Helsinki
Declaration signed

Report from Baghdad
GAT: On-call rooms
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I have just returned from the European Society of Anaesthesiology’s (ESA) Annual Meeting in Helsinki; the ‘Helsinki Declaration on Patient Safety in Anaesthesiology’ was signed by the Presidents of the European Boards of Anaesthesiology and European Society of Anaesthesiology, and the Chair of the National Anaesthesia Societies Committee on behalf of the member National societies (including the AAGBI) at the opening ceremony of the congress on June 12th. We reproduce the text of the declaration in this issue. The original Helsinki declaration was developed by the World Medical Association and signed in Helsinki in 1964. It has provided a framework for research ethics since that time. That declaration was a very important landmark in the development of the field of medicine of the principles of respect for the autonomy of the individual, and as such its influence has extended far beyond the field of research and into the day to day practice of medicine. A continuing challenge for the research community, which has led to difficulties with the Helsinki declaration, is the pressure to apply differing ethical standards in less economically developed countries. Thus the continued conduct of placebo-controlled trials of treatment for HIV when an effective treatment was available in Africa, but not in the USA, led to a particularly contentious 5th revision of the declaration which was ratified by the WMA in 2000. The current (2008) version is not recognised by regulatory authorities in the USA, and the European Commission mentions the 4th revision. Let us hope, therefore, that the Helsinki Declaration on Patient Safety in Anaesthesiology will run a smoother course, whilst having equally important outcomes.

Do we need this declaration? You may read the declaration and conclude that you/your department are already meeting the standards which it sets. I think it is important in two ways; firstly, in this age of external regulation and revalidation it is important that we continue to strive to do better ourselves rather than to simply meet externally defined standards and...
this declaration is a grand statement of such intent. Secondly, we must remember that even within Europe there are stark inequalities in the delivery of healthcare, and this declaration may help those working in challenging environments to obtain the resources needed to deliver better standards of care. On both counts, it deserves our full support.

Of course, it may be that we in the UK have a pressing need to refer to the Helsinki Declaration sooner than I imagine - as I write, the first budget of our coalition government is keenly anticipated; it is widely assumed that ‘the public sector’ will pay dearly for our collective fiscal excesses. This is sure to mean that we are all striving to deliver efficiencies of one sort or another by the time you read this. Our clinical directors will be railing against the use of relatively expensive anaesthetic agents and equipment. This seems to me to miss the bigger picture; there is increasing evidence that overall outcomes of surgery may be influenced by anaesthesia; I learned or was reminded in Helsinki that not only should we be considering aspects which are familiar to us such as maintaining normothermia, infection control and so on, but also that variables such as intraoperative BIS values [1-3] and use of long-acting muscle relaxants [4] may have an impact. If this is the case, does it really make sense to consider spending on anaesthetic agents and equipment in isolation from that on other parts of the surgical ‘package’, and without looking at costs in relation to outcomes? I am not arguing for unlimited funding of anaesthesia, but we should beware of limited views of cost-benefit.

Of course, when reading Felicity Plaat’s account of her visit to Baghdad, all of this pales into insignificance. I salute her bravery in going, and that of all those working in such difficult conditions.

Happy holidays!

Val Bythell

References:
1. Monk T, Sainin V, Weldon CW, Sigl J. Anaesthetic management and one year mortality after non-cardiac surgery. Anesthesia and Analgesia 2005;100:4-10

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
This is my last President’s report before handing over to Dr Iain Wilson at the Harrogate Congress in September. More of the comings and goings of Council members later; the last two months have seen in-house staff changes as part of the new management structure developed by general manager Mrs Joanne Silver. These changes are designed to ready the AAGBI for forthcoming changes and challenges as we move into the next decade.

We are now in the summer months, an inevitably marginally quieter time for the AAGBI. By the time this is published we will have had the GAT meeting in Cardiff. At that meeting we are sad to see current Chair Felicity Howard and Honorary Secretary Sue Williams leaving. They have both made considerable contributions to GAT ensuring continued interest of UK trainees in the political side of specialty life. We congratulate Rob Broomhead as a worthy successor as GAT Chair. Our next major meeting is the Annual Congress in Harrogate for which Dr Richard Griffiths has put together an exciting and far ranging program. We are pleased to welcome the Presidents of the ASA(USA), ASA(Australia) and the CSA(Canada) to Harrogate. They will take part in the political forum at the meeting and then go on to attend the Common Issues Group meeting the following weekend.

There have been several developments since my last report. Two new ‘glossies’ have been published, one on Management and one on the Anaesthesia Team, reflecting some of the major changes which have occured in the NHS and our specialty over last few years. The Global Oximetry Project which the AAGBI has been involved in since the outset is coming to fruition. A manufacturer has been appointed and very soon robust, easy to use pulse oximeters will be finding their way to remote third world hospitals to improve patient safety, a truly remarkable achievement! Nearer to home the AAGBI Council has decided to throw its weight behind the development of a national Anaesthesia Record Form. This has been acheived in Wales but in the rest of the UK a mish-mash of different forms exists.

It is becoming increasingly difficult for all of us to get away to meetings these days. We are considering holding more scientific meetings over weekends, and we have given the go-ahead to invest in more video/audio conferencing facilities at 21, Portland Place.

The SAS committee along with the SAS group at the Royal College have produced a report on the current working conditions for SAS doctors up and down the UK. They leave much to be desired in some Trusts/hospitals and our colleagues at the BMA have been influenced by this report and are taking up some of the issues raised. Clinical Directors from around the country met at a meeting organised by ourselves and the Royal College. This was well received and covered a variety of issues including SPA time and PA/As. We may move to hold these CD meetings more than once a year.

Some of your Executive attended the European Society of Anaesthesiology meeting in Helsinki. Here the AAGBI held its own session on Patient Safety at the same meeting that the Helsinki Declaration on Patient Safety was signed. This is a document designed to bring all countries to an acceptable standard of patient safety in our specialty and draws much from experiences from developed countries such as our own. We would also benefit from the standards expounded because, clearly, much still has to be done in patient safety even in more advanced countries. Voting took place in Helsinki for positions on the National Anaesthesia Societies Committee(NASC) and we should congratulate Dr Geraldine O’Sullivan who was made chair and Professor Mike Wee who was elected to the committee. Other important meetings taking place during the summer are a meeting between officers of the Association of Surgeons of Great Britain and Ireland (ASGBI) and ourselves and meetings with the GMC and BUPA over a variety of issues all of which will be reported back to you in one form or another.

Finally I would like to thank all those on Council and Executive who have worked with me over the past 2 years, particularly Dr Les Gemmell as Honorary Secretary who has kept me ‘on the straight and narrow’ in exemplary fashion and to Dr Ian Johnston an Honorary Treasurer who lets nothing of financial consequence past him. Ian carries on as Treasurer but Les and myself demit office for Dr Iain Wilson as President and Dr Andrew Hartle as his Honorary Secretary. We wish them well. The only senior Council member leaving this year is Dr Ranjit Verma. He has made major contributions to the AAGBI. He is not lost to the specialty as he continues as Council member at the Royal College. We wish him all the best for the future.

On a personal note, the AAGBI remains financially secure with a host of exciting projects in development for the future. It has been a priviledge to be President of an organisation which I know will go from strength to strength in the years to come.

Dr Richard Birks
President
It does seem like an implausibly short time since the GAT committee was welcoming Felicity Howard as our chair. The revolving door to the office has however turned and it falls on me to fill her not inconsiderable shoes!

That “me” is Rob Broomhead, a year 5 SpR on the North Central London rotation. This is my 4th year on GAT, a 4th year in which I can hopefully build on the work and efforts of the last three. It is not an easy time to be a trainee anaesthetist, a fact of which I am acutely aware. The role of the doctor, let alone the anaesthetist, is at a potential crossroad of uncertain change. We can no longer assume that the endpoint of our training will be with the attainment of a consultant post; the numbers, both in terms of finance and workforce planning, suggest that for many of us this simply will not be the case. Trainees have long been conscious of the enlarging disproportion between CCT holders and new consultant appointments. The new hybrid conservative/liberal democrat government seems not to suggest any imminent change in direction.

EWTD continues to polarise opinions in a “marmite-like” fashion; although many suspect that it will have a detrimental effect on training should it continue in its current comportment, the evidence that this is currently happening in anaesthesia remains at best anecdotal. At the time of writing, a national report is being composed that summarises and will give our training will be with the attainment of a consultant post; the numbers, both in terms of finance and workforce planning, suggest that for many of us this simply will not be the case. Trainees have long been conscious of the enlarging disproportion between CCT holders and new consultant appointments. The new hybrid conservative/liberal democrat government seems not to suggest any imminent change in direction.

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We are one year further into national recruitment; one year into what is hoped will be a productive step forwards towards ensuring transparency, fairness and consistency within the ST/CT allocation system. I await your opinions.

More and more consultant posts are being advertised with less than the expected 2.5 SPA sessions assured. This is a worrying development; we can all point a crooked finger at consultant colleagues who do little more than recline in NHS chairs or contemplate cryptic crossword solutions in time allocated for supporting professional activity but equally, there are many more who use their sessions to good effect. Non-clinical responsibility is the quintessential differentiation between a consultant and a registrar; if SPAs are removed from job plans then we are in real danger of introducing a 2-tier consultant grade; a senior registrar post in everything except nomenclature. This is something that I feel personally very strongly about, an outcome that I will strive to avoid.

The GAT committee is misunderstood by some and actually derided by others. I firmly believe that all trainees need a forum for their opinions. The more input we receive, the more able we are to forward a representative viewpoint. We spend a great deal of time sitting on working parties, discussion groups and RCoA and AAGBI meetings so that trainees in the UK and Ireland have a voice; we work very hard to ensure that we are conspicuous whenever decisions are made that have a potential impact on trainees. The AAGBI website is an improving medium that allows us to return that information to you, so we will endeavour to keep it up-to-date and accurate as well as making use of e-mail lists as appropriate. It is all too easy to criticise and whinge. Unless you are doing something productive then you may as well be talking to a brick wall. Talk to us, we will try to help.

We are on good terms with the Royal College, contrary to some suggestions. I hope to reinforce the relationship so that the trainee influence can burgeon. The potential exciting birth of a satellite RCoA group will allow further cross-pollination of ideas and concerns.

Under the leadership of Felicity, and Chris before her, I have seen the GAT committee continue as the only truly nationally representative anaesthetic trainee group. Even the staunchest critic can no longer level the accusation of us being a London elitist clique; I’m one of only two left (and I’ve spent most of my life North of Watford Gap). No two chairmen are the same, nor should they be. All members of the GAT Committee are individuals with their own experiences, views and voice. As Chair it is my job to ensure that we work well as a cohesive unit, to facilitate effective team allocation to make use of our individual strengths. Anaesthesia has its house in relatively good order in comparison to many other, especially non-craft, specialities. I hope that this will continue to be the case.

Felicity, I wish you the best for the future.

Dr Rob Broomhead
GAT Chair
### The Mersey Menu

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For Information on all MSA Courses - msoa.org.uk
Helsinki Declaration on Patient Safety in Anaesthesiology

This is the full text of the declaration as signed in Helsinki on 12th June 2010.

