to the SESA board a week later another solution was needed quickly. Further research revealed a programme (WebYep[4]) that could be incorporated into the website, again allowing individuals to remotely update the website with no previous web experience. The user simply adds text directly to each web page as though using a standard word processor.

Since completing this project, I have come to learn that there are other free Web Development Programmes available (e.g. Joomla[5]) that have the functionality of permitting users to update content remotely as part of the package. It may be worth looking at these options first rather than trying to piecemeal individual programmes together as we did.

Two more free resources used in the website worth mentioning are Google Calendar[6] and Google Analytics[7]. A SESA Google Calendar was created to track important events including courses, exams etc. The SESA website was then programmed to ‘show’ the Google Calendar on one of its web pages. This again permits new information to be made immediately available to trainees. Details of any event of interest can automatically be added to the users own on-line calendar.

Google Analytics allows collection of information on how the web site is used. The amount of information offered is huge but includes simple details such as the number of visits to the website, a breakdown of the pages viewed, the most popular pages, length of time spent per page etc. By using this information we are able to identify the pages used most and target them as the location for new content to be published.

The updated SESA website went live in August 2009. A trainee satisfaction survey was conducted after 6 months and showed that 87% and 84% of trainees rated the appearance and ease of navigation of the website as good or excellent. 97% viewed the website as a useful resource.

We hope that this article makes more individuals aware of this resource and encourages its use as the first port of call for information for both trainees and those with training responsibilities in the South East School of Anaesthesia. It aims to accommodate the interests of the large number of trainees in the region and if you feel that there are any improvements that can be made please email us your comments.

Working as a small team on this lengthy project and trying to identify free or low cost resources has been a very rewarding experience. We hope that by outlining our experiences we may encourage others to develop further resources to benefit our training. We would also welcome comments and recommendations from those with web development skills to help us continue to improve the South East School of Anaesthesia website.

Please note we are not promoting any particular system or supplier, just mentioning the ones we found and used. We have not received any external funding with regard to the setting up or running of the website.

References

Dr Giancarlo Camilleri
Anaesthesia trainee, London/KSS deanery
Email: gcamilleri@me.com
Tel: 07743 779487
20th National Acute Pain Symposium

Thurs 16th & Fri 17th September, 2010
Crowne Plaza Hotel, Chester

Just some of the Topics

- Extended release epidural morphine
- Tapentadol - a new analgesic
- Procedure specific pain treatment modalities
- Varicella vaccine in the management of varicella related pain
- Local anaesthetic toxicity
- Funding and the modern acute pain service
- Acute Pain & its Modulation : New research Directions
- Complimentary & Alternative Medicines in Acute Pain
- Spinal opioids

For details & bookings contact:
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Poster exhibition

This meeting is essential for doctors & nurses with an interest in Acute Pain Management

Registration Fees
Consultant/NCCG £ 345
SpR/SHO £ 275
Nurses £ 185

For every anaesthetist who has worked in the Anaesthetic Department at Guy’s or St. Thomas’ Hospital, before or after their amalgamation

Friday 5th November 2010
12:30 - 17:00
Scientific Meeting at St. Thomas’ Hospital
(Approved for four CPD points)

19:00 Drinks Reception
20:00 Gala Dinner
at The Honourable Society of the Middle Temple,
Middle Temple Lane, London EC4

Details from:
Diane Wallis, Anaesthetic Department,
St. Thomas’ Hospital
Tel: 020 7188 0652, Fax 0207 188 0628
Email: Diane.Wallis@gstt.nhs.uk
Dear Dr. Bythell

The proposal for a national anaesthetic record advanced by Dr. Richard Griffiths and Alex Goodwin (Anaesthesia News, February 2010 271, p.9) and the actions determined by Dr. Helen Hartley (Anaesthesia News May2010, 274 p.30) to undertake a national survey of anaesthetic charts with a view to producing a “National Standard” chart, should be strongly supported. However, I wish to point out that a “standard chart” has been available in Britain before. I refer to the “Nosworthy” chart of 1937[1] and 1963[2] to which I was introduced in the 1960s at Aberdeen Royal Infirmary. This defined the basic structure for most modern records, both paper and electronic [2,3].

