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When the Second World War ended in 1945 the economy of the United Kingdom was in tatters. A long period of austerity followed the end of the war, and food rationing even became more severe for a time and continued until 1954. Nonetheless the United Kingdom still had a vast Empire (including India) to govern and police, and the British dependencies were clamouring for their independence. Most United Kingdom politicians tacitly agreed that this should be granted as soon as possible.

The Indian sub-continent had well defined administrative and military structures, and independence was proclaimed in 1947, albeit with partition which initially precipitated mass migration and interracial strife. In many other British colonies and protectorates directly governed from London, military actions were fought by British forces in the two decades following the war against terrorists and insurgents to achieve stability before orderly transference of power. These campaigns included those in Palestine, Malaya, Cyprus, Kenya and Aden.

In addition the United Kingdom had Occupation Zones to govern in Germany and Austria, and contributed troops to the United Nations force in the Korean War (1950-1953). All these commitments meant that, despite the impoverished condition of the United Kingdom it had to maintain a large army, navy and air forces. The citizen-soldiers who had served so magnificently in the Second World War, and who were naturally anxious to get back to civilian life, were demobilised as soon as possible after it ended in 1945, leaving a small core of regular more senior officers and other ranks. The consequence was that the large requirement for more junior officers and men had to be met by the continuance (until 1963) of two years of compulsory National Service for all young men when they reached the age of eighteen. Male medical students, provided they were making adequate progress in their studies, were deferred until they qualified as Registered Medical Practitioners before being called up. Young women, whether medical (there were proportionately fewer of them in those days), or otherwise in the general population, were exempt from National Service. (1)
The medical branches of all three armed services were in a difficult position. Most of specialist clinical medicine and surgery during the Second World War was practised by experienced young and middle-aged pre-war civilian specialists who had gone into uniform “for the duration”, while those relatively few pre-war regular military specialists were absorbed into senior administration. The demobilisation of all these specialist clinical experts left a very real gap in provision for the armed services, and influenced the way young post-war National Service medical practitioners were deployed.

The recently registered male practitioner had several alternatives open to him. Firstly he could join the medical branch of one of the services immediately. Few of them decided to do this. Most were allowed to gain some experience in a six-month House Physician or House Surgeon appointment before joining up, but many were permitted to spend a further six months in a specialist department. The demobilisation of all these specialist clinical experts left a very real gap in provision for the medical branches of the armed services, and influenced the way young post-war National Service medical practitioners were deployed. The recently registered male practitioner had several alternatives open to him. Firstly he could join the medical branch of one of the services immediately. Few of them decided to do this. Most were allowed to gain some experience in a six-month House Physician or House Surgeon appointment before joining up, but many were permitted to spend a further six months in a specialist department. The demobilisation of all these specialist clinical experts left a very real gap in provision for the medical branches of the armed services, and influenced the way young post-war National Service medical practitioners were deployed.

University teaching hospitals were in a privileged position in the early days of the NHS. They were directly responsible to the Ministry of Health and were only tangentially involved with the regional hospital structure that was developing. For the moment little had changed since the introduction of the NHS so far as the organisation of the hospital was concerned. Although Consultants were now paid on a sessional basis by the NHS, instead of being honorary in the old system, in fact they only attended the university teaching hospital on two or three days each week, in order to conduct rounds of their beds, examine the patients and issue orders, to undertake outpatient clinics and, in the case of surgeons, to operate. They had appointments at other peripheral London hospitals that had private wings (St. Bartholomew’s did not) and they had their private consulting rooms in Harley Street with access to private nursing homes in the vicinity. I, as House Surgeon was responsible for my Chief’s patients twenty-four hours a day, seven days a week, for the whole six months, with only an occasional night off with permission and by arrangement for cover by another house surgeon, and a one week holiday. I was resident in the hospital of course, and my salary was £9.00 per month after tax (equivalent to about £160 today) plus keep. Between the Chief and myself in the hierarchy was the “Chief Assistant”. He was part-time and a much more superior being than even the old Senior Registrar. Again I was fortunate. Hosford’s Chief Assistant at that time was Reggie Murley, who many years later became Sir Reginald Murley, President of the Royal College of Surgeons of England. He was perhaps the most skilful surgeon that St. Bartholomew’s produced in a generation. He was at that time resuming civilian practice after a distinguished wartime career as a surgeon in the Royal Army Medical Corps (RAMC), and he had already been appointed as an NHS Consultant in a County Hospital in St. Albans. He was outspoken but approachable. He taught me much about basic surgery and the way to approach patients with consideration.

I had had little time for girls in my somewhat shortened undergraduate medical course but it was not long into my HS appointment that I developed a passionate admiration for a vivacious red-headed junior nurse. My devotion was initially from afar but, after I had received a supposedly anonymous Valentine card (I am now told half sent in jest) I became bolder. Our relationship began to blossom in time snatched in odd places around the Hospital between duties, and in the short periods of free time that I had available outside of it. I was not allowed in the Nurses’ Home, or my young lady in the Resident Staff
Quarters. It must be remembered that this was the era of Richard Gordon's *Doctor in the House*!

As my six months as a HS drew to a close, I decided that I needed more time to complete my courtship, for I knew that I had rivals. I therefore decided to opt for a further deferment from National Service to spend six months in a specialty. I applied for obstetrics, then considered to be the plum junior job, but was not appointed. However, I was offered anaesthesia. I had enjoyed my month as a student and had found the anaesthetists to be pleasant people and willing to teach. The Head of the Department, Langton Hewer, (the founder and for twenty years Editor of Anaesthesia), was also welcoming, as were the other senior and junior anaesthetists, so I accepted the offer. True, I was not yet minded to take up anaesthesia as a specialty; I intended to be a GP. However I thought that anaesthesia would be a useful sideline for a GP, but I had not realised the degree of specialisation that was taking place in the new NHS. However, I cannot deny that I really became an anaesthetist for the love of a lady. I have never regretted this eventuality for I have been well content with both choices!

I took up the post as the junior of the three Resident Anaesthetists working at St Bartholomew's in London on July 1st 1949. There were only three Residents because the Hospital buildings had suffered severe damage due to the bombing and consequently many special surgical departments, thoracic surgery and neurosurgery amongst them, were still evacuated to the old mental hospital at Hill End, near St. Albans, while the London site was being rebuilt and enlarged. Richard Gordon (Ostlere) was the Senior Resident Anaesthetist at Hill End at the time.

As it happens it was the end of an era. My principal duty was to administer the “black gas” (nitrous oxide, minimal oxygen and asphyxia) in the outpatient department for the manipulation of limb fractures and for dental extractions (including total clearances) as well as for incisions of various septic abscesses (antibiotics were not yet widely available). I joined my seniors in the operating theatres as often as I could and gave general anaesthetics for emergencies and caesarean sections on my own after hours. Thiopentone induction for inpatients was well established, but all patients, even thoracic cases, breathed spontaneously oxygen, nitrous oxide, ether and/or trichloroethylene, or oxygen and cyclopropane. Tubocurarine in small doses was used as an adjuvant to soften abdominal muscles in the spontaneously breathing patient. Spinals and other regional techniques were little used. This was well before the introduction of both halothane and the rapidly acting local anaesthetic lignocaine in 1956. When I returned in 1952, after two years in the Army (working on my own as the sole anaesthetist in the British Military Hospital in North Malaya) general anaesthesia had undergone a revolution. Professor Cecil Gray's Liverpool technique (tubocurarine paralysis with controlled ventilation), which was considered eccentric and even dangerous by my seniors at St. Bartholomew's in 1949, had been generally accepted. Most anaesthetists were vigorously “squeezing the bag” but mechanical ventilators had yet to be introduced. (1,2)

We three Resident Anaesthetists operated a rota system out of hours and at weekends. This gave me more time with my red-headed nurse, who was now working at Hill End Hospital. I bought a 1928 Austin 7 out of a small legacy left to me by a Great Aunt. We had many happy hours together in the Hertfordshire countryside. We became engaged, and had a wonderful Christmas in the Hospital, as was the custom in those days. However I joined the Army in February 1950. Initial training courses in Hampshire and London lasted until April and we managed to see each other quite often. However, there came a day when I left my tearful fiancée to join the *Empire Trooper* waiting at Southampton docks bound for Singapore.

I returned in February 1952 in another troopship, the *Empress of Australia*. To my great joy I saw my red-headed fiancée waving from the upper balcony of the old Ocean Terminal at Liverpool as the ship docked. We were married in August 1952. I was by then also wedded to the specialty of anaesthesia. My wife was my counsellor and support during the long ascent through the Registrar grades of the NHS and throughout my career as a Consultant, as well as in the twists and turns of our life together, and continues to be my loving companion in retirement.