The European Board of Anaesthesiology (EBA) decided to write this declaration in June 2009. The first draft was completed at the EBA autumn meeting, which was hosted by the AAGBI at 21, Portland Place later that year. Over the next few months the EBA in cooperation with the Safety Committee of the European Society of Anaesthesiology (ESA) produced the final version of this blueprint for patient safety in anaesthesia.

This document was launched at the opening ceremony of the ESA in Helsinki and at a session on the Declaration it was signed/endorsed by the WFSA, the European Patients Federation (EPF) and numerous other European societies including the RCoA and the AAGBI. Other healthcare stakeholders are welcome to endorse the Declaration and to join the EBA and ESA in their initiative in improving patient safety in Europe and beyond. The declaration represents a shared European view of that which is worthy, achievable and necessary to improve patient safety in anaesthesia in 2010.

The declaration recommends practical steps that all anaesthetists can successfully include in their own clinical practice.

To ensure the recommendations are taken up the EBA and the ESA have launched a joint Safety Task Force to put these recommendations into practice and it is envisaged that the declaration will be reviewed regularly.

We hope the Declaration may become a tool for continual improvement in standards of patient safety in European anaesthesiology serving the best interests of our patients.

For further information please refer to the article on the Declaration which is published here or online: tinyurl.com/helsinkideclaration

Please take time to read the Declaration which is endorsed by your society, the AAGBI, and if you have any comments or questions please forward them to me.

Dr Ellen O’Sullivan (eosullivan2000@eircom.net) Secretary/Treasurer, European Board Anaesthesiology/UEMS

BACKGROUND

Anaesthesiology shares responsibility for quality and safety in Anaesthesia, Intensive Care, Emergency Medicine and Pain Medicine, including the whole perioperative process and also in many other situations inside and outside the hospital where patients are at their most vulnerable.

- Around 230 million patients undergo anaesthesia for major surgery in the world every year. Seven million develop severe complications associated with these surgical procedures from which one million die (200,000 in Europe). All involved should try to reduce this complication rate significantly.
- Anaesthesiology is the key specialty in medicine to take up responsibility for achieving the goals listed below which will notably improve Patient Safety in Europe.

HEADS OF AGREEMENT

We, the leaders of societies representing the medical speciality of anaesthesiology, met in Helsinki on 13 June 2010 and all agree that:

- Patients have a right to expect to be safe and protected from harm during their medical care and anaesthesiology has a key role to play improving patient safety perioperatively. To this end we fully
endorse the World Federation of Societies of Anaesthesiologists International Standards for a Safe Practice of Anaesthesia.

- Patients have an important role to play in their safe care which they should be educated about and given opportunities to provide feedback to further improve the process for others.

- The funders of healthcare have a right to expect that perioperative anaesthesia care will be delivered safely and therefore they must provide appropriate resources.

- Education has a key role to play in improving patient safety, and we fully support the development, dissemination and delivery of patient safety training.

- Human factors play a large part in the delivery of safe care to patients, and we will work with our surgical, nursing and other clinical partners to reliably provide this.

- Our partners in industry have an important role to play in developing, manufacturing and supplying safe drugs and equipment for our patients’ care.

- Anaesthesiology has been a key specialty in medicine leading the development of patient safety. We are not complacent and know there are still more areas to improve through research and innovation.

- No ethical, legal or regulatory requirement should reduce or eliminate any of the protections for safe care set forth in this Declaration.

**PRINCIPAL REQUIREMENTS**

Today we pledge to join with the European Board of Anaesthesiology (EBA) in declaring the following aims for improving Patient Safety in Europe. Close cooperation between European organisations will be required to achieve these goals, for which the input and efforts of the European Society of Anaesthesiology (ESA) will be instrumental:

1. All institutions providing perioperative anaesthesia care to patients (in Europe) should comply with the minimum standards of monitoring recommended by the EBA both in operating theatres and in recovery areas.

2. All such institutions should have protocols and the necessary facilities for managing the following:
   - Checking Equipment and drugs
   - Preoperative assessment and preparation
   - Syringe labelling
   - Difficult/failed intubation
   - Malignant hyperpyrexia
   - Anaphylaxis
   - Local anaesthetic toxicity
   - Massive haemorrhage
   - Infection control
   - Postoperative care including pain relief

3. All institutions providing sedation to patients must comply with anaesthesiology-recognised sedation standards for safe practice.

4. All institutions should support the WHO Safe Surgery Saves Lives initiative and Checklist.

5. All departments of anaesthesiology in Europe must be able to produce an annual report of measures taken and results obtained in improving patient safety locally.

6. All institutions providing anaesthesiological care to patients must collect the required data to be able to produce an annual report on patient morbidity and mortality.

7. All institutions providing anaesthesiological care to patients must contribute to the recognised national or other major audits of safe practice and critical incident reporting systems. Resources must be provided to achieve this.

**CONCLUSION**

- This declaration emphasises the key role of anaesthesiology in promoting safe perioperative care.

**CONTINUITY**

- We invite anyone involved in healthcare to join us and sign up to this declaration.

- We will reconvene to annually review our progress to implement this declaration.

**DURING THE EUROANESAETHIOLOGY 2010 OPENING CEREMONY, SATURDAY 12 JUNE 2010, THE HELSINKI DECLARATION WAS SIGNED BY:**

Dr. Jannicke Mellin-Olsen,
President, European Board of Anaesthesiology/UEMS

Prof. Paolo Pelosi,
President, European Society of Anaesthesiology

Prof. Hugo Van Aken,
Chairperson, National Anaesthesia Societies Committee on behalf of the ESA Member Societies

**THE HELSINKI DECLARATION ON PATIENT SAFETY IN ANAESATHIOLOGY HAS BEEN APPROVED BY:**

European Board of Anaesthesiology Officers
   President: Dr. Jannicke Mellin-Olsen (NO)
   Secretary/Treasurer: Dr. Ellen O’Sullivan (IE)
   Vice-President: Prof. Seppo Alaluhta (FI)
   Past-President: Prof. Johannes Knape (NL)

ESA Board of Directors
   President: Prof. Paolo Pelosi (IT)
   Past-President: Prof. Johannes Knape (NL)
   Secretary: Prof. Andreas Hoeft (DE)
   Treasurer: Dr. Maurizio Solca (IT)

Non-Officer: Prof. Daniela Filipescu (RO)
Non-Officer: Prof. Charles-Marc Samama (FR)
Non-Officer: Prof. Robert Sneyd (UK)

NASC Chairperson: Prof. Hugo Van Aken (DE)
The APAGBI Linkman scheme is 5 years old and the national meeting returns to London for 2010. All APAGBI Linkmen are eligible to attend, but we welcome the participation of any grade of anaesthetist, including trainees, with an interest in paediatric anaesthesia.

The programme will include the following topics:

- Provision of paediatric services in a District General Hospital
  - What’s happened after the Tanner Report?
  - Innovation
  - Supporting the team

- Teaching and training
  - Website developments

- Professional standards
  - Peer review update

- Clinical conundrum – an opportunity to discuss management of common paediatric anaesthetic problems and the issues it raises in your practice

Registration fee: £150

Application forms will be available from August 2010 to download via the APAGBI website: www.apagbi.org.uk or further information, please contact: apa.linkman2010@aagbi.org / 0207 631 8804
Anaesthesia
August 2010

G. Cave, M. Harvey, G. Prince, D. Lahner and J. Desmet

Effect of hypertonic saline on electrocardiography QRS duration in rabbit model of bupivacaine toxicity resuscitated by intravenous lipid. *Anaesthesia* 2010;65: 792-798

Intravenous lipid emulsion has very recently, and very rapidly, become established therapy for bupivacaine induced cardiotoxicity. In this article however, Cave et al explore a potential modification of our now standard lipid emulsion treatment.

Speculating that as hypertonic saline can reverse the cardiodepressant and arrhythmogenic effects of bupivacaine via a mechanism different to that likely for intravenous lipid, then combining treatments may be cumulative. They examine return of spontaneous circulation and haemodynamic and ECG parameters in rabbits, during lipid emulsion resuscitation with and without hypertonic saline. What did they find? Well they found an early benefit, which may indeed be important in initial resuscitation. Early ECG QRS prolongation was less at 9 min with lipid plus hypertonic saline, compared with lipid alone. This effect wasn’t there however at 20 min. The authors didn’t see any differences in the rates of circulatory return or survival.

The authors are careful not to over claim. They admit their work is preliminary, it wasn’t powered to show differences in survival, or rates of circulatory return, and it is of course in rabbits. This is a balanced article with an initial encouraging finding and the authors are already pursuing further work on the back of this. We can only be interested in any further results they produce.

A Chakladar, S. M. White

Cost estimates of spinal versus general anaesthesia for fractured neck of femur surgery. *Anaesthesia* 2010;65: 810-814

In an NHS facing ‘efficiency savings’ or dare I say, cuts, then this sort of article is interesting and timely. Chakladar and White take one of our commonest operations, that of repair of fractured neck of femur and ask which is cheaper, general or spinal anaesthesia. They tell us that in 2005, in the UK, we spent £864 million looking after our patients with fractured neck of femur. Can we as anaesthetists help reduce this colossal bill?

This work was a theoretical exercise. Chakladar and White asked 20 consultants what they would normally do and costed their recipes out as carefully as they could. They went as far as costing ECG electrodes. They used their hip fracture database to calculate mean anaesthetic and surgical time and calculated personnel costs as accurately as possible from that data. Spinal anaesthesia came out tops in this financial head to head. Per case, in Brighton, spinal anaesthesia will save you £80 compared with general anaesthesia. I expect this result will translate quite readily to most of the rest of the UK.

The authors freely acknowledge the weaknesses of their study; it is based on questionnaire and retrospective database analysis. There are also things such as the fractional cost of monitors that aren’t included. I think they have, however, made a credible attempt at estimating costs.

Rather depressingly, the authors point out that the relative cost of anaesthesia for patients undergoing hip fracture repair was only 3.8% of the Payment by Results revenue received, so that cost savings in anaesthesia won’t have much financial impact. The largest cost was personnel, at 46% of total cost and a cost that is difficult to reduce. Trauma is meant to be led by senior personnel. In spite of this, in the current financial climate we are all expected to try and reduce costs. Chakladar and White argue that if spinal and general anaesthesia are broadly clinically equal, then cost must be a consideration. Spinal anaesthesia saves the NHS £80 per case.

JE Hall Editor, *Anaesthesia*

NHS operating framework revised by the new government

Most of you will be aware of changes to various NHS targets and ‘vital signs’ made by the new government. It might be worth checking out the details which are set out in this document, which was published on the 21st June. The revisions outlined include:

- Abandoning the 18-week target in favour of performance-management of median waiting times
- Revising the target for 4h wait in A and E downwards from 98% to 95%
- A commitment to publishing detailed performance data online (as part of the strategy to link payments to quality)
- An intention to ensure that hospitals are responsible for patients for 30 days after discharge

Emergency Medicine – the anaesthetist’s perspective.

The Referral

A referral is a request for help. Although it may not seem like it, many patients that could be referred are not, with more experienced emergency medicine physicians having a good understanding of what constitutes an inappropriate referral. The question we should be therefore be asking is “why this one?”

