Report on the AAGBI Annual Congress

Anaesthesia in Cameroon

SAS report
WSM LONDON
14-16 January 2009
QEI1 Conference Centre, Westminster

NOT TO BE MISSED!

- Core topics
- Scientific sessions
- Workshops
- Winter Dinner and Dance

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www.aagbi.org/events/wsm

THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland
Your own correspondent travelled down from Norfolk to Torquay in two easy stages arriving in time on Tuesday for the Linkman Conference which this year was run the day before the Annual Congress. This was well attended and was followed by a Linkman dinner, which is a new introduction.

Wednesday morning saw the start of the Annual Congress at the Riviera International Conference Centre which was a brisk 15 minute walk from the main Congress hotel. The sun shone on the calm sparkling waters of Torbay and the palm trees reminded one that Torquay had a very different climate from most of Britain. However, the waterfront buildings were now showing signs of faded glory.

This year Rob Sneyd, Chairman of the AAGBI Events Committee, and his colleagues went to great lengths to improve the scientific content of the meeting without omitting non-clinical topics which have proved popular in the past, such as ACCEA and retirement planning. This proved successful, as this year we had the highest attendance of any Congress so far.

As in previous meetings, workshops (some organised in conjunction with Specialist Societies or industry partners) were run throughout the meeting on:

- Difficult Airways
- Ultrasound
- Neuromuscular
- Cardiopulmonary exercise testing
- Education
- Thoracic epidurals
These are always popular, and as usual, many were over-subscribed. This year saw an increase in the number of seminars organised by Industry on a variety of topics – participating companies included Schering-Plough, AstraZeneca, and Timesco.

There was a large Industry Exhibition which provided a useful resource for delegates as well as a popular meeting place. Some of the busiest stands were the ones which provided espresso or cappuccino, as an alternative to the “official” catering! In the same area was the ever-impressive art exhibition (see separate report on page 24), organised this year for the final time by Dr Anne Sutcliffe. Thanks are due to her for her sterling efforts over the last few years.

Wednesday morning saw parallel sessions on blood transfusion and affecting outcomes which were followed by the official opening by President David Whitaker and the Intavent Orthofix Lecture “Nitrous Oxide: has it outstayed its welcome?” which was superbly given by Professor Paul Myles from Melbourne, Australia. He expanded on the theme of the importance of research in anaesthesia and whether the continued use of nitrous oxide is justified. The answer was equivocal and your own correspondent will still continue to use said gas as part of his anaesthetic technique.

After an excellent lunch in the exhibition hall delegates returned to sessions which included neuroanaesthesia, new surgical techniques - a session organized by the Association of Surgeons of Great Britain and Ireland - and the ever-popular retirement session, which was very well attended by those with an eye on such things.

The early evening saw a drinks reception in the Exhibition hall sponsored by Janssen Cilag where a “mystery guest” appeared. Since 2008 Torquay was celebrating the centenary of the birth of one of its most famous residents, Agatha Christie, it came as no surprise to see Hercule Poirot in person.

The format for Thursday was very similar to Wednesday’s. The opening sessions included obstetric anaesthesia and “Health Service Redesign”. The latter probably needs further explanation and comprised a lecture on elective orthopaedics in a private treatment centre, a talk on how to improve the efficiency of any organisation and finally one on the value of the fully functioning pre-assessment clinic.

Mid-morning brought the Draeger Lecture given by Professor John Laffey (Ireland) on current knowledge of ARDS, including treatment strategies. This was followed by three more sessions in parallel: “Papers you need to know about”, Safety, and ACCEA. Your own correspondent was particularly riveted by the charismatic lecturing style of Prof Brian Toft, the United Kingdom’s only Professor of Patient Safety (at Coventry University).

The afternoon saw the last formal AGM. Regular readers of Anaesthesia News will be aware that the new Companies Act no longer requires organisations to have formal AGMs. As a result of this act, the AAGBI constitution needed to be redrafted, which has been superbly done by the Honorary Secretary Dr...
William Harrop-Griffiths in consultation with the Association’s legal team. The new constitution has been posted on the website and was available for prior consultation and comment by members. This was officially adopted, and the new Officer nominations were confirmed. These are: Dr Ian Johnston as Treasurer elect, Dr Les Gemmell as Honorary Secretary, Dr Ellen O’Sullivan as Honorary Membership Secretary and new President Dr Richard Birks. The outgoing president Dr David Whitaker handed over the Chain of Office to Dr Birks who gave him a vote of thanks for all his hard work during the preceding two years.

The climax of the scientific programme for the day was the post-afternoon tea session on the Cauldwell Xtreme Everest project. The Everest team gave a good account of the expedition. Some of the early scientific data are now beginning to be processed; however the picture is still far from complete. The truly fascinating thing about all this is that the Sherpas are clearly physiologically different from anyone else. This difference clearly needs looking into, which is what the Everest Team are planning to do in 2012.

The Congress Dinner was held that evening in the Imperial Hotel and was well attended. The Agatha Christie theme continued with a murder-mystery scenario put together by professional actors. (The maid did it). Many diners continued their evening after the dinner by dancing to a good local band with the bar showing little sign of closing.

Despite the night before, the final morning saw a good attendance first thing with sessions on intensive care, ultrasound applications in anaesthesia, and free papers. Coffee time came around appropriately fast and was followed by the main session of the meeting, The 50th John Snow Lecture: “Do academic departments of anaesthesia really need to do research “ which this year was given by Professor Ronald Miller from California and supported by Schering-Plough. The theme of his thought-provoking talk was now that anaesthesia has become so safe what should the specialty be getting involved with and what direction should the specialty be going in?
AVIATION APHORISMS

Many aviation aphorisms can easily translated to the world of anaesthesia.

Submitted by Sophie Bishop
SpR in Anaesthesia, NW Deanery

It’s best to keep the pointed end going forward as much as possible.

Keep looking around, there’s always something you’ve missed.

A pilot who doesn’t have any fear probably isn’t flying his plane to its maximum.

Be nice to your first officer, he may be your captain at your next airline.

Takeoffs are optional. Landings are mandatory.

Always remember you fly a plane with your head, not your hands. Never let a plane take you somewhere your brain didn’t get to five minutes earlier.

Remember, you’re always a student in a plane.

When a flight is proceeding incredibly well, something was forgotten.

There is no reason to fly through a thunderstorm in peacetime.

After lunch the Coroner’s Court was dramatically brought to life in the form of an inquest into the cause of death of a young girl under anaesthesia. The drama was written by Dr William Harrop-Griffiths and the dramatis personae were: Dr David Bogod as “The Coroner” (he is the Deputy Coroner for Glamorgan). The trainee who administered the anaesthetic was Dr Susan Williams, the grieving mother Dr Hilary Aitken, the Lawyer for the hospital Dr Andrew Hartle, and for the anaesthetist Dr Liliane Field, who is both a qualified anaesthetist and barrister who works for the Medical Protection Society. The anaesthetic clinical director was played by Dr William Harrop-Griffiths.

The scenario was that the SpR who had newly arrived in the hospital (first week in post) was asked by the clinical director to do a Day surgery list, without specifically checking what was on it and whether the new SpR was familiar with hospital policies. A drug error resulted from the hospital stocking a non-formulary concentration of metaraminol. The coroner reminded everyone that the purpose of the inquest was to find the cause of death but not to apportion blame.

The inquiry needless to say centered on drug and systems errors. It was so well done that the audience felt that they actually were in a real life coroner’s court. The coroner finally summed up and outlined the possible verdicts. The options included manslaughter, or the new category of corporate manslaughter, or accidental death. The jury was the audience who found in favour of corporate manslaughter. This was a brilliant finish to the conference.

Next year’s Congress is in the new BT Convention Centre in Liverpool on the 23 – 25 September 2009 - hope to see you there!

Nick Denny
AAGBI Council member
The role of the Honorary Treasurer of the Association of Anaesthetists of Great Britain and Ireland and its charity, the AAGBI Foundation, is to ensure that the financial aspects of our business are carried out efficiently on behalf of the 10,000 members.