**Thomas B Boulton**

President of the Association of Anaesthetists of Great Britain & Ireland 1984-1986

References


What is *Anaesthesia* News for? It was originally produced so that the increasing number of Association meetings and seminars could be listed outwith *Anaesthesia*, along with items about Association business. If you look at old copies of *Anaesthesia*, you will be surprised to see how much of the “core business” of *Anaesthesia* News appears therein. We have of course recently removed the seminars and events listings from the magazine and published them in a separate booklet, so it’s worth re-examining the question now – what is *Anaesthesia* News for? How many members would miss it if it wasn’t there?

This may seem a heretical question for the editor, of all people, to be asking. But I think that every so often, as with all things in life, it’s worth standing back and looking at what you do (our nursing colleagues call it “reflective practice”). *Anaesthesia* News as it has currently evolved is a multifunctional beast – it includes information from Council and Officers for members, and articles contributed by members. With due respect to my erudite Council colleagues, I like the latter best – as Forrest Gump said “You never know what you’re going to get”, and we’ve had some absolute crackers submitted over the years. We also have the adverts – easily overlooked, but it’s quite clear that many organisations consider *Anaesthesia* News one of the best media to get the information about their meeting to a wide audience. There is no doubt that *Anaesthesia* News gets a message out – when we started doing related articles a couple of years ago round about the time that nominations were open for Council elections, the numbers standing shot up. I hope that members perceive *Anaesthesia* News allows them to have a feel for what the AAGBI Council gets up to on your behalf. I know from speaking to my own colleagues that it’s easy for members not to realise all the things that go on, and I believe strongly that *Anaesthesia* News is the correct medium for Council to do this. The President makes his regular reports, and committee chairman will confirm that I’m regularly on their tail to get them to write about the aspects of AAGBI’s work for which they have responsibility.

What *Anaesthesia* News lacks is immediacy – I start assembling it two months before publication, and sign it off several weeks before it appears. I felt this greatly during last year’s fast-moving MTAS debacle, where *Anaesthesia* News was really unable to offer any useful information as events evolved. This often catches contributors out – I occasionally receive items referring to a specific event too late for it to be usefully included. So “News” is possibly a bit of a misnomer! The other thing that the wider anaesthesia community doesn’t always spot is the subtitle “The Newsletter of the Association of Great Britain and Ireland”. The focus is very much on the Association and its members, so occasionally I turn down items which are of more relevance to other organisations.

So much for the serious stuff. The thing that makes this editor’s job a joy is the arrival of an unsolicited article that is either genuinely funny (Rob Sneyd’s “Signal Flags” in November 2007, and Scoop’s cardiac arrest kit in August 2006 live in my memory) or revelatory, or unusual. I work on the principle that if it interests or entertains me, a significant number of you will probably be diverted also. I would like to encourage more of you out there to send articles to *Anaesthesia* News – I don’t want...
it to turn into an undiluted recitation of what Council has done. The chances are if you’ve done something interesting, or something has struck you as funny, at least some of your fellow anaesthetists will think so too. And the entertainment value of well-constructed jolly good moan should not be underestimated (a technique I frequently employ myself). Take Ivan Ezegas - he has turned the grind of working as a locum in the modern NHS into an entertaining tale, aspects of which we all recognise. So if you have something you would like to share with the wider anaesthetic community, please send it along to anaenews@aagbi.org. On my wish list is a couple more irregular pseudonymous correspondents (are any of you at a loose end following the demise of “Hospital Doctor”? and more interesting non-anaesthetic activity – remember the guys that made the Bollywood film?

I know how many members read Anaesthesia News – one of the things I didn’t realise when I became editor was how often I’d be buttonholed at meetings (usually in a good way!) about something which had appeared in its pages. I hope you care about what’s in it, as I do, and I always enjoy getting feedback – so let me know what you think. Anaesthesia News (like the AAGBI itself) doesn’t have a statutory function, so only exists because its readers want it to. I think a strong vibrant Anaesthesia News reflects a strong vibrant Association and membership, and with your support, we can continue to flourish.

This month we have the second instalment of Tom Boulton’s memories of the early years of the NHS, in which he reveals the rather unexpected reason that he chose to become an anaesthetist. Safety is always part of the Association’s core business, and Alex Grice from Exeter writes about the system in use in his hospital to monitor and minimise adverse events. On a slightly less serious take on the same issue, Scoop has identified many more uses for ultrasound in the practice of anaesthesia than you ever thought possible...

Hilary Aitken

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**ANAESTHESIA APHORISMS**

Submitted this month by John Asbury, Glasgow, Ramana Alladi, Ashton-under-Lyne, and Yoav Tzabar, Carlisle.

**Notice when the solo trainee surgeon suddenly moves into ‘hyperanatomical teaching mode’: it’s time to say Where did you say your consultant was?... and document it in your notes.**

**Always know the location of the nearest self inflating bag; if all else fails you can keep a patient alive on room air.**

**Be aware of the added precautions necessary when you are working solo compared with working with somebody else – and vice versa.**

**Keep your working area tidy, free of discarded drug packets, then you’ll know where to find your emergency drugs when the emergency strikes. It’s also makes it easier for somebody to help you in an emergency.**

**Never refuse a coffee break.**

**Nobody minds you not knowing the first time, but everybody minds you not asking.**

**When demonstrating a practical procedure to a new trainee: it takes 20 years of practice to make it look that easy.**

**Giving an anaesthetic is more an art than science. It is beautiful to watch a good anaesthetist at work.**
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2009 Congress Chair: Dr Matthew Fysh
Email: bsoaCongress@btinternet.com
Every time a patient is treated in hospital, they face a significant risk of harm related to the delivery of their care. Papers published in the 1990s consistently highlighted the association between medical errors and adverse outcomes for patients [1]. In the United States pressure to address this issue did not really exist until the Institute of Medicine published a report in 2000; ‘To Err is Human’ [2]. This report received florid attention from the government, the media and the public, and forced healthcare organisations to prioritise patient safety. In the United Kingdom the Department of Health published along similar lines in the same year. ‘An Organisation with a Memory’ [3] examined the scale of adverse healthcare events in the NHS and the systems available to ensure we learned from these errors. In producing a series of recommendations designed to address the lost opportunity to learn more effectively, this report served to reinforce the role patient safety now plays in the NHS. The realisation that one in ten NHS patients were harmed by the healthcare they received, and that half of these adverse events could be avoided through system change, was a sobering point – one that was hoped could catalyse a major change in the way we viewed patient safety.

Unfortunately when the National Audit Office reassessed the progress made in patient safety by 2005 (‘A Safer place for patients – Learning to improve patient safety’ [4]) it was clear that results were disappointing. Even though a culture of safety was evolving, there was little solid evidence that healthcare was any safer. National reporting systems were seen to be lacking, and the systems for analysing and learning from adverse events were underutilised. This lack of progress contrasted markedly with changes previously seen over a similar time-frame in what are now regarded as ‘highly reliable’ industries.

In industry, developing a ‘mindfulness’ in employees (i.e. employees having a constant concern about the possibility of failure), flattening the hierarchy in which they work, and operating in an appropriate environment have led to significant reductions in error. Healthcare aspires to similar reliability, but up until this point has not yet managed to define the steps necessary to achieve this. This has been further compounded by the lack of senior clinician and management engagement in this area. Many Trust executives and Boards have spent time focussing on financial pressures and target delivery until recently, and as a result in some trusts patient safety issues had a lower priority. However, several changes over the last few years have served to make the case for reducing avoidable mortality much stronger.

Hospital standardised mortality rates (HSMR) provide a simple and easily understood way to compare the safety of different healthcare organisations. These data have become universally available to patients and purchasers alike through organisations such as Dr Foster [5], and when combined with the patient choice agenda, provide a powerful impetus for Trusts to engage in improving patient safety. It is also conceivable that in the future purchasers will refuse to pay for costs incurred by adverse events occurring during an in-patient episode: this already occurs in the United States with some insurance companies. This
would create a huge financial pressure on Trusts with a poor record on patient safety and a high adverse event rate. The case for introducing change and placing patient safety high on the organisation’s list of priorities is therefore necessary not just for the patient, but also for the organisation. The question that naturally follows is whether you can improve the level of safety in your organisation, and if so how.

Work from pilot sites in the UK has shown that Trusts actively working on reducing hospital mortality can achieve a reduction of their HSMR by up to 20%, irrespective of where they started from [6]. This shows that it is possible to make significant improvements in your organisation. The HSMR is useful as a summary statistic but is not sensitive to rapid changes over time. The adverse event rate, plotted over time on a run chart, is better suited and can be measured with the aid of a ‘global trigger tool.’ Based on work arising from the Institute of Healthcare Improvement in the States and subsequently modified by the NHS Institute for the UK, the adverse event rate is calculated by checking through sets of patients’ notes selected at random.

In Exeter we use note reviews in one of two ways. Every month twenty sets of notes are chosen at random from a list of patients admitted during the preceding month. These notes are examined with the aim of counting the total number of adverse events that occurred. This can be extrapolated to give the adverse event rate per thousand bed days (ours is currently around 80 per 1000 bed days) which can then be plotted on a run chart to determine a median value over time. Changes that impact on patient safety should reduce adverse events and this should be reflected on the run chart by a drop in the median value.