At the recent Association of Paediatric Anaesthetists’ meeting in Glasgow in the section devoted to anaesthesia in developing countries, the observation was made that the companies who make equipment including recording systems concentrate their production developments on approximately 40% of the world population. It is improbable that the majority of the poor populations will be able to take advantage of their products in the foreseeable future.

However these patients deserve safe anaesthesia. Although they have little money, these countries usually have plenty of intelligent people keen to learn. To help them a simple well drafted anaesthesia record, to be completed by a second trainee while another administers the anaesthetic, would be a significant teaching tool. They would learn from observation of to the basic physiological data related to drug administration and surgery. Data collection and analysis using either the “low tech” Holerith system of the original Nosworthy record or a marginal data-coding system processed by commercial software could be incorporated. The record should be affordable, or better, free, distributed by the philanthropic groups who teach anaesthesia. Download from the internet would be another possibility. Optimising the anaesthetic record in the United Kingdom as Dr. Hartley proposes is a worthy aim but it should be global.

Ian Keith, MBChB,PhD,FRCA,
Department of Anaesthesia,
Saint John Regional Hospital,
Saint John, New Brunswick, Canada E2L 4L2

References:
1: Nosworthy, M D, Method of keeping anaesthetic records, British Journal of Anaesthesia 1943;18:160-179

National Anaesthesia Record

Following the brief article by myself and Alex Goodwin (Anaesthesia News February 2010 page 9), I have been approached by a number of organizations and individuals regarding the proposal for a national anaesthetic record. I am indebted to Helen Hartley, from St Thomas’ Hospital, who has been conducting a national survey of charts for her support. I do not intend to specify a national minimum dataset, but a national record that is the same in every NHS hospital in England, and maybe even Wales, Scotland and Northern Ireland. There would be a hardcopy and an electronic version.

With Council’s support, I have set up an initial scoping meeting that will be held at 21, Portland Place this Autumn. I already have a list of interested parties, but this meeting will be open to all who are interested in making this project happen. The provisional date of the meeting is October 15.

Contact me via secretariat@aagbi.org (marking the e mail for my attention) if you would like to contribute to this process.

Richard Griffiths
Council member

Dear Editor

ASA status – Is there uniformity in classification?

The introduction of the ‘WHO checklist’ has certainly made an impact in terms of communication with the team and also helping to know each other and work as an effective team.

One very interesting issue raised during the checklist process is the ASA physical status classification.

I was anaesthetising a patient with ovarian malignancy with pelvic extension. The patient had no other systemic illness and had normal exercise tolerance. She was listed for an elective palliative colostomy. This patient could be classed as ASA II (mild systemic disease) or ASA III (severe systemic disease). The surgeon then argued that the disease is a constant threat to life and if left alone complete obstruction, which would be life-threatening would ensue hence the classification should be ASA IV.

Looking at the ASA physical status classification,
ASA I – normal healthy patient,
ASA II – IV are all defined in terms of systemic disease (mild, severe and severe with constant threat to life),
ASA V – moribund, not expected to survive without operation,
ASA VI – declared brain stem dead, whose organs are being removed for donor purposes.

Most uncertainty arises while classifying ASA II – IV. It would be interesting to know what the ‘systemic disease’ term includes.

It would be interesting to know if other Anaesthetists have experienced similar arguments in this subject.