The responsibilities are wide-ranging and include the day-to-day issues involved with employing our staff, running meetings, the maintenance of our property and all aspects of investment. This involves regular work with other members of the Executive and Council, and also our different staff members.

I was delighted with the success of the Torquay Annual Congress and would like to congratulate Professor Rob Sneyd and the Events Team, and also thank all of our members who attended the meeting. The scientific content was first class and the feedback superb. We believe that taking our Annual Congress to different locations is important to encourage as many members as possible to come and join us. It is a good opportunity for Council to meet a large number of colleagues to get the feedback that is so important for Council's work. There is limited finance available these days for NHS CME purposes and an increasing number of competitors in the market. Some of these are private companies run for profit, unlike the Association. The AAGBI is dependent on the financial support of members for our events, so please register for WSM 2009 in January and Annual Congress Liverpool next September. Also remember our excellent seminars and Core Topics program!

Unlike many other societies, the AAGBI and the AAGBI Foundation are fortunate that previous Councils have slowly built up our resources into a good financial position. We own our building and have adequate reserves for the day-to-day running of the business as well as for future developments. At present, we employ 18 full time members of staff (finance, events, house management, archives, secretariat and membership services) and have built up a service for Specialist Society support. The ambition of each successive Council is to leave the AAGBI in a better position with all issues, financial and political, dealt with effectively during their time in office.

As one of the long-term funding institutions for anaesthesia research in the UK, we were delighted to join with Anaesthesia (our journal), the Royal College of Anaesthetists and the British Journal of Anaesthesia to form the National Institute of Academic Anaesthesia earlier this year. This development will increase the amounts of money available for research in the UK, and we also hope it will help anaesthesia to attract significant NHS funding, not only in the academic departments but also for the NHS anaesthetist who wishes to continue with their research interests on a smaller scale.

The investment market has been turbulent this year and following good gains in previous times, we are hoping to get our portfolios optimised to resist the general share price falls that have been happening recently. Thesis, our investment managers, have followed our ethical investment policy and we continue to monitor their performance in these unstable times.

I am delighted that despite all the financial pressures being experienced in the UK, our Overseas Anaesthesia Fund (OAF) continues to attract the support of many members. A recent barbecue in aid of OAF attended by over 100 people raised £2000 for OAF – well done Ranjit Verma - a great effort! Many anaesthetists in different countries are hugely grateful for the kindness of UK colleagues who take time to remember them in their difficult times. A full report of the recent activities funded by OAF will appear in next month's Anaesthesia News.

I have greatly enjoyed my first two years as the Honorary Treasurer and will hand over to Ian Johnston, who was elected Honorary Treasurer Elect at the recent Annual General Meeting, in September 2009. As always, I am very grateful for the expertise of our financial adviser Francis Wirgman and the hard work and skills of our staff: Liz Devine, Christine Grainger and Jane Messum.

Dr Iain H Wilson
Honorary Treasurer
In need of guidance

The other day I was in my anaesthetic room in that short hiatus when you’re all ready to go, and are just waiting for the first patient to arrive from reception. (If I added all these hiatuses together, how many years of my life would that add up to? But that’s another editorial altogether.) I was idly perusing all the guidelines stuck to the anaesthetic room wall, when it occurred to me that there were an awful lot of them. I decided to count them (regular readers will already be aware that I need to get out more). There were twenty three of them. Fired up by the task in hand, I went into theatre, where I found a further twenty. Forty three guidelines! One theatre! They can’t possibly all be useful. They may even present an infection hazard – everything else does these days, so why not slightly dog-eared sheets of paper tacked up with Sellotape?

Obviously I exempt from criticism the very fine guidelines produced by our own Association – the machine checklist and the MH sheet were there. Both are laminated which I gather means the infection control police would approve. The ALS algorithms might also be handy (I did once ask for them to be removed from the section of wall in direct line of sight of the patients). Ditto the failed intubation drill, although I have always wondered at which point during the failed intubation you get a chance to read the protocol carefully.

But then we get to the slightly less crucial stuff. Two antibiotic policies. Sounds very useful, until I explain that one supersedes the other, and for both the only relevant line is the one at the very end which reads, “This guideline is not intended to replace agreed guidelines for antibiotic prophylaxis in elective surgical patients.” There’s lots of stuff about ordering drugs, checking fridge temperatures, cleaning lead aprons (obviously a significant anaesthetic duty), and some that I think are just plain out of date that nobody has bothered to remove. Sadly I have failed to identify the Holy Grail of guideline-spotting – two directly contradictory policies on the same wall.

In addition, of course, there’s the policy folder, with lots more policies and guidelines.

We are drowning in guidelines. Nobody can possibly be familiar with them all. And is the theatre a safer place for having them?
At the Annual Congress in Torquay, we had a mock inquest (see report on p.3). One of the factors highlighted was the trainee’s lack of familiarity with guidelines operational in her new post. William Harrop-Griffiths, playing the clinical director of anaesthesia, produced two large A4 lever files of policies which the trainee was meant to have read and absorbed in two days. This raised a laugh from the audience, but only because everyone recognised the truth of the situation. How do you spot the crucial one amongst all the rest?

I used to sit on my hospital’s Drug and Therapeutics committee, a fine producer of guidelines, where I even produced a couple myself. One of mine was about which regular medication to give or withhold from patients on the day of surgery. The nurses liked it, and it all worked swimmingly. Two years down the line, this guideline is still operational, but the nurses on the ward now have never heard of it. So many guidelines about everything else have been produced in the interim, it’ll be filed up the back of the policy folder. Sometimes, just out of badness, I write “please administer regular drugs as per protocol” on the premed section of the anaesthetic chart to see what happens.

Last month in our articles about the induction process, both authors highlighted the feeling that it was all just a box-ticking exercise, and much of it was so the Trust could say they’d done it to cover their backs in the event of an incident. Many guidelines are for exactly the same reason. Enough of the guidelines! I’m sure we could do away with 95% of them and have a return of common sense instead.

It’s been a time of change for Anaesthesia News. Iain Wilson, who has been a stalwart assistant editor for many years, has stepped down, and been replaced by Isabeau Walker. I would warmly like to thank Iain for all his hard work and support over the years, and to welcome Isabeau to the team. I’m sure we’ve not heard the last of Iain in Anaesthesia News as I intend to make sure he will continue to contribute articles. Val Bythell has been appointed as Deputy Editor, and Mike Wee continues his excellent work as the remaining assistant editor.

Finally, this is of course the December issue, so I would like to wish you all a very Happy Christmas, and I look forward to your continued support and interest in Anaesthesia News in 2009.

Hilary Aitken
A watercolour painting (illustrated) by Stephanie Greenwell, the former Anaesthesia News editor, has been selected as the AAGBI 2008 Christmas card, with all profits going to the Overseas Anaesthesia Fund. Many of you will have seen the original which was exhibited in the AAGBI art exhibition in Torquay in September.

The cards cost £4.95 for a pack of ten, including P&P. £1.95 will be donated to OAF for each pack sold. To order, photocopy and complete the form below. Forms can also be downloaded from the AAGBI website.

AAGBI Charity Christmas Card Purchase Form

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email: info@TheAnaesthetistsAgency.com
www.TheAnaesthetistsAgency.com
SASM audits all deaths of patients admitted under surgical care in Scotland, whether or not they have received an operation. It is a voluntary audit in which all deaths are peer reviewed by consultant surgeons and consultant anaesthetists (for the operative deaths) from a different Health Board. The most recent data is from 2006 (2007 data will be published in December 2008) with a return rate of over 91% for the 3639 deaths under surgical care. This is believed to be the highest rate of return in any voluntary medical audit worldwide, and virtually every consultant anaesthetist and surgeon in Scotland takes part.

The named consultant surgeon completes a SASM review form, and if an operation has taken place, the consultant anaesthetist completes the anaesthetic part of the form. Annually over 1100 consultants take part. This is only possible because of willingness of the profession to participate. (It is interesting to note that almost 25% of the ‘no returns’ in 2006 were generated by just 5 (0.4%) consultant surgeons who refuse to participate.) Anonymity is guaranteed, and consultants in Scotland view SASM as a non-threatening process.