The determination of the number of adverse events is helped by using the UK version of the global trigger tool[7]. Essentially this tool is divided into five care modules – general care, surgical care, intensive care, medication and lab results (table 1). Each module lists a selection of triggers which represent events easily detectable from clinical notes and which are commonly associated with adverse patient events. When a trigger is found, the notes are checked to see if an adverse event followed. Triggers do not always lead to an adverse event, and adverse events can occur without a trigger. However, using the trigger tool dramatically increases the detection rate and decreases the time taken to examine the notes. An example would be a patient on warfarin whose INR rises above five. In itself this is not an adverse event; however, if the patient starts bleeding as a result of a high INR then over-anticoagulation becomes an adverse event. When looking through a set of notes if you see a high INR in the labs section you can then look at the corresponding clinical section to see if any bleeding complication arose – triggers allow you to focus your attention without reading the whole case note from start to finish.

Note reviews are conducted by two people to increase reliability. Anaesthetists are ideal participants, as our speciality has had a strong safety culture for many years. As well as a strong belief in the benefits of controlling error we have a unique insight into both medical and surgical aspects of a patient’s care, and this has proved useful when conducting note reviews that include both these patient groups. In order to limit variation in the interpretations of the notes we limit the number of people acting as the second reviewer – this produces a more consistent data set.

In Exeter the notes are reviewed by two people - a consultant anaesthetist and a senior nurse/midwife. We have a team of five senior staff with backgrounds in intensive care, surgery, medicine, emergency medicine or midwifery and we cannot emphasise strongly enough the benefits of this approach. Each reviewer looks at the notes with a different perspective and together a better overall picture is created. Other centres also use pharmacists and physiotherapists with similar beneficial results. Looking at twenty sets of notes a month allows the adverse event rate to be calculated, and patterns may reveal improvements which may be undertaken, although information from mortality note reviews are more powerful for this purpose.

Table One

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<th>UK Global Trigger Tool</th>
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<td><strong>Module</strong></td>
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Mortality note reviews follow a similar process but are conducted in more depth. In the first instance a set of fifty consecutive deaths from about four to six months ago should be reviewed. Patients are initially categorised into ward or ITU admission, and active or terminal care [8]. In the UK very few (if any) patients are admitted to ICU for terminal care so this group contains very few patients. As an example, case review may reveal issues surrounding the application of ICU care bundles if a patient was admitted to ICU for active care but subsequently died. Similarly, reviewing notes of patients admitted to the ward for active treatment may reveal issues surrounding the timing of care (speed of diagnosis, not recognising deterioration), an inappropriate setting for care, poor medicines management (antibiotic doses missed, anticoagulation issues) or hospital acquired infections. This active ward group represents the majority of the patients we review in Exeter, and is likely to give us the best information for identifying interventions. When examining the notes, why the patient died, whether the death was avoidable, whether the care was of a high standard, whether any deterioration was recognised in a timely manner, must be elucidated. In this process a pattern or a recurring problem may be detected that requires an intervention. It is fair to say that a significant degree of interpretation is required with mortality note reviews (was this delay reasonable, was treatment adequate, was this response appropriate?) and having two people review the notes helps keep conclusions fair.

If this work is to produce tangible benefits there must be an avenue through which changes can be implemented. In Exeter we have set up a Patient Safety Group that is chaired by the Director of Nursing and attended by the Medical Director, Governance Manager, senior nurses, hospital consultants and the team working on the note reviews. This forum allows the information to be presented, discussed and plans for improvements made. The Patient Safety Group reports to the Trust Board through the governance committee, and also feeds information down to the directorate governance groups to enable a hospital-wide system of learning.

When the group was first set up it became apparent that much work on patient safety was already in progress within the Trust - on reducing hospital acquired infections, reducing hospital falls, recognising the deteriorating patient as well as the larger-scale investigations for major critical incidents. The group was therefore able to oversee this work, ensure the findings were distributed throughout the trust as well as co-ordinate new interventions arising from the note reviews. The group in Exeter has been active for six months to date, so is still very much in its infancy, but this system provides a mechanism to make real differences within the organisation as well as increase the profile of patient safety. With a higher profile comes an increased awareness of patient safety issues for all hospital staff and that will hopefully lead to further reductions in avoidable error.

Dr Alex Grice
Consultant Anaesthetist
Royal Devon and Exeter NHS Foundation Trust

References
5] http://www.drfoster.co.uk/Guides/

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
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12
Why should I organise a meeting?

Organising a meeting helps to develop and show personal skills. It involves discipline and organisation of time and resources, plus diplomacy and tact when securing speakers. It is extremely rewarding to see the successful fruit of your labours when a meeting runs smoothly and is appreciated by attendees, and it's always a good addition to a CV.

Where do I start?

You could either spot a “gap in market”: a target audience that is not served by currently available meetings, or approach organisers of an established meeting to volunteer your assistance as an apprentice.

By joining an existing faculty you will become familiar with the plethora of small yet important jobs which are necessary for a successful event. Such meetings will adapt and evolve content and structure with time, enabling you to play a more important role. The organisational teams of some meetings change yearly, allowing opportunities for new volunteers to get involved.

For a new conference to flourish you must plan your objectives carefully. Be clear in your mind who is going to attend (trainees, trainers, cross or single specialties) and what the content and format is going to be. There will be colleagues in your hospital (and certainly within your school of anaesthesia) who have experience of this, so try to enlist their help. Run your proposal by them; they should be able to offer support and spot potential flaws and problems at an early stage.

Venue

The venue has to be fit for purpose. Currently the yearly study budget entitlement for trainees is around £600 so if they are your proposed delegates there is little point in holding your meeting at a five-star hotel, however plush the surroundings. Any sponsorship acquired may allow you to obtain better facilities without stretching the trainees’ limited budget. Equally if you want to attract more eminent speakers it is probably not advisable to base the meeting in the local youth hostel with catering in the adjoining greasy spoon cafe.

The venue needs to have conference facilities capable of housing all the delegates with comfort and suitable audiovisual equipment. Other points to consider include accessible location, parking, accommodation and catering facilities. Most venues have a conference planner, and telephone or email enquiries with a follow-up visit help to confirm that this is the venue for you.

You need to plan accommodation if you intend to span several days. Again it needs to be tailored to your target group. It is helpful to have several options in differing price brackets; at a meeting attended this year in France, consultants stayed within the hotel itself whilst most trainees were in the adjacent apartments.

Educational Content

All anaesthetists are obliged to remain up-to-date and aware of developments in anaesthesia; the Royal College of Anaesthetists (RCoA) recommend that at least 50 Continuing Professional Development (CPD) points are achieved per annum. Independent organisers of meetings need to apply to the RCoA for CPD approval. This process needs to be COMPLETE before the start of the meeting. This means that your proposed academic programme needs to be available for scrutiny at least three weeks in advance.

The RCoA CPD system has been in operation since April 1995. The latest details can be found within the booklet “CPD Guidelines (Update 2005)” available on the website at http://www.rcoa.ac.uk/docs/CPD_guidelines.pdf

Once the academic programme is finalised, you need to complete the
CPD application form and return it along with two copies of the programme to the RCoA. It normally takes about two weeks for approval. Until this time you cannot advertise that CPD points are available for the meeting. As a caveat you must also be prepared to take an attendance record at your meeting: the RCoA can request a copy up to 5 years afterwards!

The programme will be meeting-specific. It is much easier to attract reputable speakers and quality abstracts if you have a well-respected educational faculty in place early. They will be a magnet for colleagues as speakers and will be proficient at selecting the best submitted abstracts should you be inviting presentations. You will need to establish a policy on meeting fees/expenses etc. If you have a limited budget then this should also be taken into account when inviting speakers from a distance.

Try to be multimodal in your approach to content. A mixture of lectures, small group discussions and tutorials will suit more people than a single approach. If you are appealing to trainees then consider a trainee prize. This encourages interaction between consultants and trainees - generating a more relaxed environment and encouraging introductions which may be mutually beneficial in the future. The possibility of an addition to a CV may swing the decision about which meeting to attend. Another possibility to increase participation is a ‘Best Trainer’ prize, voted for by the trainees.

Consider preparing an abstract CD of all meeting content which is made available to attendees. This serves two roles - it allows a searchable record of the meeting to be kept for later reference, and gives speakers a publication for their records. When asking for abstracts, specify the format and length you require; it will save you time later on.

You need to make your meeting sound interesting. If possible, expert and international speakers will act as a centre point from which you can expand. Ask them early. Their e-mail addresses can normally be found with a Google search or you can contact their stated place of work (found with their names in all publications). Negotiate terms with them; they should probably expect to provide two or three talks in exchange for their meeting fees and expenses - make sure you have made provision for their expenses in your budget.

Money

You need to set a budget and stick to it. Take into account all income and outgoings, then set an appropriate attendance fee. You need to choose how people are going pay for the meeting. The simplest way is to get an external company to collect funds electronically or over the telephone and have an agreed flowchart with them as to who needs paying. This takes away a lot of hassle; HOWEVER they will charge you and if it is a small meeting then it probably won’t be cost effective.