As any reader of the House of God[1] or the NHS Plan[2] will know, every patient must have a route out of the emergency department. It is also the case that protocols and guidance exist for management of the critically ill patient. So when a 97 year old fully dependant man with metastatic malignancy presents with four organ failure and the medical registrar refuses the patient on the grounds he should be first seen by intensive care (and he is too busy to phone himself) the A&E doctor has little choice but to make the referral, sure of the response it will get. It is beyond the scope of this piece to analyse the motivations of the medical registrar but hard though it is I would commend you to not shoot the messenger.

A source of confusion for emergency medicine departments in larger hospitals is how to contact the right person for the task. Anaesthetic rotas are full of codenames, with various doctors having different expertise. When the ICU resident is called, an F2 doctor may appear whereas in fact the patient may urgently require the help of the maternity anaesthetist who has greater experience. We must make the process of finding the appropriate doctor as straightforward as possible so that time is not wasted on the telephone and interventions can be timely.

Making Friends

Staff in emergency departments are used to dealing with doctors from all specialties, and they quickly get to know who is helpful and who is not. A shift often begins by finding out who is ‘on’ for the various specialties, anaesthesia included. Just as we may have an opinion about a particular emergency physician the reverse may also be true. So play nicely.

Emergency medicine nurses are required to have a large skill base, but they are not ICU nurses or ODPs. Whilst many are very good at caring for the sick patient, others may not have ever seen a rapid sequence induction; they may be unfamiliar with the process and therefore feel out of their comfort zone. I observed anaesthetists who felt anxious due to an unfamiliar environment working with nurses who were anxious with the process. The meeting of these anxieties sometimes led to conflict. Simple recognition of the pressures associated with unfamiliarity and the confidence to voice these concerns appears to diffuse the situation greatly, always to the benefit of the patient.

A common complaint amongst anaesthetists is that the team disperses on our arrival. We are fortunate in the support we receive in anaesthesia and ICU, and we must be mindful that the emergency medicine department does not stop simply because a sick patient has arrived. Rightly or wrongly, everyone else must still be processed within four hours and it is dangerous to assume other patients can continue to wait unless they have been seen and assessed. Resource allocation is vital to keep the department running, and the arrival of the anaesthetist as a resource may well allow for the release of an A&E staff member. Importantly this is not an excuse for poor handover or team working, and the constant presence of the emergency medicine team may well still be required.

A smile and an introduction goes a long way when arriving in the resuscitation room. The team responds well when the anaesthetist involves them in their thought processes, particularly when choosing not to take the expected course of action. If time allows, any de-briefing which can be offered will help avoid mistakes in the future.

A&E Registrar

Without a doubt, my job is very different to that of the emergency medicine registrar. Their role is much more managerial in nature than in mine, having responsibility for keeping the department running smoothly at all times, as well as dealing with difficult patients and outside agencies such as the police.

The emergency medicine registrar must support and take responsibility for the decisions of juniors who may have no desire to work in emergency medicine in their future careers. So far we have been
largely protected from this in anaesthesia, but with the increasing involvement of anaesthesia in foundation programmes and basic training for other specialties, we could learn from emergency medicine how best to motivate such trainees.

Emergency medicine registrars work busy and antisocial shifts without respite for the duration of their training and understandably have little sympathy with the grumpy anaesthesia registrar who has been woken at 3am. Finally, if the emergency medicine anaesthesia registrar who has been woken and antisocial shifts without respite for the Emergency medicine registrars work busy motivate such trainees.

We meet, my anaesthetic supervisor and I, in her office on the morning of day one. Her office was a very large room with numerous ‘hot’ workstations, light and airy and filled with consultants eating breakfast and planning their day ahead. Comparing this to the small, airless offices of the emergency medicine consultants; isolated and dotted along a nameless corridor away from the main department, I started to realise that anaesthetics may be a very different speciality.

I was given my rota for the next few months. I was to start gently, with lists involving a high turnover of patients needing predominantly LMAs, gradually moving onto those needing ETTs and finally spending my last few weeks working in the emergency theatre where most of the rapid sequence inductions would take place. There was the option to attend the emergency department with the on-call anaesthetic team if I was free, but the bulk of my time would be spent in theatres. I would always be shadowing and supported by a named consultant. I looked at the rota, stunned. For the first time in (probably) eight years I knew where I would be and what I would be doing for more than a week in advance. Of course we have rotas in emergency medicine, but they are a rather moveable feast. Often you are phoned at short notice because of illness/the weather/some unseen disaster meaning “we need your help”. Even when I am working, I don’t know what the day will bring. Sometimes the morning involves simply supervising the juniors and making sure everything is running smoothly. On other days I have barely been able to get changed before spending all day in resus. And yet, here I had a rota which told me exactly what I would be doing and where I would be at any given time. Furthermore, my supervisor had taken the time to ensure that the lists I was assigned to were relevant to my needs as the secondment progressed. I started to envy the anaesthetists with their open-plan offices and their well-planned rotas. This was a very different speciality indeed.

Anaesthesia – the emergency physicians’ perspective

A Very Different Speciality

My knowledge of anaesthetics was practically nil. I had started my training at a time when the thought of a “casualty doctor” undertaking an RSI was frowned on and so my junior training had no anaesthetic component. I could intubate an arrested patient during a resuscitation, but the actual nuts and bolts of how to sedate and paralyse someone were a mystery to me and I was a poorer doctor for not knowing. Over the next few months I was shown the art of the anaesthetic. The books talk about doses per kilo and formulae, but it became apparent that no two anaesthetics are alike because no two patients are alike. I also realised that no two anaesthetists are alike; one opting for a slightly different mix of drugs and doses than the last. I even spent a morning with a consultant who had me manually ventilating all the cases because (he said) they were such short cases that it wasn’t worth the trouble attaching them to the ventilator. I still don’t know whether he was testing me or whether if I hadn’t been there he would have bagged them himself.

I learned about the pharmacology of anaesthesia, about its relative contraindications, about how to hold the damn bag correctly. I learned about PEEP, about the benefits of the Mapleson-C circuit and about how to extubate safely. I learned and applied more physiology and anatomy than I had at any point since medical school. Perhaps the most important lesson I learned was patience. Time in the ED is a commodity in short supply; the “golden hour” in trauma, the 4-hour target we all work within. Because of these time pressures I had lost the ability to be patient. My time in theatres made me relearn this skill; be patient while everything is set-up for the next patient, be patient while you check all the kit and equipment, be patient to ensure that the equipment is to hand before you start, and be patient while the suxamethonium works. Clearly there is a need to be expedient, but I learned the art of controlled and patient working. I was told while working in theatres “do something once and do it well”. I still work within that one simple tenet and I am a better doctor for it. And all the while I was travelling up this steep learning curve I was being supervised by consultants taking the time to show a “non-anaesthetist” the inner workings of their speciality.

...And Then To Theatre.....

And So To Theatre.....

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...And Then To Resus

On a few occasions I shadowed the anaesthetic on-call team. Here I learned first-hand the frustrations of being on-call in anaesthesics. Where the theatre was a place of relative calm, being on-call was fundamentally different. Most calls were relevant and we cracked-on without a thought. There was also a large minority of referrals which should have been handled better, and these fell into two extremes. There were those ward patients who had been allowed to deteriorate over days or even weeks before reaching some critical physiological point and someone making a
referral. There were also those patients (usually in the emergency department I have to admit) who did not need an anaesthetist but because they were pretty sick “we should ring one in case we need one”. More often than not the latter group got better because of the good treatment they received, and the anaesthetist was “released” without ever having to offer their expertise. The frustrations of both these scenarios should be obvious to everyone, and yet those referrals kept coming in.

Rapid Sequence Induction

A contentious subject which neither of us could avoid is whether Emergency Physicians should be taught to undertake a rapid sequence induction. The ability to maintain an airway in anyone who comes through the door is fundamental, but this doesn’t mean everyone needs a rapid sequence induction. We both appreciate however the rare situation where time or circumstance means the emergency physician may need to undertake an RSI, and feel it is therefore right that this skill is taught. It is also our opinion that such skills should be maintained and subject to a governance process. To say more would be to dig a bigger hole – few people sit on the fence with this issue!

In Conclusion

We doubt that anything we have written will change the world, but think it is useful from time to time to consider how other specialties work, and the motivations behind our stereotypes. We each observed the advantages and the frustrations of working ‘on the other side’ but neither of us would wish to change places permanently. Neither would we pretend that a brief secondment is sufficient to allow us the competence of those working in that environment on a daily basis.

* In the novel by Samuel Shem about an American residency, the 5th Law of the House of God is that “Placement comes first”

References


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4-7 October 2010
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On Call Rooms

Mike MacMahon on behalf of the GAT committee

One of the many concerns expressed by members of GAT in this year’s Annual on-call survey was the absence or potential loss of on-call room facilities. It is an everyday occurrence to hear members of staff question the trainee anaesthetist’s right to an on-call room – “you work a shift, you shouldn’t be sleeping” or “if you’re being paid to be here, you should be doing something useful - like audit”.

Unfortunately there is no legislation to protect rest facilities for those of us who work a full-shift pattern. What I hope to explore in this short article are some of the arguments as to why on-call rooms should be maintained. Instead of pushing to remove on-call rooms, a forward-thinking organisation would protect them and thereby protect their best asset - their staff.

What are the contractual rights of doctors in training in terms of access to on-call rooms?

A collaboration of NHS management, postgraduate deans and the British Medical Association (BMA) Junior Doctors Committee drew up the document HSC 2000/036 (in 2000)[1] which fairly stringently set out the minimum requirements of on-call and catering facilities available as part of the ‘new deal’. This applied to what was then ‘on-call’ (although doesn’t explicitly define the term). Since the widespread adoption of full shift rotas within anaesthesia, much of these regulations are no longer applicable, and there is no contractual obligation to provide a room.

So what is the current situation for trainees?

The recent GAT survey showed that 26% of respondents (anaesthetic trainees working in the UK) had no access to an on-call room. A further 16% of trainees were aware of trust plans to remove their room[2]. Comments suggest that this is frequently done to make way for additional office space.

What about consultants, what are their rights?

At the moment, the majority of consultants work a partial shift system, and are therefore entitled to access to a room. However, if the trend towards having consultants as resident on-call continues then this may well change. It is unclear what the contractual obligations will be when this arrangement becomes a reality but I would anticipate that this is a point that needs to be clarified prior to signing any contract containing compulsory resident on-call and assistance from the BMA is strongly recommended.

Why should the trust give anaesthetists access to an oncall room?

There are two separate arguments here:

1. Night-shift working confers a substantial disruption to the body’s natural circadian rhythm. This disruption has been shown to have direct and cumulative effects on psycho-motor performance. The effects of fatigue are well documented within the transport and nuclear industries, with fatigue contributing to many high profile accidents[3]. This effect has also been demonstrated within medicine and anaesthesia, effecting both technical and non-technical skills[4,5]. Clinical error leading to patient harm should be minimised at all cost. By having the facility to have a short sleep, or ‘anchor nap’ as the BMA refer to it, the effects of fatigue can be effectively combated.