Origins and involvements
SASM came into being in 1994 with the amalgamation of 2 parallel audits from Glasgow and all of Scotland which had been started in 1988 and 1989. All surgical specialties across 51 acute hospitals are covered, with the exceptions of cardiothoracic surgery and obstetrics, which are covered by UK-wide bodies. However, the Scottish cardiothoracic surgeons still provide data from their own audit for inclusion in the annual report.

Administrative structure
This can be divided into two main committees and the assessors. I have listed the members to allow the reader to see how strongly supported SASM is across anaesthesia and surgery.

SASM Board
This is responsible for strategic planning and is the top layer of management. The chair alternates every three years between the President of the Royal College of Surgeons of Edinburgh and the President of the Royal College of Physicians and Surgeons of Glasgow. Each College also sends a representative if it is not their turn to chair the Board. There are also representatives from the Scottish Board of the Royal College of Anaesthetists, the Royal College of Gynaecologists, the Royal College of Nursing, the Chair of the Management Committee, a surgeon and anaesthetist from the Management Committee, the Chair of the Liaison Group, two lay members, the SASM National Coordinator and the person responsible for clinical governance at the Information and Services Division (ISD) of National Services Scotland.

SASM Management Committee
This is responsible for the administration of the Audit and reports to the SASM Board. This contains the Chairman (currently an anaesthetist), East of Scotland General Surgery Co-ordinator, West of Scotland General Surgery Co-ordinator, East of Scotland Anaesthetic Co-ordinator, West of Scotland Anaesthetic Co-ordinator, Specialist Surgery Co-ordinator (Orthopaedic), Specialist Surgery Co-ordinator (Vascular), GAT (Group of Anaesthetists in Training) representative, a Representative from ISD, Chairman of Liaison Group (anaesthetist) and the SASM National Coordinator, who also acts as Secretary to the Committee. The liaison committee has recently been
incorporated to provide further specialty representation.

Assessors
All consultants participating in the audit are contacted and asked if they wish to act as first line assessors, which involves reviewing the completed form. A wide geographical distribution of first line assessors protects anonymity within SASM. Each first line assessor assesses approximately 60 cases a year. One third of each group will retire each year to allow continual movement but at the same time retain a degree of continuity. 1 in 10 forms with no adverse events identified by the first line assessor are reviewed by the co-ordinators to ensure consistency.

Data Collection
Deaths within 30 days of an operation or during the patient’s admission under a surgical consultant are collated from mortuaries, records offices, wards and consultants’ secretaries. A proforma is then sent to the consultant surgeon responsible for the case. If appropriate, the surgeon passes the case notes to the responsible anaesthetist who fills in the anaesthetic proforma. Whilst it is the named surgical or anaesthetic consultant who is responsible for the case, if it was a trainee who was in theatre he / she will be asked to help complete the proforma.

Each anonymised proforma is then sent to a first line surgical +/- anaesthetic assessor. Their initial assessment is fed back to the clinician(s) involved. If the assessor feels there is insufficient information on the proforma, or they have identified significant concerns they can request a case note review, which involves a second line assessor making a much more detailed review of the case management.

Areas of concern or for consideration (ACoN)
Assessors or case note reviewers may highlight areas where they feel care has been sub-optimal. These areas can be clinical (involving the surgeon or anaesthetist), or organisational. If there is an area that an alternative view may have been warranted then this is an “area for consideration”. There is space on the form for either the surgeon or the anaesthetist treating the patient to highlight areas of concern also.

SASM has provided the following definition for its participants (see box)

Feedback
Individual
All ACoNs are fed back to the clinicians involved and all anaesthetic and surgical consultants receive an individual annual report containing data from all their cases. SASM hopes that these reports could be used in an individual’s annual appraisal.

Health Board Feedback
Each Health Board receives its own summary data, in the context of totals for the rest of Scotland.

Case report book
Anonymised case reports are collated and sent out to anaesthetic and surgical consultants. These should be made available to trainees at a hospital level or can be requested from the SASM office.

These are an important part of the SASM process as they allow individual clinicians to look at problems and mistakes made elsewhere and what the recommendations were. If you are an anaesthetic trainee in Scotland and have not seen these case books, please ask your consultants to pass on the latest copy as there is a wealth of cases to learn from, and they make fascinating reading.

Guidance for the definition of an area of concern
An area of concern is an unintended “mishap” caused by medical management rather than by disease process, which is sufficiently serious to lead to prolonged hospitalisation or to temporary or permanent impairment or disability of the patient at the time of discharge, or which contributes to or causes death.

• Medical management includes actions of the responsible clinician (surgeon or anaesthetist) or other clinician, the resource available, and the system as a process. Areas of concern brought about by failure of equipment or its provision will also be included.

• Medical management includes acts of omission: for example, failure to diagnose or treat, and commission: for example, incorrect treatment. Injuries that come about from failure to arrest the disease process are also included provided that standard care would clearly have prevented the injury.

• Areas of concern may or may not be preventable. An area of concern is considered preventable if the reviewer judges that it would not have occurred if the patient had received an ordinary standard of medical care appropriate for the time: for example, omission of prophylactic antibiotics or anticoagulants specified in national guidelines.

• Assessment of preventability will be divided into two: on balance unpreventable, and on balance preventable.

• Areas of concern will also be judged on their impact with respect to death, either none, low, moderate or high.
Annual Summary
Each year in November an annual summary is published – the most recent is 2006. 10 years of data collection allows trends to be analysed. Chosen areas of practice can be more closely audited. Palliative care, peri-operative fluid management and post-operative renal failure are currently being more closely audited.

So what does it tell us?
Of the 1539 deaths associated with surgery in the 2006 report, consultant surgeons were present at 77% and consultant anaesthetists at 78% (this is up from 72% and 67% respectively in 1999).

Hospital acquired infection (HAI) was thought to have contributed in 13% of deaths (up from 11%). Critical care was used by 60% of operative deaths and 20% of non-operative deaths. 38 deaths were in patients where a critical care bed was needed but not available.

The top five “areas for concern or consideration” are shown in table 1.

Summary
These data are just a brief snapshot of all the data that is available every year from this voluntary audit. It is hoped that the dataset will continue to be robust due to diligent returns. It is interesting to note that the renal physicians in Scotland have set up an audit based on the SASM process and it is hoped that the interventional radiologists will soon follow suit. Increasingly the idea of a medical equivalent is being mooted in the higher echelons of medical decision-making in Scotland.

It is great to see and be part of an audit that works and leads to increased knowledge and better patient care. Whilst I realise that many readers will not come into contact with SASM, it is still important to know about it and to use the information available as a valuable tool.

Useful Links
http://www.sasm.org.uk/
http://www.sasm.org.uk/Reports/
Summary_Report_2006_data.pdf

Dr Adam Paul
GAT Committee Member

Dear Editor…
There’s always a way…
I read Dr Elizabeth Hall’s letter (1) describing the struggle to remove nail varnish in a post partum haemorrhage patient for, I assume, the purpose of attaching a pulse oximeter probe. May I suggest that if the nail varnish cannot or the patient does not wish it to be removed then simply turning the probe through 90 degrees so that light is transmitted laterally through a digit works fine! Of, course other body tissues can be used such as the ear lobe, nose, lip or cheek.

Dr Francis Arnstein
Consultant anaesthetist, Livingston
Thanks to several other readers who wrote with this helpful tip.
I am a Spanish consultant anaesthetist and am currently at the end of a break after six months’ work in a mission hospital in Cameroon; my work will continue there for at least one more year. This summer gap is allowing me to reflect on my initial impressions.

Before moving to Cameroon I worked in the NHS in England for six years. My aim was to become fluent in English and to gain experience which would stand me in good stead and allow me to explore options for work with an NGO (Non-Government Organisation) in developing countries. The British experience gave me a good flavour of what it is like working in a country where culture and language are different. However, that experience was in Europe and within the frame of a relatively wealthy and strong public health service. In order to prepare myself for work in a developing country I attended several seminars and the 2007 course 'Anaesthesia in developing countries' in Oxford and Kampala. This helped me to establish a network of colleagues who have been supporting and encouraging me during this initial period. After all this I thought I was prepared for what I was going to face in Africa.