Handling the monies yourself is not without its pitfalls. One option is to set up a dedicated bank account and pay in fees as and when you receive them. You must be very careful about what you do with any interest accrued. If the money makes no interest there is no ethical/legal dilemma. You can set-up your meeting as a “not-for-profit organisation”; reinvesting the interest into the “community”. The other option is to declare yourself a charity; this is much more complicated as it necessitates adherence to a set of prescriptive rules. Seek advice from a financial expert early.

Many medical equipment and drug companies may be able to offer you a financial incentive for allowing them advertising space and time at your meeting. Approach them early (whoever arranges meetings at your hospital will have business cards for local representatives). The amount of remuneration available may depend on when your meeting falls within the financial year.

Advertising

Make the best use of any free publicity you can access: SpR training days, training school websites, school and hospital e-mail lists, the pub! Attendance is required to ensure adequate funds are received to run the meeting without a deficit, and also to ensure a successful meeting.

Don’t forget…

The small but important details such as e-mailing directions to the venue, printing attendance sheets and certificates, buying prizes and thank you gifts, all of which help your meeting run more smoothly.

Make sure you get a subjective peer review of the meeting by getting feedback from delegates. This can be done electronically by online survey programmes such as “limesurvey”, with requests for survey completion sent via e-mail. The results will allow you to shape subsequent events to better meet the requirement of your target audience.

After the meeting, whilst you’re busy taking that sigh of relief, don’t forget to write thank you letters to all involved. You never know, they might come back next year!

In Summary:

Educational meetings are vitally important for the progression of medicine. They fall under the umbrella of clinical governance allowing dissemination of knowledge, skills and attitudes to further promote the training of tomorrow’s healthcare professionals. However, they would not take place unless someone is willing to organise them. It Gets easier - the first one is always the hardest!

Dr R Broomhead & Dr E Shewry
GAT Committee Members
WSM LONDON
14-16 January 2009
QEI1 Conference Centre, Westminster

NOT TO BE MISSED!

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“What you really need to know about airway problems but have never been taught”

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“An excellent course”
“A very good framework to guide assessment”
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“Loved the patient orientated approach - it really made me think beyond the immediate problems”
“Varied experience of delegates generated a lot of discussion”
“Excellent course: most of which I am not taught in normal lists at work”
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Friday 5th September 2008

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For further information and booking please contact;
Mrs. Denise Morgan-O’Neill, Office and Information Manager
Email: adam.aintree@nhs.net Phone: 0151-529 5153
The “Society of Bariatric Anaesthetists” (SOBA) is a newly formed specialist society catering for the academic and professional needs of anaesthetists interested in the area of Bariatric medicine. The society aims to provide a forum whereby specialists in this area can communicate and exchange information and other relevant data. It will also provide a voice for those working within the speciality, representing their views and interests. SOBA will encourage the formation of research networks and provide guidelines for anaesthetising obese patients.

The Society of Bariatric Anaesthetists is the brainchild of Drs Nick Kennedy and John Cousins, both anaesthetists with a regular bariatric surgery commitment, who have recognised a need for a specialist society in this area.

SOBA is a non-profit making society, hosted by the AAGBI. The society will rely upon the AAGBI to provide both administrative and professional advice to the society in its set-up stage. Any anaesthetist interested in this field is encouraged to join us. There will be a low membership subscription fee of £20 per annum.

What will SOBA offer?
As a new society, this will be guided by the membership. Our initial proposal is to ask members to join and suggest things that they would like SOBA to get involved in. In the first instance, a closed email forum on doctors.net has already been set up, which is available to SOBA members.

The initial vision is to have input into the following areas:

<table>
<thead>
<tr>
<th>Educational Role:</th>
<th>Produce guidelines for anaesthetising obese patients. Teaching syllabus, educational aids</th>
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<tbody>
<tr>
<td>Wider teaching role:</td>
<td>Special requirements of obese patients in non theatre settings. (Resuscitation, obstetrics etc).</td>
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<tr>
<td>Quality and Standards:</td>
<td>Produce outcome measures; recommend minimum standards of pre/peri/post-op care and equipment for dealing with high BMI patients.</td>
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<tr>
<td>Research:</td>
<td>To encourage formation of research networks, and liaise with industry on research projects.</td>
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<tr>
<td>Publicity:</td>
<td>To provide a voice for those working in the speciality, and to represent their interests and views. Provide the media and other outlets with information and informed comments when required. Dissemination of information to members</td>
</tr>
<tr>
<td>Scientific:</td>
<td>To arrange and host national or regional scientific meetings of interest to members.</td>
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We would encourage interested members to make as many and varied suggestions as they wish to contribute to the society aims. Please contact us via email: sobauk@gmail.com or soba@aagbi.org

SOBA will provide a newsletter and information of interest to its members. We also aim to publicise meetings, courses and training events, both national and international.

We plan to have an initial business meeting at the AAGBI Annual Scientific Meeting in Torquay in September 2008. Following this SOBA will plan to host or assist in organising our first conference. We wish SOBA to be inclusive and non-hierarchical and to involve as many people as possible. Once we have a reasonable membership, we aim to start looking at other larger projects (standards, teaching, research etc).

At present we are administering SOBA as co-founders, and are keen to continue to do this. Other members who wish to get involved are most welcome. A membership application form is available via our email sobauk@gmail.com or soba@aagbi.org
“If you feed the children with a spoon, they will never learn to use the chopsticks”

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<tr>
<th>REMAINING MSA COURSES 2008</th>
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<tbody>
<tr>
<td>FRCA Primary Course (MCQ) Week</td>
<td>Aug. Sunday 17 – Friday 22</td>
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<tr>
<td>FRCA Final MCQ Course Week*</td>
<td>Aug. Saturday 23 – Thursday 28</td>
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<tr>
<td>FCARCSI Final E&amp;SAQ Weekend</td>
<td>Aug. Friday 29 – Sunday 31</td>
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<tr>
<td>FRCA Primary Viva Weekend</td>
<td>Sept. Friday 12 – Sunday 14</td>
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<tr>
<td>FRCA Primary OSCE Weekend</td>
<td>Sept. Friday 19 – Sunday 21</td>
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<tr>
<td>FRCA Final (Booker) Course Week</td>
<td>Sept. Sunday 21 – Friday 26</td>
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<tr>
<td>FCARCSI Final Viva Weekend</td>
<td>Sept. Friday 26 – Sunday 28</td>
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<tr>
<td>FRCA Primary Course (OSCE/Orals) Week</td>
<td>Sept. Friday 26 – Friday 3 Oct.</td>
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<tr>
<td>FRCA Final SAQ Weekend</td>
<td>Oct. Friday 10 – Sunday 12</td>
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<td>FCARCSI Primary Viva Weekend</td>
<td>Oct. Friday 17 – Sunday 19</td>
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<tr>
<td>FRCA &amp; FCARCSI Mersey Selective Week</td>
<td>Nov. Sunday 2 – Friday 7</td>
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<tr>
<td>FRCA Final Viva Weekend</td>
<td>Nov. Friday 21 – Sunday 23</td>
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For Details Assessments Application Forms

WWW.MSOA.ORG.UK

* This Course starts on the Saturday and ends on the Thursday for the convenience of those wishing to attend

The FCARSI Final E&SAQ Weekend Course
Friday 29th – Sunday 31st Aug.
Council Elections

The successful candidates in the recent elections to the AAGBI Council were:
- Paul Clyburn (Cardiff)
- Richard Griffiths (Northampton)
- Isabeau Walker (London)

They will take up their posts on Council at the Annual General Meeting in Torquay in September. Many congratulations to them, and the AAGBI Council would like to extend thanks to all candidates who stood for election.

Council Nominations for Executive Posts

Council’s nominees for Executive posts which become vacant this year are:
- Honorary Treasurer Elect: Ian Johnson (Inverness)
- Honorary Membership Secretary: Ellen O’Sullivan (Dublin)

These nominations will be put before delegates at the Annual General Meeting.

Peter Baskett memorial service

A Memorial Service for Peter Baskett, AAGBI President 1990-92, will be held in Bristol Cathedral at 1.30pm on Saturday 20th September, followed by a short reception at the Thistle Grand Hotel, Broad St, Bristol. All friends and colleagues are welcome to attend.

Captions are invited for this picture of the Honorary Membership Secretary. Already suggested by a Dr WHG (from well within the M25) – “Och aye, I thought the sign said ‘Ladies’.” The editor would wish to remind him that comedy Scottish accents should only be attempted by Scots.
Spinal anaesthesia has had its ups and downs clinically over the years and as the side-effect profile has improved, its popularity has risen. It is now considered a core skill, particularly in obstetric anaesthesia. This article looks at how it all started and also looks at the men involved in the early stages of its development.