2. The cumulative effect of long-term night-shift work has detrimental effects on health. It is associated with increased risks of certain cancers[6] and cardiovascular mortality[7]. Workers in Denmark have even received government compensation for these effects[8]. Although there is, to my knowledge no evidence showing that an on-call room reduces these effects, it passes the test of logic that it should. Failure to protect the health of their employees in spite of increasing evidence of harm is ill-advised. A sensible NHS trust may take note of this information in the way that tobacco manufactures should have done for the well known deleterious effects of smoking in the 1980’s.

What can a trainee do if their on-call room is under threat?

The New deal stipulates a minimum of 20 minutes rest in every six hours of clinical
duty. The BMA and the Royal College of Physicians believe this should be in a quiet room, away from clinical activity and with the facility for lying down / reclining (although there is no stipulation for this in EWTD). In the absence of these facilities, the case for a dedicated on call room is all the more powerful.

Possession is nine tenths of the law, and once the room has gone it’s going to be very difficult to get it back. A solid case for maintaining the room should be made with a petition of affected parties. The support of the consultant body and the BMA as the trade union is essential. Email us at gat@aagbi.org to ask any specifics – we may be able to offer some useful advice from our collective experience and close links with the AAGBI council.

What else can GAT do to help?

The GAT committee feel strongly that adequate rest facilities are essential for both safety and welfare of trainee anaesthetists. As your representatives we will publish these views and collect data where you feel an injustice has occurred, but ultimately there is no vehicle for us to exert political pressure on individual trusts. We deliberated for some time whether this publication is the correct forum to publish data on which trusts had removed on call rooms; in the end it was felt too risky in terms of a potential libel case and because it may cause more harm than good. We welcome suggestions from members who have ideas as to what we as a representative body can do to improve this situation. Please also email us if you have been successful in reinstating and on-call room as your experiences will undoubtedly be useful to others in a similar situation.

The AAGBI has a working party currently looking into fatigue and the anaesthetist. These short publications are of high quality, use the best available evidence and carry significant weight in departmental affairs. Your comments will be forwarded onto the group, and may influence the direction it takes so perhaps this is the best forum to protect our rooms.

2  The GAT annual on-call survey, NJ Love, Nov 2009, Personal communication; due for publication in anaesthesia news 2010.
4  Howard SK, Rosekind MR et al, Fatigue in Anesthesia, Anesthesiology 2002; 97: 1281 – 1294
5  Smith-Coggin, Roskind et al, Relationship of day versus night sleep to physician performance and mood. Ann Emerg Med 1994; 24: 928-34
In 2008 £12m was provided for the provision of career development funding for SAS grade staff in England.

It is to be hoped that a similar system of funding will be made available in the devolved nations in the future.

The funding went from Department of Health to Deaneries and each Deanery has decided how the money was to be allocated. Most seem to have appointed an Associate Dean for SAS grade staff, though there are still some areas without such a role. Many Deaneries have sent the money to Trusts often on a per capita basis, but some (e.g. London) kept it centrally.

My Deanery (East Midlands) has encouraged all Trusts to appoint an SAS Tutor but to date not all have done so, though the numbers are increasing. My Trust (ULHT) appointed me as their SAS Tutor in June 2009 in open competition. The interview included a presentation, and applications were only accepted from the SAS grade. We are a large Trust in the East Midlands and I cover nearly 160 SAS grade staff.

Initially, I carried out a learning needs analysis of all staff, and got about a 30% return rate. This has increased to more than a 50% return rate and is still rising, but there are some SAS grades who do not seem to wish to engage. Whilst still trying to get their input, I now also use my time to organise using the funding for those who have engaged with the process. In the needs analysis I asked what generic training they would like (such as topics that would not be covered by usual study leave), and also what individual needs they had.

The needs analysis produced results very similar to that of other Deaneries in that the requests are for generic courses on communication skills, teaching, leadership, revalidation, mentoring etc.

The individual needs vary from fees to undertake post graduate qualifications such as Diplomas, to short term clinical secondments either for PMETB, or for personal development.

Once the needs analysis was carried out, I was able to allocate funding to book courses for generic skills. Due to venue sizes we did have a limit on numbers of places, which was helpful to focus minds on whether they wanted to attend, but also meant I could assess popularity of the courses without wasting money on empty delegate places. So far all are fully booked with a waiting list, and so some are to be repeated for those who could not get a place.

I then proceeded with a round of applications for individual funding. There were 13 requests which is what would be expected from the experience of other Deaneries. The bids were assessed by a small panel. Some bids were very unrealistic and would have taken the whole budget, but after discussion we have made an acceptable plan even for these. All bids have been successful though not all are fully funded, as some applications were for large amounts, so fees for postgraduate qualifications were covered but not travel expenses, though this can be claimed using the study leave that will be needed to allow the time to complete the courses. Some funding was used to cover locum backfill costs to allow relevant short-term clinical secondments. Other applicants wished to undertake some formal leadership and management training. It is likely there will be a second round of individual applications, especially as the generic days enabled a realisation that the funding is available, and that SAS grades can benefit from it. Successful applicants are expected to give regular updates on their progress, and to do a presentation to the Trust once the development has been completed.

One of the more unexpected aspects was obtaining authorisation to access the funding, due to the need for financial training before authorisation was permissible. The Trust therefore arranged for me to undertake a training module and assessment, and the successful completion of this allowed my name to be added as an authorised signatory.

The generic courses run so far have proved to be popular, and have created a positive sense of enthusiasm amongst the SAS grade staff. I have even had comments from consultants who wish they had access to the range of opportunities we have been able to organise. The SAS tutors within the Deanery are liaising with each other to share experiences and good practice, which is very helpful as we are all new to this role. The funding is a great resource and it is exciting to be so involved with this opportunity for career development for SAS grades.

Dr Anthea Mowat, Associate Specialist Anaesthesia and Chronic Pain, United Lincolnshire Hospitals Trust (ULHT). SAS Tutor, ULHT
I recently returned from an OOPE in the USA, working as a Visiting Assistant Professor in Anesthesiology at the University of California Davis Medical Centre, in Sacramento, the state capital of California.

My goals for this year were to experience an alternative healthcare system, experience working as an attending (the US version of a consultant) and, with my family, experience life in a society that was surprisingly different to our own.

**Medical Training**

Postgraduate medical training in the US seems more directed and focused but perhaps with less breadth. By the time students get to medical school, they are already post-graduates with large fees to pay, which can focus the mind when you know you have several years on a low salary. I was working with people with tens or even hundreds of thousands of dollars of debt behind them.

A four-year medical school degree awards an MD and this is then followed by a year’s internship, often in a single speciality. By the time the trainee doctor is in the last year of medical school, they are likely to have chosen their field and embarked on the process of matching for residency programmes.

This seemed a very early stage of one’s career at which to decide on your chosen speciality. I couldn’t do it. In fact, it took two years of surgery before I decided that anaesthesia was the field for me. There were residents who had completed training in other fields before commencing anaesthetics, but they were few and far between.

We’ve all worked with anaesthetists in the UK who are former physicians or surgeons. This breadth can enhance anaesthetic training although it obviously slows progression. This breadth is not as prevalent in the US and despite the aims of the Foundation Year Programme, is possibly decreasing here too. Presumably it is a matter of balancing the two sides – having broadly trained and experienced clinicians versus training in a more streamlined way to produce the end result for the health service in a timely manner. As always, I suspect that the best result lies somewhere between the two.

**Anaesthetic Training**

Having only three years to graduate also focuses the mind. I was still a 1st year SpR after three years of anaesthetic training and clearly nowhere near ready to be a consultant. Some might argue that I’m still not!

The majority of anesthesiologists in the US go straight into private practice, without the same community of colleagues that we are used to in an NHS hospital. The consequent need to achieve an independent level of practice means that training and self-sufficiency seem to advance very quickly.

After an anaesthetic “boot camp” residents would only have about four weeks of one-to-one supervised theatre time before dropping down to two-to-one supervision from an attending. Compare that to the three months I had.

Whilst the attending was still the responsible anaesthetist, it put considerably more pressure on the resident to cope in a way that I was never exposed to in my SHO training. This effectively meant that the resident would be physically alone for much more of a case than we would be when undertaking an accompanied list in the UK.

Then again, billing rules and hospital practicing privileges meant that a resident would never be working officially “solo” in the same manner as we do here. They always had to be allocated to an attending...
for whom it was mandatory to be present for specific events in the course of the anaesthetic.

When trainees in the UK undertake unaccompanied lists, they have to complete the whole process fully independently and make their own assessments and decisions. This often takes place without any involvement at all from a more senior anaesthetist. Admittedly, the department or the consultant on-call always officially supervises a trainee but this is often nominal rather than actual supervision.

In the US, the resident would have to get everything ready and be prepared for likely eventualities. There were no ODPs and that also meant no anaesthetic drugs in the theatres – these would have to be calculated and collected from pharmacy in a kit prior to starting the day. Generally not having anyone able to quickly get you equipment once you started meant that residents would become very self-sufficient and learned lots of tricks that allowed them to perform tasks ‘one-handed’.

Things seemed to run safely but there were some eye opening moments when working on ancillary lists. You were very much alone in terms of hands-on support, contrary to the way in which we work in the UK. The AAGBI guideline “The Anaesthesia Team” states clearly that “trained assistance for the anaesthetist must be provided wherever anaesthesia is provided” and that “the safe administration of anaesthesia cannot be carried out singlehandedly; competent and exclusive assistance is necessary at all times.”

Of course, in the event of an emergency, theatre nursing and surgical staff were on hand but it didn’t quite feel the same as having a trusty ODP or dedicated anaesthetic nurse.

The residents generally worked pretty hard – their hours were officially limited but not to the same extent as here. Sixty to eighty hour weeks were normal and there was no EWTD or job banding.

Certified Registered Nurse Anaesthetists:

One of the new experiences of working in California was the opportunity to work with nurse anaesthetists (CRNAs). I predominantly worked with the residents, but I would be paired with CRNAs a couple of times a week.

They were almost exclusively from an ICU or ER nurse background and so had a good level of clinical experience already under their belts. In the University of California health system, they would be paired with a physician but would be the main “anaesthesia provider” in their theatre, as that physician would be supervising multiple rooms.

My role, when working with the CRNAs, was to pre-assess the patients with them, come up with an anaesthetic plan and help to keep the lists running. They were a technically able group of practitioners who were comfortable with most procedures that we undertake as anaesthetists.

The anaesthesia residents, conscious of the limited time available for their training, were very proactive in terms of trying to perform as many of the procedures as possible. In fact, unless urgency or time pressures dictated otherwise, I would generally only get to intubate, place lines or epidurals etc, if they were unsuccessful, whereas the CRNAs were generally happy to share out procedures.

In the UC Davis Health System, CRNAs worked in the main theatre suites and on ancillary lists. In general, CRNAs were service providers in a teaching institution, so the department tried to allocate the more educational lists to the residents. This was also the case for paediatric and obstetric sessions.

Usual practice was for an anesthesiologist to supervise two theatres when working with CRNAs or residents, although when staffing levels allowed, residents could...
be supervised on one-to-one basis and attendings would work solo. Out of hours, supervision levels could drop to a maximum one-to-four ratio, which could be quite stressful if members of staff were junior or the caseload was more complicated. With major traumas coming through the door with regularity at night, it was a great learning experience for the residents – and me – but there was no doubt that it was of great help to have one very experienced CRNA on a night shift.