An English charity put us in contact with a local charity that has provided health care to a rural area of Cameroon since 1935. It is my first placement in a resource – limited country. I moved with my husband, a professional engineer, and my two children aged 3 and 6. As volunteers we receive accommodation and a small local salary to pay for food and other basic expenses. For this project we saved money, sold our house in England and budgeted ourselves for one to two years with no extra income. Expenses such as professional and personal insurance, immunisations and flights were paid by us.

Now that I look at this time in perspective I can see there are three different stages in my views about working in a developing country.

**STAGE ONE: BEFORE - THE IDEALISTIC PHASE**

Each of us has different reasons for going to work in a less affluent country.
In my case there were two reasons; one was the disappointment with my work in the wealthy world where I felt like another cog in a huge machine driven by political and macro-economic interests. Sometimes I feel that patients’ and workers’ priorities are secondary. Secondly, I wanted to feel that my skills and knowledge could help colleagues who strive to provide anaesthesia to a poor and stoical population with very few resources; I wanted to share expertise and feel that my work had an impact on people’s lives. In the background was the idealistic thought of changing the world towards a fairer society.

With this in my mind and heart I travelled to my destination remembering many words of wisdom from colleagues who had already been working in developing countries: I wrote down my personal and family objectives for the time to be spent in Cameroon; I communicated with the hospital to establish their needs. In summary I left with baggage full of good wishes and intentions.

STAGE TWO: AFTER ARRIVAL - TOUCHING REALITY

Our hospital is a 300-bed hospital with two operating theatres, one used for dirty procedures and the other for scheduled and clean interventions. There is one permanent general/urologist surgeon and one permanent gynaecologist. The workload is around 600 interventions per year. Anaesthesia is provided by nurse anaesthetists and I am the first physician anaesthetist ever to work there. It is in a beautiful setting surrounded by mountains. The hospital encloses a pleasant garden where families have siestas, picnic or pray. The cleanliness of the place is remarkable, as is the openness and friendliness of the staff and the gratitude of the patients.

I found the problems I had expected: lack of drugs (no opioids at all) and equipment. But I also found no recovery, no high dependency or intensive care, deficient preoperative preparation and very poor postoperative care; lack of order in the store room and risky untidiness in the operating theatres; donated material which was unused and deteriorating in store rooms and in general an inefficient use of the scarce resources available. But above all I found a huge resistance to change. Reading articles and letters from colleagues working in different parts of the globe in equally economically impaired countries, the problems one faces vary greatly from one continent to another. Africa has its own idiosyncrasies!

On the other hand the hospital has been operational for a very long time, providing health care to a large population; the
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An Introduction to The Writers Club and The Mersey Method

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<td>Liverpool</td>
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<td>10.00 – 15.00</td>
</tr>
<tr>
<td>London</td>
<td>Saturday 13th December</td>
<td>10.00 – 15.00</td>
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<td>Liverpool</td>
<td>Sunday 14th December</td>
<td>10.00 – 15.00</td>
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<tr>
<td>Liverpool</td>
<td>Saturday 3rd January</td>
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</tr>
<tr>
<td>Liverpool</td>
<td>Sunday 4th January</td>
<td>10.00 – 15.00</td>
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</table>

www.msoa.org.uk

for

Details, Plaudits & Application to Attend an Introduction Day
“If you feed the children with a spoon, they will never learn to use the chopsticks”
operations have been carried out for years without the 'need' for a doctor anaesthetist. With this, several questions came to my mind: Were the problems I had encountered also a hurdle for the people working in the hospital? What were their anaesthetic needs? And were they prepared to trust a foreign doctor just because I had white skin and western training? Poverty and lack of preparation makes people insecure and very fearful of changes. Trust is not built in a day, nor a week nor a month; it needs time and patience.

In spite of difficulties during those six months I trained two nurse anaesthetists, I taught in the hospital educational meetings, I assisted the neighbouring nursing school, and above all I have been learning and doing a lot of research. During this tough time the AAGBI and many colleagues have provided support which has encouraged me to persevere and continue with my work.

**STAGE THREE: AFTER INITIAL EXPERIENCE – PLANNING THE FUTURE**

I have decided to try to define the role of a doctor anaesthetist in a setting where this is unknown and try to use my expertise to improve what I saw as deficiencies in the practice here. I proposed a number of projects to the administration of the hospital. They have agreed to my plans for a course to train staff nurses to improve the management of critically ill patients. The idea is that with time and preparation it will be possible to set up a small A&E department that can deal with patients that otherwise would die or deteriorate either before or as a result of interventions. I will continue training nurse anaesthetists, including working in theatre for three days a week. I will continue to assist the nursing school in the intensive care module and teach in the hospital educational meetings.

**REFLECTIONS**

For me it would have been easier if I had had a clearer project and a role defined by the hosting organisation before my arrival. I advise anybody embarking on a similar experience to engage in discussion with the hospital to establish possible areas of focus to avoid disappointments later on.

Once in the place, I have learned that in spite of any major preparations, which are very much necessary, one needs a period of observation of the community to understand the reasons behind their practice. ‘More haste less speed’ is totally correct. I came with the European mentality of work-efficiency-results and that does not work in Africa. Also one needs to gain the trust of the local staff and work with them to promote long lasting and positive changes for the community. I have seen senior volunteers coming for short periods suggest changes to practice. Those changes lasted for the time they were there: as soon as they had left, the old way came back!

In the middle of this personal project I feel happy and fearful. Happy because it is infinitely rewarding to work for a community where always there is gratitude in their words and actions; also I am learning many new things in this never-ending project of finding the ideal way of helping communities in need. Fearful because I do not want to feel that I have failed at the end of this time, but as a good friend told me once: “There is no failure in this type of journey”

**Dr M Teresa Leiva,**
**Consultant Anaesthetist**
**St Elizabeth Catholic General Hospital Shisong,**
**Northwest Province, Cameroon**

The International Relations Committee of AAGBI awarded Dr Leiva a travel and education grant in connection with this work. For more information about AAGBI grants see www.aagbi.org/grants/travel
Derriford hospital is a teaching hospital with 1071 beds providing comprehensive secondary acute services and tertiary services covering hepato-biliary, renal transplant, neuro, plastic/reconstructive and cardiac surgery. (1)

Before August 2007 the anaesthetic out-of-hours cover at trainee and consultant level is shown (Table 1). These rota s were introduced in 2003 and are European working time directive (EWTD) compliant for 2009. Reduced trainee numbers following changes in August 2007 made the provision of five on-call trainee rotas impossible. After risk assessment and departmental discussion the junior trainee for theatre from 20:00 hours was removed commencing August 2007.

The number of trainees employed by the trust during the second week of August for each of the 3 years was reviewed. (Table 2) Trainee numbers fell over the 3 year period, and this has been predominantly at the level of SHO/ST1/2. An audit conducted over a 3 month period in 2005 was repeated in 2007 for the months August, September and October to measure consultant out-of-hours workload. Consultants were asked to complete a form when on-call. Response rates were 90% in 2005 and 100% in 2007.

The average increase in consultant workload was 1.7 hours at work per weeknight and 2.6 per weekend or public holiday. On a daily basis the impact of losing one tier of on-call trainee cover has been small; however this increase amounts to over 720 hours of additional clinical work annually. Virtually all this work is undertaken outside the “normal working day” equal to approximately 240 extra planned activities (PAs) per year or 0.8 whole time equivalent (WTE) consultants.