The initial development in spinal anaesthesia was the production of the first local anaesthetic; cocaine, a natural substance isolated from cocoa leaves by a German chemist named Gaedcke in 1855. Twenty-nine years later (1884) Carl Koller, an Austrian, used this substance to provide topical anaesthesia of the eye; and in 1892 Carl-Ludwig Schleich described local infiltration anaesthesia. The presence of CSF was discovered by Cotugno in 1764, which he described as water around the brain and spinal column. Magendie, in 1825, then appreciated that this fluid circulated between the brain and spinal column. Later, in 1891, Quincke (who lectured Bier), described a standardised technique of lumbar puncture for release of CSF for diseases associated with increased intracranial pressure, such as hydrocephalus.

The origins of spinal anaesthesia are somewhat disputed and experts are often in disagreement. It comes down to two men, a New York neurologist named J Leonard Corning, and Augustus Bier in Kiel, Germany. What is not in doubt is that Bier performed the first spinal anaesthetic for a surgical operation (1898). But Corning, in 1855, whilst experimenting with the action of cocaine on the spinal nerves of a dog, accidentally breached the dura. This caused paralysis of the hindquarters, thereby performing the first spinal anaesthetic. Although he experimented on patients, he did not use this technique for any surgical procedures. One of his first patients was a man with “spinal weakness and seminal incontinence”. He described in detail how he performed an “interspinal” injection, injecting 60 minims of a 3% cocaine solution (or 111mg). Of note, he does not mention the backflow of CSF in his description. The man in question, while standing with his eyes closed, experienced some dizziness, but “no incoordination or motor impairment was discernible in his gait”. He left the office an hour or more after the injection and seemed “none worse for the experience”.

Given that he had no motor block despite the large dose of cocaine (Bier used 10 – 15mg), it is likely that in this case Corning performed the first epidural injection. In 1900 however, after Bier had published his first reports, Corning claimed to have performed “real spinals” with 10 minims of a 2% solution (approximately 12mg).

Bier performed the first surgical spinal on August 16th 1898 at 08:35 on a 34 year old patient who was “hopelessly riddled with tuberculosis in many parts of the body”. He had a “deep-seated tuberculous ulceration of the foot” which needed surgery. The patient had had many previous general anaesthetics but had reacted badly to them so was not keen to have another. Bier proposed “spinal cocainization” to him, which he accepted.

His patient was in the lateral position and he performed a lumbar puncture (Quincke’s technique) with a fine hollow needle. Schleid infiltration of the skin and deeper tissues made the procedure painless. After piercing the dura he removed an occluding wire, and injected 3 cc of a 0.5% solution of cocaine (15 mg). It is unclear how Bier knew what dose to give, as he mentions no previous
dosing experimentation. Lucky guess perhaps? Bier waited twenty minutes before testing the block. The patient felt painful stimuli only as pressure, and so Bier carried out the operation without any problems. Two hours later the patient’s sensation returned, and he vomited and complained of a severe headache, which was still present the next day.

Bier carried out another four operations under spinal anaesthesia, all successfully. One of the patients however, an eleven year old boy, did have a high block, who, when testing the block, felt nothing to pinprick apart from his head. His pulse remained “strong and regular throughout” so it didn’t appear that he had any major problems with hypotension. The rest all tolerated the procedure very well, but all did have problems to various degrees with post-operative headaches.

Bier was pleased that these patients had suffered no pain and no dangerous complications, but was perturbed that some seemed to have side-effects which were as unpleasant as those following general anaesthesia. So he decided to perform some investigations on himself. It is a common misconception that he performed it on himself first before trying it on patients.

On August 24 1898, his assistant Dr Hildebrandt attempted to give Bier a spinal anaesthetic. During the procedure Bier felt a brief twinge in his leg as the needle pierced the dura. The syringe did not fit the needle, so CSF poured out and he was unable to inject the cocaine. It is ironic that Bier’s first spinal resulted in some of the feared problems associated with this procedure, namely a failed block, transient paraesthesia and a post dural puncture headache (which lasted for nine days).

Hildebrandt immediately described a feeling of warmth in both legs. Bier proceeded to test the block; compared to the techniques we use today, the tests can only be described as brutal, and would certainly make your eyes water. A small incision in the thigh, a long needle pushed down to the femur, “crushing” the skin with toothed forceps, a burning cigar, strong pressure and traction to the testicles and a strong blow to the shin with an iron hammer!

In celebrating their success they dined, drank wine and smoked cigars; I suppose the only proper way to mark a momentous anaesthetic landmark. Funnily enough Dr Hildebrandt woke the next morning complaining of a headache and sore legs; I’m sure it wasn’t just the wine.

Dr Bier was remarkably astute when he hypothesised that it was the loss of CSF that lead to the headache. He also advocated the use of small gauge needles to minimise this leak. It is amazing to think that spinal anaesthesia was invented before orotracheal intubation (Franz Kuhn in 1901).

Augustus Karl Gustav Bier had a remarkable career. His other major breakthrough was introducing intravenous regional anaesthesia. This only really took off in the 1960s after his death when less toxic local anaesthetics were developed. It is obvious how two of his lecturers had influenced him; Heinrich Quincke lectured him in internal medicine and introduced the technique of lumbar puncture into clinical practice, Friedrich von Esmarch was a senior surgeon in the same institution and lectured Bier. He invented among other things “Esmarch’sche Blutleere” or Esmarch’s bandage, a necessity for performing a Biers block.

Apart from contributions to anaesthesia, Bier also contributed much to surgical forestry that are still being applied today, and also invented the spiked steel German helmet of WW1 “Stanlhem 1915”, after witnessing lots of head injuries and noting that the previous helmets were made of leather and so didn’t provide adequate protection.

Despite being a pioneer in anaesthesia he thought himself very much a surgeon, and once remarked “in America they have professional anaesthesiologists. Even in Germany this institution is often praised. I can’t think of anything more boring…”

Dr Chris Jones
SpR in anaesthesia
Epsom and St. Helier University Hospitals NHS Trust

5 Corning JL: Some conservative jottings apropos of spinal anaesthesia. N Y Med Rec 1900;58:601-4
6 Hinmerk WF: The centennial of spinal anaesthesia. Anaesthesiology Vol 89(2) August 1998. 500-506 (Contains a translation of Bier’s original article)
7 Bier A: Versuche uber Cocainisirung des Rückenmarkes. Deutsche Zeitschrift fur Chirurgie 1899;51:361-9
I have recently returned from a 6 month period of Out of programme training (OOPE) in Cape Town, South Africa. In submitting my report to the Royal College and reflecting on the incredible clinical and life experiences that I had been exposed to I realised the answer to “would I go through all the hassle, grief and expense of organising my time again” was resoundingly... “Yes”; but it could have been easier. The kind of experience I was looking for would no doubt appeal to other anaesthetic trainees. I hope the following account will give people an overview of what I was able to get out of my time and may be of some help to anyone considering a similar venture.

I was based in Cape Town for 6 months and spread my clinical time covering predominantly Obstetrics, Trauma and Paediatrics. I left the UK as I entered my final year of training and upon request in Cape Town I was slotted into the local registrar rotation for allocation to lists on a day to day basis. The rota consultants were great at giving me exactly what I wanted in terms of clinical experience and I was more than happy to help cover their occasional rota gaps. This actually gave me the opportunity to act up in a consultant role regularly in any subspecialty I felt comfortable to do so. As I was unpaid I did not have an on call commitment; but joining the anaesthetic team after hours and on weekends only increased my exposure to the kind of emergency cases I had come to treat.

The clinical side of my training in South Africa was second to none but there were certainly opportunities to fulfil other requirements of your CPD portfolio. Groote Schuur has close connections to the University of Cape Town (UCT) and a very active academic Anaesthetic department has a number of ongoing projects at any one time.
The weekly departmental meetings were always topical and discussions were always animated. Points were debated in a manner that was occasionally more assertive than my delicate English sensibilities were used to but always involved good humour and a great learning experience. There are also opportunities to spend time with theprehospital paramedics although I was told in no uncertain terms that there would be some places where my personal safety could not be guaranteed – so consider carefully! The Red Cross Air Medical Service operated out of Cape Town international and was keen to meet any willing volunteers; as were the local ATLS course organisers.

Outside work, anyone who enjoys outdoor life will fit in perfectly with both the anaesthetic department and general attitude to life. Cape Town has stunning (but very chilly!) beaches and a consistent wind from October to December which is perfect for budding wind and kite surfers. Table Mountain is an incredible sight that dominates the city skyline providing a wealth of walking, mountain biking and camping. Safaris and wine tasting in Stellenbosch are all readily accessible.