I found the CRNAs to be a competent, sensible and capable group of individuals with a great work ethic and this experience has shown me that there are many ways to arrange and deliver anaesthetic services.

OR Life

The relationship between surgeons and anesthesiologists was slightly different in the US. Surgeons would be far more demanding in terms of dictating anaesthetic practice and this would be an extension of the fact that they were responsible for almost all post-operative management, including critical care.

In contrast, the speciality of anaesthesia in the UK comes with a great deal more independence as a profession. This meant a period of adjustment and some learning experiences in terms of dealing with confrontation!

There were lots of language differences. Try calling it a trolley rather than a gurney and you would get lots of laughs but the British accent was surprisingly well liked over there. I lost count of the number of times people would ask me to repeat things – not because they didn’t understand but because they just wanted to hear the accent. It was novel being considered ‘exotic’ for a change. This would occur with regularity in every aspect of life in the US. Simply opening your mouth in the supermarket was enough to make people stop and start a conversation. California is quite a multicultural society, but the British accent is not a commonly encountered one, particularly in the north of the state.

Drug names could be quite confusing. Americans refer to the vast majority of drugs by their brand names and most of these do not translate across the Atlantic. Diprivan, Valium and Zofran were reasonably obvious but many trade names were different. Versed (midazolam), Levophed (norepinephrine), Lovenox (enoxaparin) and Tylenol (acetaminophen – or paracetamol) were just some of the examples. Patients would also use brand names and give you a list of medications that they were taking that were simply alien to me. Checking the generic names of these medications, courtesy of a wi-fi enabled phone and the hospital’s free wi-fi network, became a regular occurrence for me.

The lack of anaesthetic rooms took a little getting used to but was obviously of no consequence to the Americans. After taking a patient out to recovery, it was necessary to wait for the room to be cleaned and then for the scrub staff to get all of their equipment ready for the next case before it was possible to bring the next patient round. I thought this to be fairly inefficient compared to the system of having anaesthetic and prep rooms to work in whilst the theatre was simultaneously cleaned. However, it made little difference to the downtime spent in between cases. Time is money over there and things seemed to progress at a fair pace so perhaps that is why.

We are all used to the high profile of infection control in the NHS. The public are well informed about the issue and they have dressed down colleagues for being in the restaurant in scrubs or not being seen to clean their hands prior to leaving a patient. So it came as quite a surprise to see that scrubs were not only worn all over the hospital but people would commute in them. It was common to see scrubs worn in Starbucks or the supermarket and no one would bat an eyelid. I, on the other hand, felt self-conscious being seen even in the hospital restaurant in my theatre clothes! To be fair, scrubs were far more a hospital staff uniform than they are here, so they weren’t always associated with procedures and clinical work.

In contrast, masks were compulsory in all theatres – not just cardiac, neurosurgery and orthopaedics. All members of staff needed to wear a mask for the entire duration of a procedure – even cystoscopies and dental work. So it now seems really strange not only to walk into theatre without one, but to see surgeons operating with bare faces as well. Perhaps the differences between mask wearing and theatre clothing practice show that we are led by habit as much as we are by evidence.

**In Conclusion**

I would highly recommend the chance to live and work in the USA. They do many things very differently – some better and some worse but mostly just different. It is an enriching experience and one from which I have learned a lot – including the things about the National Health Service and anaesthesia practice in this country that I appreciate all the more.

The chance to work as an attending in a foreign land, with a totally different system of training, and with surgeons whose expectations are not necessarily in line with those here has broadened my experience considerably.

In addition, California is an amazing place in which to live. It has a fantastic climate – forty degree Celsius heat and guaranteed sunshine in the summer and plenty of snow in the winter – and areas of outstanding natural beauty.

They are currently experiencing their own massive budget deficit, which will discourage the employment of visiting physicians in the publicly funded university for now, but I would have no hesitation in recommending this as OOPE.

**Dr Niraj Niranjan**

Anaesthetic SpR

Royal Devon and Exeter Hospital
Long ago, yet not so long ago as to have been lost in the mists of time, the rota was writ in men’s hearts. Men (both he and she) had no need for a master to rule the rota. In those days there were some simple rules: those who had travailed since yesterday might go home at sundown today, whilst those who travailed today might not go home until somewhat after tea tomorrow. Then, quite suddenly, the power of men declined, and the rule of the Council commenced. At first, men did not notice the weakening of their powers, as they were blinded by promises of more gold and time to pursue hobbies. And then, the Council decreed that no man might work for longer than four dozen hours per week, on pain of death to his master. Therefore, the masters of men created the Rota, which might or might not be written by the men. And those men who wrote the Rota began to feel that the power of the Rota corrupted not only their hearts, but the hearts of their kinsmen.

And where previously the men arranged to do each other’s work to allow for the pursuit of recreational quests, the Rota now had no need for such politeness. Men found themselves working many and most weekends, on account of the sudden need for half a dozen warriors where one would once have sufficed. This hardened men’s hearts, and they fell prey to announcing multiple unavailabilities during the preparation of the rota, and to stony silence in the case of a swap. The Rota grew and grew in its power, and suddenly became able to decree that men should pursue their recreational and educational quests at its whim. And in many corners of this land, the Rota became unwieldy and consumed vast swathes of time, and men grew tired of it and handed it on to others who were not men, and who had never taken part in the works of men. And of these we speak no further, except to urge men to strive to reclaim their own destiny. For there are some things which have been disturbed which ought not to have been disturbed.

But for those fellowships who have retained control of their own Rota, I urge you to spare a thought for the kinsman who must solve its eternal and possibly insoluble riddle. For those who request half a dozen weekends off in a row must somehow take part in enough labours to justify their vittels, and thereby unthinkingly condemn themselves to work as many weekends in a row. The evil power of the Rota rots away at the minds of all, creating apparent woeful discrepancies and inequities, even in the absence of evil intent on the part of the Rota writer. Some men remain uncorrupted by the evil and continue to offer their services way beyond the call of duty. Others are instantly poisoned and keep their counsel until the onset of direct threat. And when warriors fall prey to injurious circumstances at the last moment, some kinsmen find themselves unable to remain at post until nightfall on account of something called a ‘Piano Lesson I arranged ages ago’. At such times, the Rota writer becomes consumed by the awful power of the Rota and finds that next time he cannot stop himself writing ‘weekend ITU nights’ in perpetuity.

Therefore, I humbly offer the following advice. As Rota bearer, strive to carry it blamelessly for your part of the quest but prepare yourself to find that the fellowship is corrupt. For those of you who have yet to carry the burden, plan your recreation in advance, indicate it in the rightful place with due and proper notice and strive to swap whenever asked in order that you remain on good terms with all. Keep the Rota bearer high in your heart, for the task is not conducive to happiness and causes an inexorable decline in mental health. And let us recall that a ‘long day’, no matter how long, finishes with repose in one’s own bed, and that ‘The Antiques Roadshow’ no longer marks the halfway point of a weekend at work (unless you are a Ruler of men, and Rulers of men rarely work alternate weekends).

By

A recently retired rota bearer in the Shire of Devon.

With a nod to Mr. J. R. R. Tolkien
Report from the Red Zone

I have been an instructor on a course for advanced life support and trauma management for obstetric patients for several years [The MOET course*] and I have an interest in how obstetric care is affected by and can be adapted to deal with trauma. So, when I was asked if I would join a multi-professional, multi-national group planning a conference with the Obstetric & Gynecological society in Baghdad, and help run a mini-MOET, I jumped at the chance.

I had been only vaguely aware of the crisis in the medical system in Iraq. An organization called Anaesthesia4iraq has been hosting teleconferences between British and Iraqi anaesthetists and in March Dr Maan Hassan, from University College Hospital, London had arranged a teleconference with obstetric anaesthetists in Baghdad and I was hoping to meet some of those who had taken part.

The trip was organised by an American organisation - International Medical Corps [IMC] which has extensive experience of sending groups to places that Non-Government Organisations consider too dangerous to operate in!

Four of us were due to go: two American O&G specialists (a professor of obstetrics from Tennessee and a gynaecologist from North Carolina), an English gynaecologist and me. The others had all made numerous trips to Iraq which made me feel better until I had to take the MCQ quiz on IMC's security arrangements. The pass mark was 100%. I passed but found the information about avoiding kidnap strangely non-reassuring!

We flew in via Amman and slightly to my surprise, had very little trouble taking a couple of obstetric manikins through customs, despite the pelvises being used as storage for my regional anaesthesia kits!

On previous trips, except on one occasion, IMC had arranged for all activities (lectures, workshops etc) to take place in the International Zone – a very small, heavily guarded area of downtown Baghdad, as the ‘Red Zone’ – the rest of Iraq – was considered too dangerous for foreigners. The problem was that we wanted to visit our Iraqi colleagues where they worked. The gynaecologists had been asked to demonstrate and teach laparoscopic procedures and prolapse surgery. I’d been asked to perform some regional blocks for labour and Caesarean section. The solution was to drive us, heavily guarded, out of the International Zone: we travelled in a convoy with unmarked vehicles (to attract as little attention as possible). The frequent check points, road blocks and convoys of military vehicles meant that a journey of a couple of km sometimes took over an hour. This brought home to us just how difficult life is for the Iraqis trying to live and work in the city. As one Consultant said, merely getting to and from work or school put one’s life at risk and was a major achievement. Anything else was impossible. Although we would have loved to accept the many invitations to people’s homes, the security situation made this impossible.

Day one consisted of interactive lectures covering advances in prolapse surgery, laparoscopic surgery, regional anaesthesia for labour and Caesarean section and Crew Resource Management. I was slightly wary of the reaction to my presentation on the advantages of regional anaesthesia as the audience was entirely composed of obstetricians and gynaecologists. In fact the response was extraordinary: I was inundated with questions and it seemed that there was enormous surgical enthusiasm for regional anaesthesia! With a steely glint in her eye, the Conference organiser, Dr Tagreed al Haidari, promised me there would lots of anaesthetists present on the following days.

When I did have a discussion with some of the anaesthetists [who, in contrast to the obstetricians, were all men], it turned out that >95% sections were carried out under general anaesthesia: regional anaesthesia was reserved for patients considered too sick for a general. This was due not just to reluctance on the part of the women to be awake, (although that played a part) but also to lack of equipment and drugs. For example ‘loss of resistance syringes’ were...
virtually impossible to get hold of, whilst
glass syringes were no longer available. My
box of ephedrine was greeted with cries
of delight, as the absence of vasopressors
meant that hypotension was a real problem
when spinal anaesthesia was attempted.
The lack of pencil-point needles and
anything finer than 20G meant that severe,
often disabling headache was seen as an
inevitable consequence of intrathecal
anaesthesia.

The moment we walked onto the delivery
suite a sense of familiarity enveloped us:
the chief midwife swooped down on us (as
do all such chiefs) to ask me if I had come
to do ‘the painless labour’ [labour epidural]– a challenge if there ever was one!

We discovered that in general Iraqi women
do not use any analgesia during labour.
Although CTG machines were available
there was no paper for a continuous print-
out.

A rising Caesarean section rate and
increasing incidence of obesity were
familiar problems: the high proportion of
women who had accessed no antenatal
care whatsoever (too difficult/dangerous
to get to the clinic) and untreated chronic
conditions such as asthma and diabetes,
less so. Although reliable data do not exist,
the maternal mortality rate is thought to be
in the region of 310 per 100 000.