Dr.Avinash Aswath
Email: drpluspoint@doctors.org.uk
Specialty Doctor, University Hospital North Tees
Dear Editor

As someone who has always strongly advocated the early teaching of face mask anaesthesia to trainees I was delighted to see the cover photograph on July's Anaesthesia News. Imagine my dismay therefore when, on closer inspection, I discovered that the young lady charged with administering said anaesthetic had clearly missed the point. The angle of the patient’s head would indicate a marginal airway at best and, manifestly, no effective seal was being made. The verisimilitude of the tableau was further impaired by the absence of uncontrolled haemorrhage at the surgical site and the scrub nurse being at least 5 stones underweight.

“In order to be effective simulation must be as realistic as possible”.

Dr Andrew Stoddart
St Leonards on Sea.

Ed: Please read my reply in this month’s editorial

Dear Editor

As a journal purporting to promote good anaesthesia, could you please ensure that the cover photo looks more like a real anaesthetist in future? This month’s one has an obstructed airway (flexed neck, no attempt to use jaw thrust, the mask is leaking at the bridge of the nose and the hands are positioned in such a way as to show that it’s someone who has obviously never held a facemask or maintained a patent airway before.) Sorry if this sounds like a rant.

Dr. Ian Bishton,
Consultant Anaesthetist,
King’s Mill Hospital

Dear Editor

In response to Nicholas Akerman’s letter (Anaesthesia News July 2010), I too have experienced unexpected problems due to shearing of the LM airway connector. This occurred with the Intersurgical Solus single use LMA.

An elderly patient with no extensive past medical history was scheduled for fixation of her wrist on the trauma list. The anaesthetic plan was fentanyl, propofol and LMA. Fully monitored intravenous induction was followed by insertion of a size 4 Solus LMA. The mask was inserted without difficulty. However, it immediately became difficult to ventilate the patient. After a full systemic examination it became evident that this was due to a large circuit leak caused by shearing of the LM airway connector at the point where the soft tubing was attached to the rigid 15mm connector. This resulted in a major leak when the connector hinged backwards and the defect (around 75% of the circumference) opened up. The LMA was replaced and the patient went on to have an uneventful anaesthetic.

In total, there have been 5 reported incidents of this kind in our institution, including three size 2 LMAs and one size 1.5. The manufacturers, Intersurgical, first identified this problem in August 2008 and carried out an urgent review, discovering that this was due to a slight misalignment assembly jig. There was an immediate recall of Solus LMAs. The recent events at our hospital were therefore quite surprising. It was found that three of these LMAs were from the recalled lot number. They had not been supplied to the hospital directly from Intersurgical, but came from a supply warehouse. The warehouse itself had been supplied by two regional stores, which still had some old stock and had not been made aware of the initial recall eighteen months previously. This complex supply chain of equipment to one hospital highlights the difficulties with locating and reliably withdrawing stock. Despite efforts within hospitals to ensure the use of quality-assured equipment, this case illustrates the risks in equipment supply that may have a profound impact on patient safety.

I would suggest that, when an equipment recall is made that involves any patient safety implications, a thorough review of the complex supply chain is simultaneously carried out.

Helen Williams
CT2 Anaesthetics
Southampton General Hospital

Editor’s note.
This issue has been raised with the MHRA by the Chair of the AAGBI’s safety committee, Dr Andrew Hartle. A response will be published as soon as possible; meanwhile please do continue to report all equipment-related critical incidents directly to the MHRA, as well as via other local and/or national critical incident reporting systems at www.mhra.gov.uk
Portsmouth Airway Workshops

PAWS
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The course consists of a combination of lectures, skill stations, and practical demonstration working through the management of the anticipated and the unanticipated difficult airway, including human factors.