**Discussion**

The New Deal (2) and EWTD (3) reduced availability of junior doctors. The EWTD has reduced the caseload amongst trainees at our hospital (4). The introduction of specialist training has reduced numbers of trainees within our department which has resulted in an increase in out-of-hours workload for consultant anaesthetists. The final report

<table>
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<tr>
<th>Grade</th>
<th>Area</th>
<th>Experience</th>
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</thead>
<tbody>
<tr>
<td>Junior Trainee</td>
<td>Main Theatres</td>
<td>ST1 or 2</td>
</tr>
<tr>
<td>Senior Trainee</td>
<td>Main Theatres</td>
<td>ST5 and above (FRCA)</td>
</tr>
<tr>
<td>Trainee</td>
<td>Obstetrics</td>
<td>ST2 and above</td>
</tr>
<tr>
<td>Trainee</td>
<td>Cardiac Intensive Care</td>
<td>ST3 and above</td>
</tr>
<tr>
<td>Trainee</td>
<td>General Intensive Care</td>
<td>ST3 and above</td>
</tr>
<tr>
<td>Consultant</td>
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<td>Consultant</td>
<td>Complex neurosurgical cases</td>
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<td>Paediatric anaesthetic/ paediatric ICU support</td>
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<tr>
<td>Consultant</td>
<td>General intensive care</td>
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</tr>
<tr>
<td>Consultant</td>
<td>Cardiac intensive care and cardiothoracic theatres</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 1. Medical out-of-hours service provision at Derriford Hospital (Anaesthesia, critical care, cardio-thoracic anaesthesia). Additionally there is an ST1/2 on the general intensive care unit provided by a separate directorate.
in the evening has increased with plastic and orthopaedic trauma lists staffed by anaesthetists separate from the emergency team. Improved communication with surgical teams increased additional daytime list capacity for semi-urgent neurosurgical work, formerly performed out-of-hours. Discussion with surgeons resulted in less non-urgent surgery being performed after midnight. This decision should be made at a local level with collaboration between surgical teams, management and anaesthetic departments (8). A “team” approach is now encouraged amongst the resident on-call trainees who cross-cover when able to safely do so.

The impact of extra consultant cover to meet the emergency workload within the trust is 1.5 WTE (plastic and orthopaedic trauma lists) and 0.8 WTE (to cover the loss of one trainee on-call rota) which would represent an increase of 4.5% in our consultant numbers.

In 2009 the EWTD requires that the average working week is less than or equal to 48 hours. While at Derriford, trainee rotas have been compliant since 2003, it is likely to impact significantly on workforce arrangements for anaesthetic provision in other trusts. Monitoring out-of-hours work amongst consultants provides evidence for workforce planning. In our hospital this data contributed to the business plan for funding a consultant anaesthetist which will improve patient safety and aid the provision of a consultant led service.

R L Eve, Specialist Registrar in Anaesthesia
S Boumphrey, Consultant Anaesthetist
S R Wrigley, Consultant Anaesthetist and Clinical Director
Derriford Hospital, Plymouth UK

References:

Consultant anaesthetists are allocated no clinical duties the day following a general on-call. To cover this gap each Consultant on the general on-call rota has increased their job plan by 0.2 PAs per week. This equates to roughly four half-day sessions per year to be worked flexibly.

Other initiatives to reduce night work were in place at the time of the audit in 2007 but not in 2005. Anaesthetic service provision of the independent inquiry into modernising medical careers led by Professor Sir John Tooke (5) discusses the impact of the EWTD and suggests that the Department of Health explore contractual solutions to facilitate a more flexible yet legitimate approach to the EWTD.

Increasing out-of-hours workload for consultants reduces their daytime availability. It is recommended that a consultant leads the anaesthetic team (6) and this creates a dichotomy. The average on-call hours spent working in theatres either independently or supervising trainees by general consultant anaesthetists at our hospital is 6.2 hours every weekday, which means that on average they will be present in the hospital beyond midnight.

Previously an informal arrangement operated whereby if a consultant was present in the hospital beyond midnight they would not be required to work the following morning. However, given Article 3 of the European Working Time Directive (3) and the Association of Anaesthetists of Great Britain and Ireland’s recommendations concerning fatigue and the anaesthetist (7) a formal arrangement now exists.

Consultant anaesthetists are allocated no clinical duties the day following a general on-call. To cover this gap each Consultant on the general on-call rota has increased their job plan by 0.2 PAs per week. This equates to roughly four half-day sessions per year to be worked flexibly.

Other initiatives to reduce night work were in place at the time of the audit in 2007 but not in 2005. Anaesthetic service provision

Table 3. Average time spent in the hospital working independently or supervising a trainee whilst on-call - consultant anaesthetists on the general on-call rota only.

<table>
<thead>
<tr>
<th>Hours</th>
<th>2005</th>
<th>2007</th>
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<tr>
<td>Weeknight</td>
<td>4.5</td>
<td>6.2</td>
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<tr>
<td>Weekends and public holidays</td>
<td>8.8</td>
<td>11.4</td>
</tr>
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</table>
January 2009 marks the twenty-first anniversary of the start of the Winter Scientific Meeting.

Tom Boulton recalls: ‘The meeting obviously met a need at a time of the year when generally there is minimal academic activity after Christmas and, (dare one say it) when accompanying persons can take their credit cards to the January sales in London’.

Discussions about holding a Winter Scientific Meeting began in December 1986 after Professor Michael Rosen suggested it in Committee. By June 1987 a programme had been arranged. The first meeting took place on Friday and Saturday 15 and 16 January 1988 at the Royal College of Surgeons of England in Lincoln’s Inn Fields. The Winter Dinner was held in the Waldorf Hotel, Aldwych on Friday 15 January 1988. Graham Smith, Chairman of the Education Committee, Peter Morris and Mrs Catherine Goff (BOC Education Coordinator) helped ensure the success of the meeting. The technical exhibition was organised by Dr Ralph Vaughan. Annual Reports reveal that early Winter Scientific Meetings were attended by over 370 delegates.

The programme for the first meeting has survived and shows that there were twenty-four invited papers. Professor M H Holdahl of Sweden, a world leader in anaesthesia, was awarded Honorary Membership at the meeting. The four sessions covered the following areas: volatile and intravenous anaesthesia; monitoring; ‘risky’ anaesthesia and intensive care. In 1991 the practice of one of the Specialist Societies of anaesthesia arranging and presenting a lecture session began.

In 1991 the Winter Scientific Meeting moved to the Queen Elizabeth II Conference Centre but the format of Friday to Saturday meetings did not change.

The Winter Scientific Meeting has been used twice to celebrate important anniversaries of the Association of Anaesthetists. The first occasion was in 1992 when the Association celebrated 60 years since its foundation. The opening ceremony was attended by the Association’s then royal patron, Princess Margaret and the President, Dr Peter Baskett, awarded her Honorary Membership. The scientific programme, containing six sessions, was organised by Dr (now Professor) Tony Wildsmith. The first session was chaired by the President and the other five by former Presidents. Each session represented a chronological decade or event.

In 2007, the Winter Scientific Meeting was again chosen as the event to celebrate 75 years since the foundation...
Innovation at the Association

The last twelve months have seen great changes in the Association of Anaesthetists, including the opening of the prestigious headquarters at 9 Bedford Square, and the inauguration of a series of small seminars on topics of interest to the profession. We print below two items relating to further expansion in the activities of the Association on behalf of its members. Dr John Lunn reports on the first Winter Scientific Meeting, held in London on 15 and 16 January, and there is an announcement about the Sir Ivan Magill Gold Medal, to be awarded for innovative contribution to Anaesthesia.

The Winter Scientific Meeting, 1987

The Association of Anaesthetists of Great Britain and Ireland this year launched another new project, a winter scientific meeting. The proposal for this event (an original idea of our President) was first officially mentioned at the meeting of the Education and Research Committee in December 1986, the decision taken hurriedly in April 1987, and the programme announced by June 1987. The upshot of organisation which culminated in a very successful meeting held in January 1988 was the work of two or three individuals and their efforts are warmly acknowledged. Professor G. Smith made all the arrangements for the scientific programme, and obtained the agreement to speak from a guest session for the European Society of Anaesthesiologists.

The Winter Scientific Meeting has gone from strength to strength which is undoubtedly due to strong leadership and a conscientious, dedicated staff team. In 1998 the WSM was extended and became a three day meeting. In 2002 the pattern of the meeting changed with the programme commencing on Wednesday and finishing on Friday. In 2008 The Winter Scientific Meeting was rebranded and the title became ‘WSM LONDON’.