Carrying out any procedure was a bit of
a challenge as we were simultaneously
interviewed and videoed whilst doing so.
Nevertheless a couple of intrepid Iraqi
women agreed to awake procedures. Both
had had general anaesthesia for previous
sections. One smiled a lot but said nothing.
The other announced she’d have one of
those ‘English anaesthetics’ next time.
Neither ran away (in contrast with one
of the gynae patients). Both Caesarean
sections were carried out by junior
residents extremely quickly, with awesome
surgical skill.

The difficulties faced by the local
anaesthetists were illustrated by a woman
requiring ovarian laparoscopy. She had
a raised BMI and it was decided that she
required intubation. She also had severe,
untreated asthma. The Manley ventilator
could not cope with the inevitable
bronchospasm. Halothane wasn’t much
help. Oxygen saturation hovered around
75% despite an FiO2 of 1.0 (piped oxygen
was available, but not nitrous oxide or
air). Hand ventilation required 2 pairs of
hands; one set to occlude the holes in the
Magill circuit and the other to ventilate
the patient. Monitoring was increased
to include ECG and non-invasive blood
pressure (most patients are monitored with
SpO2 alone –capnography is completely
absent). Reversal of muscle relaxation was
tested by getting the patient to keep her
head off the pillow for 5 seconds. There
were no recovery facilities.

On the second day we ran an interactive
‘skills and drills’ course based on the
‘Managing Obstetric Emergencies and
Trauma’ course [‘Mini MOET’], with a brief
introduction to adult learning theory. Small
group interactive sessions, involving a lot
of laughter helped links to be forged between
faculty and Iraqi delegates. The emphasis
was on how to teach from skills stations
to scenarios. My ‘nervous candidate’
impression was a bit of a hit.

Later that day we were lucky enough to
(almost literally) bump into to Minister
for Health as we were visiting the Ibn
Sina Hospital – formerly the American
military medical facility as featured in the
TV series ‘Baghdad ER’. The Minister gave
us a 20 minute interview during which
time he described his vision of developing
continuing medical education in Iraq by
forging links with medical societies and
colleagues overseas. Since this exactly
described what the group set out to do back
in 2003, we were delighted.

The security situation prevented any outings
in the evenings and alcohol is unavailable,
so we entertained ourselves by teaching
each other American and UK English. The
next time my kids demand I take their side
in a squabble, I will announce, in a suitably
southern accent that ‘I have no dog in this
fight’. We can be proud that somewhere
in North Carolina a gynaecologist will be
describing things as ‘spiffing’ or even ‘top
notch’.

Most NGOs have yet to return to Baghdad.
The volatility of the situation makes normal
life impossible. Having seen how effective
directly interacting and working with Iraqi
colleagues can be, we are prepared to live
with the security issues and look forward
to returning as soon as funding allows. Insha
Allah.

Felicity Plaat May 2010

* MOET (Managing obstetric emergencies
and trauma) course details at
http://www.alsg.org/en/?q=en/moet
A brief history of fluorinated anaesthetics

A non-flammable ether and a non-toxic chloroform were among the objectives of chemical research after the First World War. Stability, both in vitro and in vivo, was considered an essential feature for any new anaesthetic agent. Many fluorinated compounds, newly developed as refrigerants in the 1920s, proved to be highly stable and in 1929 a 2-year fellowship for 'Pure Science Research in Anesthetic Gases' was created in the USA by the Ohio Chemical Company. Work at the Western Reserve University, Cleveland, Ohio confirmed that 'the best possibility of finding a new non-combustible anaesthetic... lay in the field of organic fluoride compounds', and it was anticipated that fluorinated derivatives of known anaesthetics would probably have the best chances of success. How right those pioneers were!

American workers of the 1930s went on to prepare a number of non-flammable mono and trifluoro derivatives of diethyl ether and chloroform. Substitution of fluorine atoms for chlorine decreased toxicity and increased stability, but none of these substances was found to be an effective anaesthetic. Hindsight suggests that the imperfect techniques of chemical analysis available at the time prevented the detection and elimination of toxic impurities which probably adversely affected the pharmacological results. Several non-halogenated ether anaesthetics also resulted from industrial research but all were flammable and none was considered an improvement of cyclopropane which had been introduced in 1929.

Fluorine technology and the atomic bombs

The enormous boost to fluorine technology from its involvement in purification of uranium isotopes used to make the atomic bombs which ended the Second World War resulted in a number of organic fluorine compounds becoming available to American workers in the 1940s. Fluorinated substances also containing chlorine and bromine were studied and the introduction of a second halogen atom - either chlorine, bromine or iodine - into fluoro hydrocarbons was found to markedly increase anaesthetic potency. Bromine substitution doubled, tripled or quadrupled potency compared with chlorine. Fairly satisfactory anaesthesia was often produced in dogs, but hypotension, arrhythmias and convulsions prevented further experimentation with most of these agents. Only four compounds were thought to be worth further study and these included CF₃CHBr₂. Halothane may be written as CF₃CHCIBr, so these American workers came very near to giving us this important agent ten years before its synthesis and investigation in Britain.

The first clinically acceptable fluorinated anaesthetic - fluoroxene (Fluoromar) - CF₃CH₂OCHCH₂ or trifluoro ethyl vinyl ether was produced in the USA in 1951. While still flammable, it was thought to be less hazardous in this respect than diethyl ether. Toxicity and clinical studies appeared satisfactory but a New Drug Application for the agent was only filed with the US Food and Drug Administration six years later, in December 1957. Methoxyflurane, a fluoro ethyl methyl ether, was synthesised in the USA in 1959 and had some ten years of clinical use during the 1960s - mainly in America - but fluoride breakdown products due to hepatic metabolism were found to be highly nephrotoxic and the agent was abandoned. By this time non-flammable halothane had appeared in Great Britain.

Halothane

At the end of World War II, the British firm, Imperial Chemical Industries, and its Research Director, Dr John Ferguson of the General Chemicals Division, decided to assess the commercial value of new
organic fluorine compounds which could be synthesised in their laboratory at Widnes, Cheshire. Presumption of stability for some of these agents, particularly those possessing CF$_2$ and CF$_3$ groups, suggested their use as volatile anaesthetics and a proposed specification or design envisaged a non-flammable liquid boiling at about 60°C which was active as an anaesthetic at low concentrations and had a good safety margin. During the early 1950s the ICI research chemist Dr C W Suckling produced a small number of new compounds which came close to these requirements and the improved analytical techniques developed at Widnes allowed almost complete elimination of impurities. The work of the pharmacologist, Dr J Raventos, suggested that one of these agents, first prepared January 1953, might be suitable for clinical study.

The first human application of halothane (Fluothane) by Dr Michael Johnstone took place in January 1956 in Manchester. The superiority of the new agent over traditional anaesthetics and those recently produced in the USA was immediately apparent. Ease of induction, rapidity of recovery and lack of flammability of halothane made this agent highly acceptable to anaesthetists and patients and it was rapidly adopted for clinical use in the western world. Cases of hepatic necrosis and liver failure following halothane anaesthesia gradually appeared, and doubts were cast on its safety when it was realised that 15-30% of the administered dose was broken down in the body. Further industrial research in the USA to find possibly safer agents was stimulated, and the requirement for non-formation of toxic metabolites and an emphasis on stability again suggested fluorinated compounds. From investigation of a variety of simple organic agents, it was found that while totally fluorinated compounds had no anaesthetic effects, ethers, and particularly fluorinated methyl ethyl ethers, appeared to be stable and generally most promising as anaesthetics. Those fluorinated ethers having one hydrogen atom and at least two other halogens, or with two or more hydrogen atoms and at least one bromine or chlorine, appeared to have the best anaesthetic potential.

Ohio Medical Products chemists found that the prime requirement of volatility excluded most compounds having more than four carbon atoms. By further eliminating those expected to be flammable, unstable to soda lime or having too high a boiling point, the number of possible halogenated methyl ethyl and methyl isopropyl ether anaesthetics could be reduced to about fifty. Thirty-six of these new agents were synthesised during the 1960s and 70s, four of which - enfurane, isoflurane, sevoflurane and desflurane - were widely adopted for use in practice during the final decades of the 20th century. Perfection has yet to be achieved but the rarity of reports of serious adverse effects from clinical use of the newest agents, and the great cost of research needed to obtain even better ones, suggests that inhalational anaesthesia has itself entered a phase of stability.

Frank E Bennetts

A detailed account of the preparation of the most recent anaesthetics by the principal investigator may be found at: Terrell R C. The invention and development of enfurane, isoflurane, sevoflurane and desflurane. Anesthesiology 2008;108:531-533
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Association between Arterial Hyperoxia following resuscitation from cardiac arrest and in-hospital mortality
JAMA 2010; 303 (21): 2165-2171

Currently around 60% of patients in whom there is return of spontaneous circulation (ROSC) post-cardiac arrest do not survive to hospital discharge [1,2]. A key factor in improving outcomes in this patient group may be inspired oxygen concentration (FiO2). While too little oxygen may potentiate anoxic brain injury, too much may increase oxygen free radical production, possibly triggering cellular injury and apoptosis.

This paper publishes the results of data obtained from Project IMPACT, a large administrative database involving 131 US adult critical care units across all disciplines. These units upload a number of data fields quarterly to a central repository. Adult patients who sustained non-traumatic cardiac arrest and were admitted to the ICU of a participating centre between 2001-2005 were included in the data analysis.

The cohort was divided into three groups (hypoxic, normoxic and hyperoxic - defined by the first arterial gas value obtained in the ICU) and the occurrence of outcomes was compared between the groups. Hyperoxia was defined as PaO2 of 300mmHg or greater, hypoxia PaO2 less than 60mmHg (or ratio of PaO2 to FiO2 <300), and normoxia as cases not classified as either hyperoxia or hypoxia. The primary outcome was in-hospital mortality.

Data from 6326 patients from 120 hospitals were included. 18% of patients were in the hyperoxia group, 63% in the hypoxia group, and 19% in the normoxia group. Baseline characteristics for all groups were similar. Patients were predominantly white and from community, non-academic hospitals. 3561 (56%) of patients died. Mortality was significantly higher in the hyperoxia group (63%), compared with the hypoxia group (57%) (P<0.001), and the normoxia group (45%) (P<0.001), and diverged significantly over time (P<0.001). Among hospital survivors, patients with hyperoxia had significantly lower proportion of discharges from the hospital as functionally independent compared to normoxia patients (29% vs 38% respectively, P=0.002). A secondary analysis using a PaO2 of 400mmHg or greater to define the hyperoxia group found even greater mortality.

Current adult resuscitation guidelines advocate 100% inspired oxygen to maximise the likelihood of achieving ROSC. However once circulation is successfully restored, clinicians frequently maintain high FiO2 - in nearly 20% patients in this study for example. Post-ROSC hyperoxia was associated with the lowest survival rate to hospital discharge among all patients, including those with hypoxia. Hyperoxia was an independent predictor for in-hospital death. The paper acknowledges that association does not necessarily imply causation, however the data support the hypothesis that hyperoxia in a post-cardiac arrest setting may have adverse effects.