Suitable for both consultants and trainees, with places strictly limited to 16, to allow maximum practical experience in the workstations

**Workstations include:**
- Fibreoptic intubation
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Registration £175 (includes refreshments)
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9th Anaesthesia Conference
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Friday 1st October 2010: Three Parallel Workshops (5 CPD points)
- Advanced Airway Management workshop
- Ultrasound guided Regional Anaesthesia workshop
- Ultrasound guided vascular access, FATS, FAST, TOE simulator workshop

Saturday 2nd October 2010 Annual Scientific Meeting (5 CPD points)
Lectures, Debate, Free paper and Poster presentations
Other attractions include: Spouse and Children’s day out, Indian Banquet and Bollywood entertainment

The meeting is open to ALL Anaesthetists irrespective of their origins

Organised by
British Association of Indian Anaesthetists

Contact: Organising Secretary
Dr Ravi Hebbali, Consultant Anaesthetist,
Glenfield Hospital, Groby road, Leicester LE3 9QP
hebbali.ravi@hotmail.com, 07709570914
www.baia.org
Particles

Dissimilation in patients with myotonic dystrophy


This case report describes a patient with myotonic dystrophy whose care was compromised by what the authors describe as ‘dissimulation’: at her pre-operative assessment she mentioned the diagnosis but gave the impression that this was unconfirmed, and denied any symptoms. In fact, the diagnosis had been confirmed on genetic testing years previously and she was wheelchair-bound with significant respiratory compromise. The authors suggest that there is a general tendency for patients with myotonic dystrophy to deny their diagnosis and any symptoms which has been reported in the neurology literature. This may be a manifestation of CNS involvement in the disease.

This case report caught my attention because I saw a patient with myotonic dystrophy in the antenatal clinic recently. The patient’s flat affect, virtual denial of the diagnosis and of any symptoms left me uncertain about the diagnosis. When I obtained the relevant hospital notes it became apparent that as with the case reported above, this patient’s diagnosis was beyond question and she has symptoms and signs which are typical of the disease.

These days it seems that half the population is at least happy to be labelled as having some sort of disease; whilst this reverse problem is unusual. We should beware of this tendency and take it into account when assessing patients with myotonic dystrophy.

Strength of association between umbilical cord pH and perinatal and long term outcomes: systematic review and meta-analysis

Malin et al. BMJ May 22nd 2010 340, p1121 (online bmj.com (doi: 10.1136/bmj.c1471)

Umbilical artery blood gas sampling is widely performed following delivery. This recent meta-analysis confirms a strong relationship between low arterial cord pH and poor neonatal outcomes. This provides the delivery team an objective measure of a fetus’ response to labour and delivery; allowing its potential use as a surrogate marker for quality assurance on delivery suites.

Before delivery, if the fetus is deprived of adequate oxygenation, anaerobic metabolism predominates. Babies with limited metabolic reserve are ill equipped to deal with this hypoxic and acidic challenge, with short and long-term sequelae resulting.

The Royal College of Obstetricians have recommended cord blood gas sampling in problematic deliveries since 1993. In NICE’s 2007 intra-partum care guidelines, samples were recommended when “there has been concern about the baby in labour.” However, at that time there was “limited evidence that cord pH is a predictor of neonatal death or cerebral palsy.”

This meta-analysis pooled data from 51 articles for 481,753 infants. It aimed to find a correlation between cord gases and neonatal morbidity and mortality. They managed to show both. With significance they linked low arterial cord pHs to mortality, hypoxic encephalopathy, intra-ventricular haemorrhage, peri-ventricular leucomalacia and cerebral palsy.

Given this, the use of umbilical arterial pH can now be validated as a surrogate marker during intra-partum care. This has implications for research, audit, quality assurance as well as individual case management. It is still not clear which pH cut off (<7.0, <7.1, <7.2) is the most effective outcome marker but each has been shown to be correlated with outcome.

So what does this mean to us as obstetric anaesthetists? The evidence says we should take an active role as a key member of the delivery team to reduce the number of babies born on our units with a low cord pH.