In organising a trip like this I certainly could have used some quite specific advice. Politics and bureaucracy in South Africa can make the whole experience before you leave lengthy, frustrating and expensive! The most important thing to do is to make your decision well in advance and have a good think about how long you can afford to be away. Getting a paid job in South Africa is virtually impossible unless you are there and in the right place at the right time so you have to assume you will need to support yourselves. My wife and I initially budgeted about £1000 per month to live on but in retrospect needed perhaps £200-300 more. We started saving about 18 months before we left. Factors such as living in a safer area and closer to the hospital put up the price but many things in Africa are a balance between cost and safety. We were there between September and March which is summer and so living was much more expensive but the weather obviously better – going over winter would certainly be cheaper. Getting approval from Groote Schuur anaesthetic department will involve sending a CV and being discussed in a departmental meeting. The process will have changed since I applied in 2006 but your programme director should advise you on paperwork required for your local training committee and Deanery as well as PMETB (the GAT handbook is also a very useful resource). The first thing I did was speak to the Royal College just to make sure what I was planning would in theory be counted towards my training.

It is important to think about what you want out of your trip and why it could not be met on your local rotation in order to justify your time out of programme - your local Programme Director should be able to point you in the right direction. Having cleared this hurdle you will need to start battling the South African bureaucratic quagmire and begin your application for registration with the Health Professions Council of South Africa (HPCSA). This will involve collating reams of official documents and the anaesthetic secretary in Cape Town was very helpful with this part of my application. You will need close to a year for this process to be completed and I would advise telling them you need the registration forms a month or two before you actually fly - because you will need to apply for your study visa which takes two weeks to process. The visa department will also need a £600 per person refundable deposit just to make sure you actually leave the country when your stay is complete!

You will need to organise travel insurance for your time abroad, and using the internet we found a policy covering both of us for about £270. Make sure you also have medical indemnity cover in South Africa. This was a simple phone call for me as I am covered by the MPS but other organisations may have different
rules. If like us you have a house then you may wish to rent it out, and that can often take time to organise. The period we chose to go - September to April - fitted reasonably well with the academic year in the UK so students are worth considering if the timing will suit them. Cape Town is not in a malaria zone but you will need to make sure all your basic Third World travel vaccinations are up to date. Our local GP practice nurse was helpful and could provide many of the jabs free of charge, so check with your practice before you go to an expensive travel clinic.

It was difficult for us to organise things like accommodation before we left because we had no feel for the city and how safe it would actually be. There are plenty of hotels and hostels to keep you going until finding a permanent place. A car is essential if you are staying for any length of time as public transport is not safe after dark and limited to “taxis” which go everywhere at 80mph and have regular horrific accidents. The car was an added cost but it can be done on a buyback basis, and although costing us just over £1000 was worth its weight in gold. For all the horror stories we heard about violent crime, we found that if you were sensible and savvy to the dangers, as you would be in any large city, you could avoid trouble - we can honestly say we never felt intimidated or frightened once.

Looking at what I have written now makes the whole affair sound expensive and difficult but if you give yourself plenty of time and are motivated then it is not so bad. Cape Town is a fantastic city in an amazing country and having gained invaluable clinical experience, taught on local ATLS courses and been involved in clinical research, made good friends with the locals and thoroughly enjoyed the outdoor life, my wife and I would certainly do it all again. An important message that we have both come back with is that working in the UK and for the NHS is not so bad compared to the living and working conditions there are abroad. It is easy to feel that the grass is greener elsewhere especially when the NHS and medical training seem to be changing so significantly. In taking a step sideways to both further my clinical training and gain a slightly broader perspective of what people actually have outside our culture and working lives we have returned with a refreshing positivity for careers within the NHS and life at home with family and friends. If you are in a position to take the plunge, you won’t regret it!
PRIMARY MSA COURSES

We are very pleased to broadcast that the success rate of Primary FRCA and FCARCSI candidates from our Primary Courses continues to be markedly in excess of the national average as is brilliantly illustrated by the fact that 91% of the candidates on the May OSCE/Orals Course went on to pass the exam. Our usual Pass Rate is somewhere between 73% & 87%.

“I passed the Osce/Viva on Monday 12th May, on my first attempt! I sincerely believe that this is in no small part thanks to you and your fantastic courses. I suspect you will retort and say, “Ah but you had to do the work...” and this is indeed true, but I firmly believe that one could work for an indefinite period of time and still not pass what is a capricious exam. The techniques which I learned at Aintree, along with the desensitising of the Magic Roundabout and in particular the OSCE practice were instrumental in my success, and worth every penny, so many thanks once again.”

“You were right on so many counts, including the effectiveness of a “charm offensive” and the need for some constructive bullshit, which seemed to do me well! The examiners were very pleasant and willing to help, even the more hawkish ones.”

“Just to let you know that I passed my Primary Viva/OSCE? I did the exam on Monday, and as I’m sure many people have already mentioned in previous years, the actual exam wasn’t a patch on the stress of the course! In fact, I think the course gave me a chance to get all the stress out of my system. Overall, I was well prepared for the day, and for everything I was asked. I am in no doubt that I owe this all to the course, without which I very much doubt I would have succeeded. Everyone at the exam was lovely, very encouraging and supportive.”

“You will be pleased to hear that I was successful. I would like to thank you so much for organising the Primary Viva Course, without it I doubt I would have been successful. I had one previous attempt at the viva in January, I think the main difference between then and now was my composure and confidence. Everything you taught on the course was true and I even enjoyed the OSCE. Thanks once again.”

“Thank you so much for your fantastic Primary OSCE and Orals course that you held at the beginning of the month. I am delighted to say that my first attempt at the Primary has been successful and that I am headed to ST3 as scheduled. This is due in no small part to your course. Although I was slightly sceptical that I would enjoy the day of the examination as you had promised, this was exactly the case! The examiners were friendly and encouraging and not nearly as interrogatory as the examiners in our Practice Vivas in Mersey. Many of the OSCE stations had been covered in the sessions at Aintree, and it was a bonus to be able to feel a bit more relaxed in those stations - especially those on History and Communication, as I felt confident that I knew what the examiners were looking for.”

“I was mindful of your comments on “pressure” and the relative unimportance of the exam in the grand scheme of things, and firmly agree with you. This, coupled with Mr. Fahey (Mike) and his positive comments made a huge psychological difference. I arrived at Churchill House with the attitude that I was going to pass, and I did.”

Further Appreciations
&
Details of All Primary Courses

WWW.MSOA.ORG.UK
Dear Editor...

Painful Music

The editorial "Don't stop the music" published in June 2008 reminded me of a funny music-related incident. A mother awaiting an elective Caesarean section was on the table. The spinal block was ready and the obstetrician had applied the drapes. In the background, a radio was playing music rather loudly. The obstetrician, raising his voice above the music, asked the usual question; "May I start?". As soon as I said "Go ahead", we heard Rod Stewart on the radio singing the words; "The first cut is the deepest. Baby I know, the first cut is the deepest ..."

Hearing this, the patient shrieked; "Oh My God!"

I was alarmed that my spinal block had failed till it transpired that the patient simply had a good sense of humour.

Prasanna Tilakaratna
Locum Consultant in Anaesthesia
Royal London Hospital

Not always harmonious

I agree with you that having the radio on is "generally a good thing", but three occasions when it was not are seared in my memory.

I had convinced a patient to have a spinal for a foot operation as he had previously suffered severe postoperative nausea and vomiting after a general anaesthetic. I told him he could listen to his favourite radio station during the operation, and he agreed. All was well until a lull in the music was broken by the surgeon's request for "Bone nibblers"...and the patient fainted. Had there been no music, the surgeon might have been more careful to curb his language while the patient was awake.

A frail anxious elderly lady was having a cataract extraction under local anaesthesia. None of us paid much attention to the music on Classic FM until the announcer said "That was 'March to the Scaffold' by Berlioz from his Symphonie Fantastique. Fortunately the lady was a little deaf!

The last occurred several years ago in our old Day Surgery Unit, while I was preoxygenating a young footballer for an arthroscopy. The local radio was playing old favourites - "Bye, bye Miss American Pie". The lyrics seemed innocent enough, until "This'll be the day that I die!" came on – while I rapidly induced anaesthesia! Shortly afterwards, two thousand miles away, many Americans did...it was 11th September 2001.

Dr Colm Lanigan
University Hospital Lewisham
London

Missing the music

We were surprised and concerned to read the editorial in the June issue of Anaesthesia News1. The editor seems to consider the ophthalmologist's choice of music to be a sufficient reason to excuse herself from the theatre during a local anaesthetic ophthalmological list. The AAGBI guidelines concerning intraoperative monitoring2 stress that monitoring standards for local and general anaesthetics should be similar, including the presence of the anaesthetist in theatre. We think this is particularly pertinent in eye blocks, which are mostly performed by anaesthetists, some of them trainees. We hope this is not a regular practice in the editor's hospital.

On a lighter note, perhaps the choice of music should be left to the patient as he or she is likely to be the most stressed individual in theatre!

Dr A Philip
Dr C Chandrasekaran
Harlow

References:
1. Don’t stop the music (editorial). Anaesthesia News June 2008, p 6-7

Editor’s reply: I thank the authors for their interest in my editorial. In common with many hospitals, our ophthalmic local blocks (now generally sub-tenon, or increasingly topical anaesthesia) are performed by the ophthalmologists, and many cataract lists have no anaesthetist assigned to them. The patients are monitored and have an anaesthetic nurse observing them throughout the case, in line with Royal College of Ophthalmology recommendations1. The eye theatre is within our main theatre suite, so anaesthetic assistance can readily be obtained if required.