Reperfusion after an ischaemic insult is associated with a surge of reactive oxygen species, which may overwhelm natural antioxidant defences. Hyperoxia worsens the severity of this oxidative stress, which may lead to increased cellular death by diminishing mitochondrial oxidative metabolism, disrupting normal enzymatic activities, damaging membrane lipids through peroxidation, and worsening brain injury.

A recent consensus statement on the treatment of post-cardiac arrest syndrome by the International Liaison Committee on Resuscitation advocated the avoidance of unnecessary arterial hyperoxia and a controlled reoxygenation strategy targeting an arterial oxygen saturation not to exceed 94 - 96%[1]. This paper supports these recommendations.

Dr Susanna Ritchie-Maclean
CT2, Peterborough

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Obstetric Anaesthesia Courses

I am a final year SpR with an interest in obstetric anaesthesia. In November I attended a course in London entitled ‘Medical Complications in Pregnancy’. I came across this course purely by chance on the internet and do not recall seeing it advertised in any anaesthesia resources. Since being on the course I thought it would be a good idea to spread the word, as it was excellent.

With study leave days and budget very limited (£920 + 10 days per annum for trainees in the South Yorkshire locality of the Yorkshire and Humber Deanery) it is difficult to cover the generic courses as well as ‘special interest’ courses without spending your own money and annual leave. I thought I would cover here what I think are useful courses and meetings in the UK for trainees and consultants interested in obstetric anaesthesia.

**MOSES - Multidisciplinary Obstetric Simulated Emergency Scenarios**

Simulation course aimed at Obstetricians, anaesthetists and midwives to promote multidisciplinary teamwork and effective communication skills. Covers emergency scenarios in theatre, labour ward and HDU. Simulation is an excellent way to learn although it's not everyone's ideal environment. Regional variations of obstetric simulation courses include: Crisis on Obstetric Anaesthesia, Obstetric Anaesthesia Training in the Simulator for SpRs (OATS), Obstetric Anaesthetic Crisis Simulation (OACS). See local simulation centre for details.

**MOET - Managing Obstetric Emergencies and Trauma Course**

Lectures, skill workshops and resuscitation simulations. For obstetricians and anaesthetists (post FRCA). This course is very useful and hands on. Anaesthetic trainees are expected to take part in all of the skill stations, not just the airway ones, e.g. forceps and ventouse delivery, vaginal breech delivery, uterine inversion. A large amount of topics are covered which are useful for all aspects of neonatal and obstetric care. Manual sent to participants for pre-course reading. Organised by the Advanced Life Support Group, £610, 3 days. See www.alsg.org for details.

**ALSO - Advance Life Support in Obstetrics**

Aimed at junior obstetricians, midwives, GPs and other healthcare professionals involved in the care of obstetric patients. A structured, evidence-based course aimed at multidisciplinary teams. It is a manikin-based course with a syllabus and lectures. As well as covering labour ward emergencies, it also covers topics such as pre-natal assessment, strategies to help parents cope with a birth crisis and malpractice issues. The course originated in the USA. Pre-course manual reading required. £390, 2 days, held at various locations around the UK. See www.also.org.uk for details.

**Obstetric Anaesthesia**

OAA annual scientific meeting. Comprises lectures, forums, free papers, poster presentations, and exhibitions. The programme is always excellent, varied and up-to-date with national and international speakers. The location varies each year around the UK. Consultant £350 (£380 non OAA member), trainee £250 (£270 non OAA member), 2 days. See www.oaaeetings.info for details; next meeting 20 – 21 May 2010. Additional option for 19 May, delegates can attend workshops on difficult airway management in obstetrics/ ultrasound guided TAP blocks/ultrasound guided central neuraxial blockade. Tourist trails are also available on 19 May, organised for delegates and/or non-anaesthetic partners.

**Refresher Course on Obstetric Anaesthesia**

This annual course, which is run by the OAA, is aimed at those anaesthetists who only cover obstetrics when on-call. It is a one-day course and is traditionally held in October at the RCOG. The course covers all relevant aspects of obstetrics and obstetric anaesthesia. The lectures are given by anaesthetists and obstetricians. See www.oaameetings.info for details; next course 13 October 2010.
Medical Complications in Pregnancy

Organised on an annual basis (2009, 15th year) by Consultant Obstetric Physicians through the Symposium Office, Imperial College, London, in association with the Royal College of Physicians. It is for obstetricians, physicians, obstetric anaesthetists and GPs. Out of the 253 delegates who attended in 2009, anaesthesia was represented by 12 consultants and 7 trainees. In one London deanery senior trainees intending to pursue a career in obstetric anaesthesia are actively encouraged to attend this course. The course covers just about everything you will ever want or need to know about medicine for the parturient. If like me, you've not done medicine since you were a JHO twelve years ago, you will find this course most informative. With national and international speakers it covers a vast array of topics within medical subspecialties, which are useful in our practice to manage high-risk patients. Held at the Royal College of Physicians, London. (It is in a very impressive building at the corner of Regent's Park and meets my approval with Molton Brown products in the toilets akin with our very own AAGBI toilets!) £515, 3 days. See www.symposia.org.uk for details; next course 3 - 5 November 2010.

Three-day Course on Obstetric Anaesthesia and Analgesia

This is an annual course organised by the OAA aimed at trainees and consultants. This is the only course of its kind outside North America. Greater than 40% of the delegates are from overseas, with more than 25 countries being represented at the last course. Five free places are offered every year to anaesthetists from countries that would have difficulty attending the meeting due to financial constraints. It is definitely worth attending both by the anaesthetist covering labour ward on a regular basis and by trainees intending to pursue obstetric anaesthesia in their consultant posts. National and international speakers cover ‘generic’ topics as well as news and updates on up and coming developments in obstetric anaesthesia. Relevant paediatric, obstetric, obstetric medicine and medico-legal lectures are given by experts in these fields. See www.oaameetings.info for details; next course 8 - 10 November 2010.

Cases and Controversies in Obstetric Anaesthesia

Lectures, clinical cases, debates. Up-to-date topics covered by national and international speakers. A refreshingly short course. Organised on an annual basis by the Obstetric Anaesthetists’ Association (OAA), held at Church House Conference Centre, London. £180 (OAA members), £200 (non OAA members), 1 day. See www.oaameetings.info for details; next meeting 2 March 2011.

I would like to thank Dr Geraldine O’Sullivan, Consultant Obstetric Anaesthetist for kindly reviewing this article. I greatly value her opinion.

Dr Gill Hilton MRCS FCArCSI FRCA
Anaesthetic SpR Glasgow Teaching Hospitals NHS Foundation Trust

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20th National Acute Pain Symposium

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

Just some of the Topics

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

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

Poster exhibition

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

We wish to report a near-miss incident when a blunt needle was used to draw up rocuronium from a vial through a rubber stopper. A small rubber fragment was drawn up into the syringe as shown. It is important to use a sharp needle while drawing medication through a rubber stopper to decrease the incidence of coring [1,2].


Open Ether

I was fascinated to see two articles on ether anaesthesia in a 21st century journal.

My own introduction to anaesthesia was as a medical student in Melbourne in 1962 when I asked the junior houseman giving an “open ether” for an appendicectomy whether I could “have a go”. I happily poured ether onto the Schimmelbusch mask until the surgeon looked up and said “this blood’s awfully dark, sport.” Respiration and pinkness came back fairly soon to my relief. Yes, it was a safe anaesthetic as far as stopping respiration before the heart, but looking backwards from an era when we become concerned if the oxygen saturation fell to 90 or below, I still worry about the minor degrees of harm to cerebral function that we may have inflicted in those days.

Sydney Berger, Consultant Anaesthetist (Retired)
We work around this deficiency every day but it significantly increases workload (and risk) by distracting from patient care.

• The common gas outlet switch
A new tranche of anaesthetic workstations are coming into the market (from a variety of manufacturers) fitted with a switch that diverts all gases from an inbuilt circle to a separate common gas outlet, while still allowing both breathing systems to be connected. We are aware that our department is not the only one to have experienced critical incidents as a result of these switches. One example is the preoxygenation of patients using a breathing system which contains no fresh gas.

A thorough machine check is recommended in manufacturers instruction manuals (many of which run to more than 150 pages), but this misses the point that this design is inherently dangerous. As stated earlier, machines and equipment should be designed so that it is as easy as possible to use them correctly and as difficult as possible to use them incorrectly.

• Alarms
Human factors are applicable not only to mechanics as exampled above. Considerable research has been conducted to elicit the best ways to alert humans to dangerous situations. Although all our anaesthetic alarms will meet the relevant ISO standards, much well conducted psychological research has been ignored in place of company led intelligent software that prioritises alarms in ways that do not assist the anaesthetist as well as they might

Summary
We understand that not everyone will be satisfied with the resulting features of any product design but making things more ergonomically friendly will enhance patient safety, which at the end of the day is our first and most important priority.

Meeting regulatory standards alone is not enough. We do not believe that machine and monitoring manufacturers (& BAREMA) set out to make our working lives more difficult but we do believe they could try much harder, via a different avenue, to design their equipment to be much easier and safer to use. There are many human factor professionals out there in the big wide world who, we are sure, would be happy to bring their expertise to the table to help do just this.

We would ask BAREMA and each of the manufacturers this question…

“Have you involved human factor experts in the design of your equipment? And if not why not?”

Dr Jigna Modha, ST3 Anaesthesia
Leicester and South Trent School of Anaesthesia
Dr Christopher Frerk, Consultant in Anaesthesia
Northampton General Hospital

Flying and Anaesthesia
I enjoyed the letter from Emma Sans-Solachi and James Hadlow (1) regarding the analogy of anaesthetist and pilot, but would like to add further to the discussion.

During one of our consultant anaesthetic appointments committees, the obstetrician/gynaecologist member of the panel “humourously” suggested that anaesthesia was just like flying.

“Induction of anaesthesia was like take-off and landing similar to emergence”, he stated, much to his delight.

“In between times there was little else to do!”

Following the successful appointment, when the panel was relaxing prior to departure, one committee member, a visiting professor of anaesthesia, asked if he could clarify certain matters with said surgeon.

“With regards to anaesthesia being similar to flying”, the professor stated, “Unlike an anaesthetist, the pilot doesn’t have to contend with a person armed with a sharp knife, attempting to hack through their controls halfway through the flight!!”

Touché

Yours sincerely
Graham Philpott
Consultant Anaesthetist, Broomfield Hospital, Essex

Reference (1) Sans-Solachi E and Hadlow J: Extubation: are we cleared to land? Anaesthesia News, June 2010; 275:28

Dear Editor

With regard to Dr McHady’s (Anaesthesia news April 2010) and Dr Self’s (Anaesthesia news June 2010) point about the relative inaccessibility of wristbands for checking blood products prior to administration in theatre, one option (for non- head and neck procedures) is to remove one of the wristbands in the anaesthetic room post induction and tape it to the patients forehead. The wristband can be removed at the end of the procedure and the same band (or a new one) reapplied to the patient’s wrist either prior to leaving theatre or in the recovery room.