Dr Robert Whittle, ST5 Anaesthetics, Newcastle-Upon-Tyne
The Final FRCA Examination & The Final FCARCSI Examination 2011

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I intend to sit the Final FRCA Examination (Please Tick)

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Is it me, or are hospital name badges getting more confusing by the day? Mine proudly and simply declares my role to be that of a “Consultant Anaesthesiologist”. Others identify the wearer as a “Staff Nurse” or “Domestic Supervisor” – all very clear and comprehensible. I have even come to terms with the badges that say “ST3 – Medicine”. My chum Buffy helped me translate this as “Registrars, only not quite as much bloody use as they used to be”. So far, so good. However, I imagine my surprise when I came across someone bearing a badge that announced that she was an “Extended Role Nurse Specialist”. I felt it my duty to accost the aforesaid badge-wearer and to ask her to explain what she did for a living. It appears that she was a nurse but that she was no longer employed to do any nursing. Instead, she was being paid to do something that doctors usually do. Specifically, someone had taught her to do colonoscopies, and she now spends all her time in some dark corner of the hospital peering up people’s bottoms. This set to me thinking about why someone who had trained to be a nurse, and most likely had been an excellent nurse, decided to put it all behind her and dedicate her life to the natal clefts of the great British public. It may have been because she found nursing boring. It may be because she gets paid more to delve between buttocks than to be a nurse. It may be because she perceives that doctors have a higher status than nurses, that she aspires to that status and therefore wishes to do things that doctors do. Or perhaps it is simply that she looks at what others do and thinks: “I can do that”. We are all guilty of this. Even I have, on occasion, seen little reason why I could not hare round a racetrack every bit as fast as that nice Mr Button. How hard can it be? Whatever the reason for this particular ex-nurse making the transition from bedpan-peddler to buttock-parter, there seems to be a lot of “role extension” going on these days.

Role extension is an interesting phenomenon, for it is only rarely a genuine extension of an existing role. More often, it is the adoption of a different role, most commonly that of a better-qualified, better-paid or higher status role within a profession associated in some way with that of the would-be extender. No one boasts of the extension of their role down the social, financial or professional ladder – extenders always seem to extend upwards. Therefore, nurses extend their roles not by doing things that other nurses do better or in a different way, but by doing things that nurses tend not to do - most usually things that doctors do. Role extension of this sort is not exclusive to medicine, as anyone who has had the misfortune to come across a “Police Community Support Officer” will know. They look like policemen, talk like policemen and do some of the simpler things that policemen tend to do. The hard fact is that they are not as well trained, well-paid or as proficient as proper coppers.

It is easy – and indeed very tempting - to say to extended nurses: “if you want to do doctor stuff, why not do the training and become a proper doctor?”. However, this oversimplifies the issue and belittles the often genuine desire of the extenders to better themselves while benefitting their patients. The truth is that within the craft of every skilled workman, there are tasks that are simple, tasks that can be made to look simple given practice, and tasks that are genuinely difficult. The simple tasks are very appealing to those with more ambition than training and, once the simple tasks are performed successfully by the role extenders, it is only human nature that they will seek to further extend their role towards more complex tasks that should really only be performed by the fully trained craftsman. The phenomenon of the ever-expanding role-extenders may derive in part from their original training in a closely allied trade. If you teach physics graduates to give simple general anaesthetics to fit adults, it is likely that they will be happy with this role. If you train ODPs to give straightforward anaesthetics, it will simply be a matter of time before they will want to do thoracic epidurals on small children undergoing open-heart surgery. This is terrifying. It is not without its potential dangers, and I am increasingly of the opinion that we should first look outside medicine when we seek someone to perform the simpler tasks for which we do not have the time, patience or doctors.

I will conclude by reporting a nightmare that I had the night after meeting the “extended nurse”. I was about to go on holiday and, after waiting excitedly in the Departure Lounge for what seemed an age, I was asked to board. At the top of the steps to the plane stood a man with peaked cap, epaulettes and stripes around the distal ends of his sleeves. This was evidently the man who would fly the plane to my chosen destination with confidence and expertise. As I shuffled towards him, I saw that he had a badge on his chest. It bore these four chilling words: “Extended Role Baggage Handler”. I screamed so loudly that I woke myself up.

Keep well, Victor