Peter Morris, our Honorary Secretary, with the help of other officers, attended to all the important details of the organisation of the meeting. Ralph Vaughan organised the trade exhibition under what can only be described as very difficult circumstances. The value of this exhibition to those who attend meetings is much appreciated. The other staff of the Association has to cope with the work generated by the organisation of meetings and on this occasion our BOC educational coordinator, Mrs Catherine Glynn, excelled herself.

A guest session for the European Society of Anaesthesiologists will be included in the programme for 2009 for the first time. There will also be another chance to visit the Cabinet War Rooms for those who missed out in 2007. So book now to attend WSM London 2009 which will be held between 14 – 16 January!

Trish Willis,
Heritage and estates Manager,
AAGBI

References:


Archives of the Association of Anaesthetists of Great Britain and Ireland ME2/ series.
Rabbitting on about the art exhibition

The 2008 Exhibition is over and as always brought pleasure to hundreds of delegates. It was the biggest ever with 205 exhibits. Following Imelda Galvin’s success last year, we had a lot of exhibits from trainees. For the first time, we also attracted work from two ODPs; Chris Shirley and Clive Davies. Special thanks go to Galia Kwenty who brought five large and beautiful paintings all the way from Edmonton, Alberta. I have never considered introducing a children’s section but if Danisha Kerr’s exhibit is any guide to the untapped talent within the anaesthetic paediatric community, I certainly should have. I mention Danisha again later but for now I should tell you that she is five years old and our youngest ever exhibitor.

Dr Robert Cruickshank was this year’s runaway winner. His frieze entitled ‘Boring case, slightly more complex than originally thought’ consisted of sketches created over thirty years. At 50 feet long, this exhibit was challenging to put up and take down but the effort was well worth it! His work stands out as the most popular exhibit ever and I am sure will still be talked about in years to come. The runner up was Jason Walker with his photograph entitled ‘Skaters’.

Usually, a number of exhibitors fail to win because several of their exhibits get votes but the split means than none get enough to win. I have therefore named an exhibitor of the year. This is the person with the highest average vote per exhibit. Given that Robert Cruickshank had only one entry, he is also my Exhibitor of the Year. Several other exhibitors also deserve special mention because of the popularity of their exhibits. They are Kathy Smith, Danisha Kerr, Samantha Shinde, Hussain Haider, James Nickells, Ruth Spencer and Barrie Fischer.

I am almost certain that the first Exhibition was held in Birmingham in 1995. If I am correct, the 2008 Exhibition was the 13th. Thirteen is an unlucky number. As I am highly superstitious, I concentrated on the fact that this was my fifth (and final) exhibition! As it turned out, 13 is a very lucky number as the table below shows.

Many visitors to the exhibition are reluctant when we try to sell them raffle tickets, perhaps not realising that the Royal Medical Benevolent Foundation is a vital lifeline for doctors in financial distress. Those of us who attend conferences and are in regular employment are paid well. But there are a lot of young doctors who are ill or unemployed for genuine reasons. Not only do they not have an income but also they have no pension. They really do need financial assistance and the RMBF helps them. Although many delegates do not support the raffle, a few individuals make generous donations. This year, I am particularly grateful to the gentleman whom I suspect would be embarrassed.

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<td>29</td>
<td>30</td>
<td>19</td>
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<tr>
<td>New exhibitors</td>
<td>23</td>
<td>12</td>
<td>11</td>
<td>18</td>
<td>4</td>
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<td>Money raised for the RMBF</td>
<td>£1900 at least</td>
<td>£850</td>
<td>£1000</td>
<td>£956</td>
<td>£650</td>
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to be named but whom I must mention. His extraordinarily generous donation of £1000 means that this year our donation to charity is twice its normal size.

As the years have gone by, the character of the exhibition has changed but enthusiasm for it has most certainly not. I am convinced that the reason the exhibition remains popular is that each year we enjoy a variety of exhibits from a variety of exhibitors. My goal has been to encourage everyone who does anything artistic for a hobby to show us what they do. My other major message has been that we welcome work from everyone. Whoever you are, whatever you do and however tenuous your relationship with anaesthetists, the exhibition needs you.

Before 2004, artists dominated due to John Edwards’ support and encouragement, although we did also exhibit photographs, sculpture, embroidery, stained glass, woodwork and various other unique items. I am pleased to have expanded the number of photographs and added variety in the form of jewellery, tiaras, decorated plates, welcome curtains and paintings on glass. Now that I am stepping down, the character of the exhibition will probably change again in the next few years. I know it will flourish in the care of Stephanie Greenwell and Di Dickson. I am most grateful to them for taking over the organisation. In 2009, they will be worrying about their first exhibition just as I did in 2004. I wish them every success and urge you to support them as enthusiastically as you have supported me. The earlier you promise exhibits, the happier they will be! Contact them via the AAGBI or Julie Gallagher now.

I cannot sign off without recording my heartfelt thanks to Trish Willis who helped me in my early years and latterly Julie Gallagher. Both of them have given me fantastic support and assistance. Without the hard work of Trish, Julie and others at Portland Place, there would be no exhibition. I would also like to thank Stephanie Greenwell and Hilary Aitken for giving me space in Anaesthesia News to publicise the exhibition.

Finally … thank you to everyone who, over the past five years, has given me exhibits or visited the exhibition. You know who you are. Your support and enthusiasm have ensured that the exhibition’s popularity continues to grow.

Anne Sutcliffe

For information about next year’s exhibition in Liverpool, contact Julie Gallagher at AAGBI.

The winning photograph – “Skaters” by Jason Walker
Society for Education in Anaesthesia (UK)

Annual Scientific Meeting

TRAINING, EDUCATION & ASSESSMENT OF ANAESTHETISTS - AN UPDATE

Monday 16th March 2009

THE SAGE
NEWCASTLE-GATESHEAD

- Length of training – do competencies change anything?
- Update on Trainee Assessment tools
- Departmental teaching in the era of e-learning
- The Changing role of the College Tutor
- Setting case numbers for training
- The NIAA
  - Plus
  - Abstracts invited for Free Papers.
  - Trainee Prizes of £150 and £300.

Submission deadline 2nd February 2009
Posters welcome - deadline as above. Prize £50
Cost: £125 for members/£150 for non-members
(including one year membership)

For further details/registration form, please contact:
Barbara Sladdin, Administrator, Northern School of Anaesthesia, Royal Victoria Infirmary, Newcastle upon Tyne. NE1 4LP. Tel No: 0191 282 5081 or email: Barbara.Sladdin@nuth.nhs.uk or visit www.SEAUK.org

The Association of Paediatric Anaesthetists of Great Britain and Ireland

Annual Scientific Meeting
The Brighton Dome, Brighton
Thursday 12th, Friday 13th March 2009

Thursday 12th March
New Horizons in Paediatric Oximetry
Understanding Pharmacokinetics
The Paediatric Airway: APA guidelines
Free Papers and Posters:
Trainee prizes

8th Jackson Rees Lecture
Michael Rosen (The Childrens’ Laureat)
“Communicating with Children”

Friday 13th March
Preparing The Child for Anaesthesia
Advances in Pain Management
Developing New Drugs in Children
Imaging Techniques in Children

Workshops
TIVA, Airway management, Simulator based scenarios, Ultrasound techniques in Paediatrics

Speakers include: Prof Brian Anderson (NZ), Prof Ros Smythe (Director MCRN), Dr David Polaner (USA) Prof PA Lonnqvist (Sweden), Dr Gail Pearson, Dr Neil Morton

For further information and registration consult the APA website: www.apacbi.org.uk or contact: the APA Event Coordination Team on 02076318804 or email: apa2009@aagbi.org
The name comes from a common phrase, well known to us anaesthetists.

No patients have been harmed during the creation of this artwork over thirty years.

This is a pen and coloured crayon doodle of an aerial view of a rail network which started innocuously on A4 lined paper during a dull lecture while a medical student in Newcastle in 1978. The doodle has grown slowly over 30 years mostly from left to right completed during quiet moments, while resident on call, at home and during the odd delay that occurs now and then while waiting for cases. It just kept on growing and is now fifty feet long.

As the years passed, the artist’s materials and the fixation techniques changed; even the British landscape has changed as the early sections to the left have coal mines, gas works and steel works, now mostly vanished, and the motorway service station has very few cars parked! The latest sections were done in the 21st century.