Dr Richard Eve, SpR 5 Anaesthesia and Intensive Care, Peninsula deanery

BAREMA Response - 9th June 2010
Thank you to Drs Modha and Frerk for the detailed review and response, as we all are acutely aware the design and manufacture of medical devices is complex and impacted by many requirements, including Human Factors.

I will not attempt to deal specifically with the points raised by Modha and Frerk but respond more in a general sense, as noted in the summary “not everyone will be satisfied……” this is a significant issue and challenge for the manufacturers and also the profession. The views and comments received from the profession are a crucial part of the development program implemented by medical device manufacturers. This in terms of user acceptability, and for the manufacturer with information needed for Medical Device Regulation compliance.

There are many other factors which impact on the design and use of all medical devices including anaesthesia systems, too many to list here but one which we all cannot exclude is the financial environment whether we like it or not. One other area where both the profession and industry could work together very effectively would be with regard to the training and education of both parties. This would have the benefit of increasing each others knowledge and hopefully a broader understanding of the issues, but possibly not all the solutions.

Finally, manufacturers have used human factor experts, maybe not to the extent some users would have wished, however more focus and attention is being given to the topic following the recognition of the role of “Human Factors” in system and equipment design.

On behalf of BAREMA we look forward to further discussion with the profession on this subject.

Paul Sim, BAREMA – Deputy Chairman
Dear Editor

I read with interest the summary of the latest ASRA guidelines, in the May issue of Anaesthesia News, on regional anaesthesia in patients receiving thrombo-prophylaxis. There still appears to be a ‘hole’ with respect to the recommendations for neuraxial procedures in patients receiving subcutaneous unfractionated heparin (UFH).

UK practice, based on expert opinion rather than specific evidence, states that neuraxial procedures should be delayed for 4 hours after subcutaneous UFH and that further administration of the drug should be delayed for 1 hour after the procedure (1, 2). In fact, there is concern that this is still not long enough for the subcutaneous injection with its slower onset and longer half-life than the intravenous injection (3).

NICE guidelines on thrombo-prophylaxis recommend low molecular weight heparin (LMWH) as opposed to UFH except in patients with renal failure (4) and written guidelines for the timing of neuraxial procedures relating to subcutaneous LMWH administration are explicit (5) unlike those for UFH.

I recently worked in the USA where many surgical patients received 5000U subcutaneous UFH two hours prior to arriving in the OR suite. Placing an epidural in this context went against my training. Some of my more experienced anesthesiologist colleagues would place the epidural, quoting the ASRA guidelines that state, “In patients receiving prophylaxis with 5000U subcutaneous UFH twice daily, there is no contra-indication to the use of neuraxial techniques.”

Others argued that the guidelines make no mention of timing (other than suggesting that the risk of bleeding could be reduced by administering the heparin after the block). They would seek out the surgeon to arrange for the injection to be delayed until after the epidural was placed or they would omit the procedure.

The surgeons could be quite frustrated by this apparent inconsistency but I took the more conservative view, wary of the consequences in this more litigious environment. Knowing which surgeons gave pre-operative heparin and making the phone call was the only way in which I ended up placing these epidurals.

The specific timing instructions for LMWH and the lack of them for UFH are Grade 1C recommendations in this ASRA practice advisory. I wonder if anesthetists in the UK would be happy to place epidurals in this manner and whether a change in practice could be recommended here? Or is the lack of guidance with respect to UFH academic because so many NHS trusts use LMWH as their standard prophylaxis? I will be interested to see what the upcoming AAGBI guidelines say on the subject.

Dr Niraj Niranjan, Anaesthesia SpR
Royal Devon and Exeter Hospital


I was entertained by a recent short article in The Daily Telegraph which had the immortal headline “Del Boy better than anaesthetic, surgeons find”. The real story (which wasn’t entirely clear from the article) is that a consultant anaesthetist has had a portable DVD player rigged up so that his patients undergoing major joint replacement under spinal can watch a DVD of their choice during the procedure. The patients like it, and find it a better distraction than listening to music.

So let’s look at that headline again.

“Del Boy” – interesting choice of title from the many DVDs available. It carries a slight whiff of something a little dodgy, doesn’t it?

“better than anaesthetic” – er, no. Actually there’s a long established, perfectly acceptable method of anaesthesia being employed.

“surgeons find” – ah yes, the sting in the tail. Our orthopaedic colleagues, bless them, tend to have very little idea of what’s going on on the other side of the blood brain barrier, but once again the clever surgeons get the credit for an anaesthetic innovation.

Just as well we have broad shoulders.

Hilary Aitken, Consultant anaesthetist, Paisley

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An important acquisition for the AAGBI Library – the first textbook of ether anaesthesia

In February 2010 our Treasurer supported the purchase of a ‘jewel in the crown’ of any anaesthetic history library. This was *A treatise on the inhalation of the vapour of ether, for the prevention of pain in surgical operations; containing a numerous collection of cases in which it has been applied* by James Robinson, published in 1847.

I have been associated with the library for nine years, during which time I have seen it develop into arguably the best depository of early British textbooks and pamphlets on anaesthesia.

James Robinson was one of the foremost dentists in London in the 1840s. He wrote articles for the journal of the Baltimore College of Dental Surgeons, which in 1846 awarded him an Honorary Doctorate of Dental surgery. He lived at 7 Gower Street (now numbered 14) just a few hundred yards from the home of Dr Francis Boott, 24 Gower Street (now the site of number 52, Bonham Carter House). When Boott received news by letter from Jacob Bigelow of Morton’s public demonstration of ether anaesthesia in Boston, he approached Robinson to help set up a trial of the astounding new technique. They improvised an inhaler from a Nooth’s Apparatus (for soda-water). On Saturday 19th December 1846 at Boott’s house, James Robinson administered ether to Miss Lonsdale and then extracted a molar tooth – witnessed by Boott and family.

The success of this trial led to further trials and modification of Robinson’s inhaler – constructed by Hooper of Pall Mall. Boott invited the famous surgeon Robert Liston to see these proceedings. Then on 21st December ether was administered from Squire’s inhaler to Frederick Churchill, on whom Liston performed (fortuitously) a painless amputation of a leg through the thigh.

Just after Christmas, Robinson showed the new technique to John Snow. In January 1847, unfortunately some administrations of ether by Squire’s inhaler failed to produce satisfactory anaesthesia. Robinson further perfected his own inhaler, which proved reliable – and he became acknowledged as the local expert. In late February 1847 Robinson published *A treatise on the inhalation of the vapour of ether – the first textbook of anaesthesia in the world*. This was seven months before the publication of John Snow’s more famous work *On the Inhalation of the Vapour of Ether*.

In March 1847 Robinson was the first British anaesthetist to suggest the use of oxygen in conjunction with ether. Thereafter he was superseded by John Snow as the leading anaesthetist in London. However, he proceeded to further honours in dentistry, being appointed Surgeon Dentist to the Royal Free Hospital in 1848, and Surgeon Dentist to Prince Albert in 1849. In December 1856 he became founder President of the College of Dentists of England.

Tragically James Robinson died aged only 48 years in March 1862. This was the result of haemorrhage from accidental puncture of his femoral artery when pruning with a pocket knife. The late Richard H Ellis said of him “Rarely, I think, has a person who has done so much been overlooked by so many for so long”.

**References**

Alistair McKenzie  
Hon Archivist, AAGBI
Where did the name Magaluf originate? Apparently it’s the onomatopoetic noise made by a British tourist trying to order a drink after about 2am. Coincidentally, it’s also the first sound they make on waking in the afternoon. I gathered this knowledge not from first hand observations but by watching a medical education programme on BBC3 (i.e. for the Youff.) Worryingly I think the sort of alcohol consumption figures quoted were seen by the target audience more as a challenge than a warning. Like the Olympics it seems the records are broken every year. (The bar is set higher!). Now it appears we Brits have reached the natural limits of alimentary debauchery. Undeterred, our elite drinkers are resorting to ever more imaginative means of auto-anaesthesia. You can buy “shots” of ethanol vapourised in oxygen. Taken like an inhaler, these result in an instantaneous hit following absorption across the alveolar membrane! If mere alcohol no longer thrills at all, the plucky experimenter can buy balloons of N₂O for inhalation (note – without O₂!). One can only imagine this must rapidly diffuse into the space in the cranium previously occupied by grey cells creating dangerous levels of pressure but at least avoiding a vacuum. It can only be a matter of time before the demand for “Jackson Juice” on the streets of Magaluf opens up a whole new field for Graseby and Alaris. (Tadger Controlled Infusion?)

This is what the bankers refer to as an emerging market and perhaps the AAGBI should take the lead, encouraging the development of licensed street anaesthesia practitioners. Could we find significant numbers of anaesthetists willing to beach all day and work all night? Mmmm. Perhaps the EWTD would stipulate limits to shift lengths making it acceptable to trainees (no more than 2 hours sunbathing without an ice cream break!) or perhaps it might appeal as a nice little earner in retirement. It might even offer a solution to the spectre of unemployed post CCT doctors and could look good on CVs. Such an early move by the Association could set a schedule of fees before BUPA even catches on.

Of course regulation would be essential as would proper equipment checking procedures (corkscrew – check; wet wipes – check!). Inevitably there would be an exam – the Experimental Sedation Paralysis and Narcosis Abasement test. I know, you’re way ahead of me here – and there would obviously have to be an oral as part of this – the Viva España. Do send me a postcard!

From our correspondent Scoop O’Lamine

Dr Harry Thickster was suspended from the register by the GMC on 20th August 2016.

Colleagues at his hospital were upset to discover that Harry had been assessed as “definitely below average” by the new GMC e-Knowledge scoring system which has recently been developed to manage and supervise all learning by anaesthetists.

“The system is very clever” reported Mr Flik who has recently moved from Germany to assist with the regulatory project. “It can detect when you log on, which e-sessions you read, how long you took to learn the material and most importantly scores your answers to the questions. This means an instant record of academic performance for all anaesthetists across the UK is available. Following a recent Freedom of Information enquiry we have decided that in the interests of openness, we need to make this information available to the Trust, GMC and patients.”

Unofficial sources reveal that six months previously, Dr Thickster was aghast when called to see Dr Thinlipz, Medical Director of his hospital. The initial meeting identified that despite insisting on the full NHS allocation of one Non Patient Activity (NPA) session weekly (NHS consultant contract 2014), Dr Thickster had managed to complete all 87 mandatory core eLearning sessions in 4 hours. This extraordinary NPA session was reported to the Trust by Mr Flik.

At the GMC hearing Dr Thickster revealed that he had felt the need for a concentrated approach to core learning before a busy private list. He acknowledged he was a fast reader and that perhaps his minor twitch had advanced sessions on quite quickly. However he found it difficult to explain his low scores on all the assessments. Initially he objected to the notion he might “just have guessed them all ” but neither could he explain how his overall score of -26 occurred.

The hospital and GMC had no choice but to suspend Dr Thickster until he has successfully completed the full programme of 4,326 sessions of eLearning offered by the new Anaesthesia College of Learning, “taking at least an hour over each session”.

Mr Flik was unapologetic, “The system is brilliant. There is no need for study leave or funding now that our extensive e-Learning system with full tracking is available. When combined with our easy to use – e-Casebook tracker and MMC (new), a career in NHS anaesthesia will be even more rewarding than ever before”.

Fortunately Scoop hopes to be retired by this point!