The AAGBI guidelines state: “The same standards must apply when the anaesthetist is responsible for a local/regional technique...” (my emphasis).

Where’s the propofol going?

During a routine induction of anaesthesia recently, it was noted during injection of propofol that the syringe plunger was distorted, and that propofol was leaking past the seal – and hence not into the patient. As can be seen from the photograph, while the plunger position would suggest that approximately 50 mg had been administered, in fact only around 30 mg is not in the syringe. No abnormality had been noted while the propofol was being drawn up.

Fortunately a second syringe of propofol was close at hand, so a rapid switch was made and the induction continued uneventfully. Yet another thing for the anaesthetist to look out for during induction!

Simone Rowell
ST in anaesthesia, Paisley

More than just secretions……...

During my current position as an anaesthetist with Mercy Ships serving in Liberia, West Africa, I was a little shocked at what I recently found in a child’s mouth before extubation. Upon routine suctioning of the pharynx following a cleft palate repair, apart from the usual blood and secretions one normally retrieves, I was greeted by 2 intestinal roundworms (Ascaris Lumbricoides) each approximately 15 cm long.

Ascaris is one of the most common parasites found in humans and it is estimated that 25% of the world’s population is infected with this nematode. The worms are a potential cause of airway obstruction and it is worth considering this in patients returning from or living in areas of endemic parasitic infestation.¹

Nigel Barker, m/v Africa Mercy
Liberia, West Africa

13th National Acute Pain Symposium
Thurs 4th & Fri 5th September, 2008
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Ketamine in Acute Pain
Acute Pain in the Military Operational Field
A Painfully Big Problem (Pain in the Bariatric Patient)
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Gabapentin in Acute Pain
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Intensive Care Refresher
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This one day symposium will cover major areas of general Intensive Care.
Aimed at all Critical Care Staff – Consultants, Trainees, Nursing Staff: the national and international faculty will present:
- Mechanisms of lung injury in the Intensive Care
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“Changing Face of the NHS—what is the future?”
13th November 2008
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A Date for your Diary!

Topics includes:
- The Darzi Report
- “FAB & Speak”
- Revalidation
- Working Time Directives
- New Government Health Policies and its Impact on the NHS

A cross section of delegates at the 2007 Annual Conference

Trade Exhibition/Sponsorship Opportunities

There will be a small trade exhibition at the conference, located in the restaurant area of the college. Stands are available at a cost of £500.00 for the day.

AIM Trainee Prize Essay Competition

“15 Ways in which I would change the NHS”
No more than 1000 words. Please send essay to aim@aambl.com
Closing date: 14th September 2008
Anaesthesia and Ultrasound

From our correspondent
Scoop O’Lamine

Dr Ivan O’Brain was recently appointed National Anaesthesia Safety Champion following his successful campaign to ensure that ultrasound was introduced as a routine tool during anaesthesia. Until Ivan’s pioneering work in the NHS, ultrasound was largely limited to regional anaesthesia and central venous cannulation.

Ivan explained that following his two year £5m DoH project to describe the potential of ultrasound in perioperative safety, he had described a series of new uses of the tool which he hoped would become routine within the NHS following the recent NPSA “Must do within 6 months” notice. These are discussed below, but it should be appreciated that Ivan’s new concept of an anaesthetic room real-time MRI scanner which checks endotracheal tube placement and spinal needle placement may supersede some of the concepts described.

- Correct identification of the oral cavity. A simple scan starting from the nose can rapidly confirm visual clues that the patient is the correct orientation in the anaesthetic room and also that the mouth is positioned in the normal anatomical position.
- Confirm no air in bags of IV fluids.
- Confirm when antibiotic powder has dissolved in a glass ampoule.
- Diagnose death using an echocardiographic image of the heart.
- Scan journals for articles of interest.
- Image the anaesthetised brain to determine the level of MAC being delivered by the vaporiser.
- Differentiate between Bain and circle systems in the dark.
- Confuse managers by scanning their heads and playing scan from one of a hamster brain downloaded from the internet.
- Check whether coffee cup fluid-filled or empty

Dr Ivan O’Brain would be very grateful for further ideas that he could propose to the DoH for consideration.
Dr Ruxton wonders if the way the NHS is going predisposes to a schizophrenic frame of mind, where thinking is deeply disconnected from reality. He has recently come across several pronouncements from managers that seem to be so cut off from what is actually happening that he is concerned for the mental wellbeing of those who made them. As he knows one of the pronouncers, with whom he used to work and who then was the model of sense and sensibility, his concern is personal.

Many of Dr Ruxton’s readers will have been frustrated by the state of patients’ case sheets. Trusts seem unwilling to spend anything on paper records, because they will all be computerised soon, won’t they? Patients with long histories and multiple folders are not the only ones who suffer. Even single volume folders are merely piles of papers, with or without a buff sheet of thin card front and back, held together not by the plastic loose-leaf binder but by one or two thick rubber bands. The sheets inside are in no order at all, and inflated by voluminous ward records, fluid charts, records of patient’s possessions, “care pathway folders” and forms often with nothing written on them at all.

He does not blame the Records Department, they are as poorly staffed as any in the hospital, and while weeding out irrelevant papers and rebinding folders that have fallen apart should be a prime task, they are rushed off their feet just storing and retrieving the folders. So the following directive from the Management rather got his goat:

All staff please note multiple volumes of medical records MUST NOT under any circumstances be separated as to do so could result in a Clinical Incident.

Many Thanks
Medical Records Managers.

When important clinical, nay medico-legal documents like the anaesthesia record from a previous operation are likely to have been lost from a patient’s folder because of the chaotic state of the packaging, Dr Ruxton does not take kindly to such idealistic and patronising advice. Indeed, he yielded to temptation and replied thus:

To all Medical Records Managers.
All staff please note that medical records are no longer maintained, so that the folders are non-existent, the binding falling apart and the rubber bands holding them together breaking under the strain. Important papers, anaesthesia records, operation notes, discharge letters, are frequently lost.
This MUST NOT under any circumstances be allowed to continue; as to do so could result in a Clinical Incident.

Dr Ruxton
Dr Ruxton is suitably ashamed of himself, for satire is wasted on those whose perception of reality is impaired, but it did make him feel better.

But even more detached from reality was the recent decision of a senior member of our theatre management. Dr Ruxton paraphrases, as he has not read the original memo himself; he only sedated the theatre sisters who were expected to implement it. “List overruns are not an acceptable reason to cancel patients.” This came to a head when an unexpectedly difficult and major case, early in an all-day list, led to there being three more patients on that list at 5pm. Sister ran around theatres; senior nurses only run to fires or haemorrhages, “had been very busy”, scraping together a theatre team to continue as long as possible, as others had children to collect from carers and after-school clubs, or even just to go home to. That made an extension to 6pm possible but even that left two patients undone. The emergency theatre team were invoked, but quite rightly Dr Ruxton’s colleague, the consultant anaesthetist on-call, dug his heels in on behalf of our surgical colleagues, who had other urgent cases to deal with.

So the ‘manager on duty’ had to be informed. What they were supposed to do? Dr Ruxton has no idea – would their enthusiasm to get those patients their operations as quickly as possible be any greater than that of the surgeon, champing at the bit and eager to go on until midnight. Dr Ruxton was willing to “gas the suckers” as he has no children now, but who would pass the instruments? Theatre managers, maybe. Many have been theatre staff in their past, but they may not be recently experienced and anyway, no offer was forthcoming, so I’m sorry to say, these patients had to be postponed to another day.

Unfortunate, undesirable and most unsatisfactory from the patients’, or anyone’s point of view. But unacceptable? List planning is an inexact science, as are surgery and anaesthesia. We cannot and never will be able to plan as easily as a hotel can book rooms, or even as a clinic can book appointments. As a Prime Minister said when asked why things went wrong in politics, “Events, dear boy, events”. Things happen. And at the end of the day - literally, not in the clichéed sense - there may not be time to do every planned operation.

The emphasis on time limits for treatment, even non-urgent treatment, leads the public to believe differently. Recently, in Dr Ruxton’s own theatre, a major and unexpected bleed occurred that prolonged the operation’s duration three or four times and led to their transfer to another hospital and the intensive care unit. Dr Ruxton is delighted to report that the patient made a rapid and full recovery, despite an eight-litre blood loss, thanks to exemplary teamwork by all concerned. But did we receive the thanks of that patient?

Actually, Dr Ruxton did; the old boy was most thankful, but the letter of complaint from his family’s solicitor included as a contention that they had not been informed of the problem until four hours after it happened.