The landscape also contains Iron Age Hill forts, stone circles, a roman villa, golf courses, airfields, innumerable castles, windmills and a sewage farm. Aliens have done crop circles here and there.

Anne Sutcliffe says that a Clinical Psychologist had a look at the work while in Torquay and it apparently shows fluctuations in my mood over the years. If this were the case, there would be a long dark tunnel in 2007 during the MTAS debacle. The lowest mood occurred apparently in the mid eighties, while I was a trainee anaesthetist when I did the “peat bog” section. This was the panel which had coffee spilled on it!

One section was done while I was studying for the FRCA in 1987 and, as so often happens, the diagram of the Brachial plexus went a bit wrong.

Nobody outside the family knew about the work and it has never previously been displayed. The kids have been wondering for years what has happened to all their felt tip pens.

Rob Cruickshank
Consultant Anaesthetist, Leeds
It has been a fairly busy year for the SAS Committee of the Association, a year which began with a lot of uncertainty about the new SAS Contract. I welcome the introduction of the new Contract, which may not have been what many expected but it is here to stay. The implementation of the new contract is in full swing as I write.

The Association has published the long-awaited “glossy” on the SAS Contract, which has detailed guidance on the old and the new contracts. It is available for download from the AAGBI website (http://www.aagbi.org/sas/publications.htm) and has been sent to all SAS members. My thanks go to Dr Les Gemmell and the working party for all their contributions to the glossy. I do hope that it serves as a reference and gives appropriate guidance on contractual matters. It will be a good addition to the SAS Handbook we published earlier as a source of useful information. I wish you all the very best with your negotiations.

The proposed joint meeting of the SAS Committees of the AAGBI and the RCOA has taken place, and was very well attended. It was a worthwhile exercise and enabled the two organisations to work together on a broader forum and also to take some important decisions that matters SAS doctors. It is hoped that the joint effort will continue for the benefit of all SAS members of both organisations.

A major survey of SAS anaesthetists will be conducted in the near future. The aims of the survey are to assess various issues facing SAS doctors regarding careers, job plans, terms and conditions and other matters so that the Association and the College can address them effectively. The questionnaires will be sent to all identified SAS doctors working in anaesthetics. I would urge all recipients to spare a few minutes to fill them in to ensure the best quality of information reaches the Councils of both organisations.

This year the AAGBI SAS audit and research prize has been awarded for the first time, to Dr Smita Oswal. May I remind all the SAS members to look for the next call for applications and apply for the prize in larger numbers.

The editor of the journal ‘Anaesthesia’ informs me that the journal receives very few contributions from SAS doctors. Surely you may have interesting case reports or results of audit projects to report on. Please do try and contribute to the journal.

We had very successful SAS seminars last year, and the repeat of SAS review day has been fully subscribed. The Association will be holding the 2009 SAS Joint Review Day at 21 Portland Place. Two new seminars are planned for next year: one will be dealing with stress and associated issues and the...
other with management issues. Please look out for further details in the seminar programme.

The lunchtime SAS session at the Annual Congress in Torquay was very well attended and received. We had interesting talks on revalidation from Professor Dodds, ‘The Role of SAS doctors in the present manpower structure’ by Dr Andrew Tomlinson, and an inspiring account of the contribution of SAS doctors to anaesthetics by Dr Chris Rowlands.

The recent College census revealed that there are approximately two thousand SAS doctors working in anaesthetics. It is important that as many SAS doctors as possible join the Association to strengthen the representation and the voice. I would like you to encourage your friends and colleagues who are still not members of the Association to join. The membership department of the AAGBI will give you assistance in this matter.

I am really pleased to inform you that the council of the AAGBI is wholeheartedly involved in the cause and welfare of SAS doctors and I have had full support from the past President Dr David Whitaker and the incoming President Dr Richard Birks and all the members of the Council. I request all the members to get involved with the Association and pass on any suggestions and criticisms you may have to me. Every comment will be taken seriously and acted upon.

As Chairman of the SAS committee, I would like to thank you for all your feedback and suggestions so far and of course the support, which makes my job easy and worthwhile.

Dr Ramana Alladi
Chairman, SAS Committee, AAGBI
Win your way to the ASA 2009

An all expenses paid (*) trip to the ASA 2009, New Orleans, USA. Oct 17-21 2009

BIS™ in Clinical Practice -A Case Report Competition-

The winning case report will be selected by 3 AAGBI appointed judges

Closing Date 31st May 2009

For details on how to enter please visit www.aagbi.org

* The award will cover the following expenses for the main author only to attend the ASA 2009: Standard Airfare, 3-4 star hotel accommodation, additional ASA lecture fees
In July, the AAGBI contacted all its consultant members and asked them to tell us their usual and customary fees for a basket of procedures commonly performed in the private sector. I am delighted to report that we had a very good response to the survey: more than 4,000 responses to individual questions from over 500 members were received. Figure 1 shows the regional distribution of those responding to the survey.

Table 1 shows the fees charged by the respondents expressed as a median [IQR], i.e. the mid-point of all fees charged, followed by the fee below which 25% of respondents charged (first figure in the IQR range) and the fee below which 75% of the respondents charged (the second figure).

If this basket of 17 fees is compared with the benefit maxima paid by three leading Private Medical Insurers (PMIs) that make their benefit tables readily available to surgeons and anaesthetists, it can be shown that on average, benefit maxima made available by BUPA to its customers are 17% lower than the median fees charged by anaesthetists. The benefit maxima offered by AXA PPP are 16% lower than the median fees charged by anaesthetists. Only WPA has benefit maxima that are very close to the fees charged by UK anaesthetists.

<table>
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<th>CODE</th>
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<td>Total hip replacement</td>
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<td>J1830</td>
<td>Laparoscopic cholecystectomy</td>
<td>£445 [£381 - £475]</td>
</tr>
<tr>
<td>T2000</td>
<td>Inguinal hernia repair</td>
<td>£195 [£180 - £214]</td>
</tr>
<tr>
<td>C7180</td>
<td>Cataract</td>
<td>£305 [£273 - £324]</td>
</tr>
<tr>
<td>Q1800</td>
<td>Hysteroscopy</td>
<td>£176 [£159 - £190]</td>
</tr>
<tr>
<td>Q0740</td>
<td>Total abdominal hysterectomy</td>
<td>£320 [£288 - £325]</td>
</tr>
<tr>
<td>M6620</td>
<td>Incision of bladder neck</td>
<td>£150 [£145 - £170]</td>
</tr>
<tr>
<td>L8510</td>
<td>Varicose veins – one leg</td>
<td>£213 [£200 - £225]</td>
</tr>
<tr>
<td>L2950</td>
<td>Carotid endarterectomy</td>
<td>£555 [£537 - £660]</td>
</tr>
<tr>
<td>B2780</td>
<td>Mastectomy</td>
<td>£265 [£230 - £280]</td>
</tr>
<tr>
<td>B2800</td>
<td>Breast lump excision</td>
<td>£176 [£160 - £190]</td>
</tr>
<tr>
<td>F3480</td>
<td>Tonsils and adenoids</td>
<td>£198 [£174 - £220]</td>
</tr>
<tr>
<td>F0910</td>
<td>Wisdom teeth extraction</td>
<td>£175 [£160 - £180]</td>
</tr>
</tbody>
</table>
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

We also surveyed other fees, some of which are not covered routinely by PMIs. Table 2 provides these results. It is worth noting that there was considerable variation in the fees charged for ICU services. The maximum fee charged for the initiation of ICU care lasting three hours ranged from £100 to £1,000. That for the daily care of a patient in ICU ranged from £50 to £500.

There was a marked regional variation in the fees charged. Table 3 shows the median fees charged for the main basket of 17 procedures expressed as a percentage of the overall median fees.

This disparity between the fees charged and the benefit maxima paid by BUPA may reflect the fact that BUPA has not made significant changes to its benefits schedule for 15 years. AXA PPP in issuing its benefit schedule in the same month that we conducted our survey appears to have chosen benefits for their members that are closer to the benefits reimbursed by BUPA than the fees that are usual and customary. It is worth noting that the Average Earnings Index rose by >90% in the period 1993 – 2008.