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Tel: 01642 854601  
PLACES ARE LIMITED
Today’s healthcare professionals are expected to keep up with the wealth of new knowledge created in their field on a continuous basis. The duties of a doctor include keeping “professional knowledge and skills up to date”. This presents clinicians with a considerable challenge, because it requires them not only to continuously read through a vast quantity of journal articles, but also to understand their quality. The Specialist Library for Surgery, Theatres and Anaesthesia (http://www.library.nhs.uk/Theatres/) aims to help with this task by providing a collection of relevant quality appraised resources. It is one of over 30 specialist libraries within the National Library for Health (http://www.library.nhs.uk), each serving particular areas of practice.

At the time of writing, the Specialist Library for Surgery, Theatres and Anaesthesia contains over 2,200 freely accessible guidelines, policies, reviews, reference documents and patient information resources. The collection is constantly added to and updated. Resources include National Institute for Health and Clinical Excellence (NICE) guidelines, systematic reviews from the Cochrane Library and records from the Database of Abstracts of Reviews of Effects (DARE) that highlight the strengths and weaknesses of effectiveness studies.
In addition, the library commissions guest editorials on topical matters. For example, ‘The SAS Anaesthetist’ (image 1), written by AAGBI Council member Ramana Alladi, highlights the role of staff and associate specialist doctors in anaesthesia. The library also publishes a series of mini topic reviews. These brief reviews, written by the library’s topic advisors, give a summary of the evidence surrounding an area of interest. Recent reviews include ‘Explaining the risks of treatment to patients’ and ‘Anaesthesia for day case surgery’ (image 2).

The team behind the library

The Specialist Library for Surgery, Theatres and Anaesthesia is managed by a team consisting of four lead clinicians plus a team of information specialists and librarians (http://www.library.nhs.uk/Theatres/AboutUs.aspx). The lead clinicians act as editors-in-chief for the subject areas of surgery, anaesthesia, perioperative management, and soon, critical care (see below). An external panel of stakeholder organisations ensures that the library content is relevant. There is also a network of topic advisors, who use their professional knowledge and expertise to provide advice on the quality and relevance of resources within their particular area of interest.

Our clinical leads:

Professor Mike Larvin
Specialist Library Director and Clinical Lead for Surgery

Professor of Surgery at the University of Nottingham, consultant general surgeon at Derby Hospitals NHS Foundation Trust and tutor for the STEPTM (Surgical Training Education Programme) Foundation at The Royal College of Surgeons of England.

Dr. Sue Harding
Clinical Lead for Theatres

Consultant anaesthetist at the University Hospitals of Morecambe Bay NHS Trust (UHMB) since 1996. Her specialist interests include obstetric and paediatric anaesthesia and the use of information technology to improve patient care and safety.

Dr. David Treacher
Clinical Lead – Critical Care

Sub-Dean of Teaching at the St Thomas’ site of Guy’s King’s and St Thomas’ Medical School. His career has been spent almost entirely within the field of critical care with an emphasis on respiratory medicine. He will represent the interests of all members of the critical care team as the library extends its scope into this field.

Dr. Ranjit Verma
Clinical Lead - Anaesthesia

Consultant anaesthetist at Derby Hospitals NHS Trust and a Council member of the Association of Anaesthetists of Great Britain and Ireland. Professional interests include obstetric anaesthesia and computing and technology in anaesthesia.

Expansion into Critical Care

During 2008 the library will be expanded in scope to include critical care. This will aim to help staff working in Intensive Care Units, High Dependency Units and Critical Care Outreach Teams, as well as critical care patients and their families. This development involves carrying out several stages previously undertaken when the library was initially developed, such as identifying interested parties and topic advisors. A meeting to identify the key themes and sub-themes of critical care to be included in the library took place in Derby on 31st July. If you have
responsibilities in the areas of intensive and critical care and are interested in contributing to the development of the Specialist Library in your field of practice, please email speclib@rcseng.ac.uk.

**Combining evidence and expertise**

“Good doctors use both individual clinical expertise and the best available evidence, and neither alone is enough” (Sackett et al, 1996)

The Specialist Library for Surgery, Theatres and Anaesthesia (and soon Critical Care) makes every effort to deliver the best available evidence to healthcare professionals in the perioperative field. There are also plans to harness the collective expertise of surgeons, anaesthetists, theatre and critical care staff and to provide a forum for NHS staff to network and share knowledge. The technology for these new features will be provided by the Specialist Library’s umbrella organisation, the National Library for Health, in the near future, and we hope that NHS staff working in theatres and critical care areas will join discussion groups. News on these developments will be available from the Specialist Library home page.

Mrs Steffi Sams and
Miss Polly Setterfield
Information Resources librarians,
Royal College of Surgeons of England
Ranjit Verma, AAGBI Council Member

**Facts and figures**

- Recently the library attracted over 10,000 unique visits per month for the first time.
- You can subscribe to the monthly e-mail list of new resources or one of the RSS feeds.
- Over 500 guidelines, 1,000 evidence documents and continuously increasing.

**References**


2 General Medical Council (2006) *Good Medical Practice*

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**John Snow 150th Anniversary Event**

When the Health Secretary, Alan Johnson, joined the House of Commons he was advised never to be seen in Soho, or in a pub before lunchtime. He ignored that advice on June 16th to mark the 150th Anniversary of the death of John Snow. Mr Johnson unveiled a blue plaque at the John Snow Pub in Broadwick Street, in the presence of many members of the Snow family, the John Snow Society and other interested groups. The plaque was sponsored by the Royal Society of Chemistry, whose President, Professor Jim Feast hosted the event and the event was held in conjunction with WaterAid, a charity that raises money and campaigns for clean water and sanitation throughout the world.

Although the emphasis of the day was on John Snow’s work on the cholera outbreak centred on the water pump in Broad Street, his pre-eminence as one of the first specialist anaesthetists was celebrated as well, particularly his administration of chloroform to Queen Victoria for the birth of Prince Leopold, heralding the social acceptability of obstetric anaesthesia. The event concluded with a toast to John Snow, taken, incongruously for the surroundings but in keeping with his teetotalism, in fresh, clear drinking water.

It was an honour to represent AAGBI at this event, and to present Mr Jeremy Pelczer, Chairman of WaterAid with a donation of £250 from the Association.

- The John Snow Pub is in Broadwick Street, Soho, London EC2Y 8BX
- Do you know of a famous anaesthetist from your area that might be commemorated with a blue plaque? If so AAGBI would like to know details.

Andrew Hartle
Many anaesthetists have an interest in Information Technology, as evidenced by the early emergence of an electronic form of the trainee logbook and organisations such as SCATA (Society for Computing and Technology in Anaesthesia), which has among its numbers some Council Members of both AAGBI and the Royal College of Anaesthetists. The rapid development of IT, including projects such as the Electronic Patient Record (EPR) was recognised as having a potential major impact on the working lives of anaesthetists everywhere in the UK.

These changes are viewed as so important that, rather than each organisation work on them separately, the Association and Royal College formed a Joint Informatics Committee two years ago, modelled on the system used for the Joint Committee on Good Practice (JCGP). In this way, matters relevant to anaesthesia can be managed in a joined-up way, with both Councils kept up to date. The committee has three members each from the two Councils, plus representatives from SCATA, the Group of Anaesthetists in Training (GAT), the regional advisers, college tutors and IOTA (International Organization for Terminology in Anesthesia).

The Chairmanship and administrative support for the Committee rotates between the College and Association every two years. Dr Keith Myerson of the College chaired the committee for the first two years, and after the last meeting in May, I took over as Chairman. AAGBI will support and host the Committee until 2010. Other AAGBI Council representatives at present are Professor Alistair Chambers and Dr Ranjit Verma.

It’s already clear that EPR, Payment by Results and almost every other development in the NHS that involves IT will need senior, united input from anaesthesia. The aim of the Joint Informatics Committee is to ensure anaesthesia’s voice is heard where it needs to be so we can mould events rather than react to them. Enormous amounts of public money are being spent on health IT projects; it’s vital that clinicians have input into these.

We’re particularly interested in hearing about successful local projects which could be rolled out nationally. Anyone with suggestions for IT initiatives, questions or comments is welcome to contact me via chloesmith@aagbi.org.

Andrew Hartle
Council Member AAGBI
Chairman, Joint Informatics Committee
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5-6 December – Nottingham

Critical Care
19 November – Hitchin

Chronic Pain
15 September – Hitchin

Ultrasound Guided Venous Access
31 July – Hitchin
11 September – Hitchin
13 November – Hitchin

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The two-day introductory course is designed to teach those who have little or no experience in the use of ultrasound in their normal daily practice. The course comprises of didactic lectures on the physics of ultrasound, ultrasound anatomy and regional anaesthesia techniques. The lectures and hands-on sessions will concentrate on the brachial plexus, upper and lower limb blocks.

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

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

Chronic Pain
The course is aimed at chronic pain specialists, or other interested parties practising in chronic pain medicine who have little or no experience of musculoskeletal ultrasound and who wish to obtain an introduction to ultrasound in chronic pain medicine skills.

Ultrasound Guided Venous Access
This one-day course comprises didactic lectures, ultrasound of the neck, hands-on training with live models, in-vitro training in ultrasound guided puncture and demonstration of ultrasound guided central venous access.

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