William Harrop-Griffiths
For the Independent Practice Committee of the AAGBI

<table>
<thead>
<tr>
<th>CODE</th>
<th>NARRATIVE</th>
<th>FEE; median [IQR]</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1890</td>
<td>Caesarean section</td>
<td>£305 [£282 - £350]</td>
</tr>
<tr>
<td>A5210</td>
<td>Epidural in labour</td>
<td>£195 [£120 - £250]</td>
</tr>
<tr>
<td>17240</td>
<td>Start of ICU care (3 hours)</td>
<td>£300 [£250 - £350]</td>
</tr>
<tr>
<td>50004</td>
<td>Daily ICU rate</td>
<td>£148 [£100 - £194]</td>
</tr>
<tr>
<td></td>
<td>Liposuction</td>
<td>£393 [£300 - £490]</td>
</tr>
<tr>
<td></td>
<td>Breast implants</td>
<td>£400 [£330 - £500]</td>
</tr>
<tr>
<td>A5750</td>
<td>Facet joint injection</td>
<td>£120 [£120 - £221]</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Region</th>
<th>Average fee as percent of UK median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wales</td>
<td>110%</td>
</tr>
<tr>
<td>South East</td>
<td>102%</td>
</tr>
<tr>
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<td>Northern Ireland</td>
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<tr>
<td>West Midlands</td>
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<tr>
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</tr>
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</table>

Table 3
NAW
Northumbria Airway Workshop
www.northumbria-airwayworkshop.nhs.uk

Hands-on experience
Accredited for 10 CE PD points by The RCoA

4th-5th Feb 2009
10th-11th June 2009
30th Sep-1st Oct 2009

At
North Tyneside General Hospital

This workshop is for all grades of anaesthetists

Workshop objectives

• Theoretical knowledge about Fibreoptic Laryngoscope and its care, techniques of fibreoptic intubation under regional and general anaesthesia, prediction of difficult intubation, DAS guidelines and an update on the latest devices for difficult airway management.

• Candidates will learn and practice fibreoptic intubation on a mannequin through oral, nasal routes, ILMA, LMA, and Oxford box etc.

• On the 2nd day, every participating doctor will perform at least one fibreoptic intubation on an anaesthetised patient under supervision & will have further opportunity to practice above techniques on a mannequin. Candidates will learn and practice cricothyroidotomy, PCK, Glidescope, C-Trach, Aintree catheter ILMA Airtraq etc on a mannequin.

Course fee £275. Places limited to 10 per course

Contact
Dr I Parvez or Dr A Tate
NAW
Department of Anaesthesia
North Tyneside General Hospital, Rake Lane
North Shields NE29 8NH
Tel: 0191 293 2519
Email: Iftikhar.Parvez@nhct.nhs.uk or Andrea.Tate@nhct.nhs.uk

GAT Prizes at Cambridge 2009

GAT Registrars’ Prize

Entrants must supply an abstract of not more than 250 words.

Shortlisted entrants will be asked to make an oral presentation followed by five minutes of discussion.

The winner receives the President’s Medal and a cash prize.

GAT Audit Prize

Entrants should submit an abstract of no more than 250 words detailing their completed audit project.

A cash prize and certificate will be awarded to the winner.

AAGBI History Prize

The Association of Anaesthetists will award a cash prize of £1,000 for an original essay on a topic related to the history of anaesthesia, intensive care or pain management written by a trainee member of the Association.

The £1,000 prize will be awarded for the best entry.

CLOSING DATE
FRIDAY 17 APRIL 2009

Full details can be found on the AAGBI website
http://www.aagbi.org/grants/trainee.htm

If you have any additional queries, please contact Chloë Hoy on 020 7631 8807 or gat@aagbi.org
Mersey Primary MCQ Course  
14.00 Sunday 18th – 16.00 Friday 23rd January  

(Established 1997 – Over 2000 candidates)

Only Available to candidates for the February (RCA) & (CARCSI) Examinations.  
An Intensive Course of MCQ Analysis

Group Assessments on Course August 2008

If it was well worth coming - Mark 5.  
If it was a complete waste of time - Mark 0

Please Encircle 0 1 2 3 4 5

(Because of the large number of candidates on this course, consensual Feedback is submitted by Groups of Candidates as opposed to One Feedback per Candidate)

79% of candidates gave a score of 5  
21% of candidates gave a score of 4

Focus on PME & Stats is good  
An excellent course – I would recommend it to colleagues  
Thanks for a great week

The sheer amount of questions & unremitting hours spent with them is infinitely more than anyone would achieve in their own time  
Great to do so many questions

A much more efficient was of revising – time well spent – Thank you  
Everyone feels much more comfortable with Physics  
There is no better way to pool knowledge  
We all feel we can approach the exam more confidently  
Catering and admin support was faultless / flawless  
Great way of getting through and understanding so many MCQs – especially physics  
Thank you !!! Really good course  
Enjoyed the course – very worthwhile – Thanks  
All staff were very professional and helpful  
We now realise how many hours a day you can actually work  
We are all now addicted to MCQs  
Gives a good indication as to the actual breadth of knowledge required  
Brilliant course – extremely well organised

Aintree Hospitals, Liverpool  
Course Fee £300  
Breakfasts, Lunches & Refreshments

See www.msoa.org.uk  
Plaudits, Details & Application Procedure

Information on all other Mersey Courses for the early New Year
Ultrasound where you need it, when you need it.

The new M-Turbo™ ultrasound system and S-Nerve™ ultrasound tool.

The new M-Turbo: ultrasound with the power to transform the way you practice. Incredible image quality for increased accuracy and efficiency across a range of applications in a versatile system that you carry right to the point of care.

The S-Nerve ultrasound tool was designed by anaesthesiologists for anaesthesiologists. Focus in on your target area in seconds, using just two controls: for speed and accuracy. Mount it on its stand or on a wall or ceiling for zero footprint.

See for yourself.

Ultrasound Training Courses 2009

2009 course dates:
Advanced Ultrasound Guided Regional Anaesthesia
9-10 January - Newcastle
Ultrasound Guided Venous Access
5 February – Hitchin
16 April – Hitchin
11 June – Hitchin
30 July – Hitchin
10 September – Hitchin
12 November – Hitchin

SonoSite, The World Leader and Specialist in Hand-Carried Ultrasound, has teamed up with some of the leading specialists in the medical industry to design a series of courses, for both novice and experienced users, focusing on point-of-care ultrasound.

Advanced Ultrasound Guided Regional Anaesthesia
This course is organised by the ultrasound user interest group of ESRA UK and Zone (RAGBI) in conjunction with SonoSite Ltd for the advanced training in ultrasound guided regional anaesthetic techniques. This two-day advanced practical course is aimed at anaesthesiologists already proficient in regional anaesthesia and comprises didactic lectures on ultrasound anatomy and regional anaesthetic techniques including practical workshops.

Topics include:
- Introduction to the US machine
- Lectures on upper and lower limb anatomy / abdominal wall anatomy
- Cadaveric workshops: upper and lower limb anatomy / abdominal wall anatomy / US appearances of the abdominal wall
- Sonoanatomy of the lower limb
- Video demonstration of US guided blocks
- Hands-on workshops: models / needle techniques using phantoms

Ultrasound Guided Venous Access
This one-day course is aimed at physicians and nurses involved with line placement and comprises didactic lectures, ultrasound of the neck, hands-on training with live modes, in-vitro training in ultrasound guided puncture and demonstration of ultrasound guided central venous access. The emphasis is on jugular venous access, but femoral, subclavian and arm vein access will also be discussed.

Fee: £450.00 (two-day courses) includes VAT, lunch, refreshments and course materials.
£250.00 (one-day courses) includes VAT, lunch, refreshments and course materials.
The management of Lesser Gradgrind NHS Trust has planned for the forthcoming Christmas period, and wishes all its staff and patients to enjoy the festivities in a responsible and safe manner. Accordingly, the following policy has been drawn up.

Christmas trees – these are an infection hazard, and are expressly forbidden.

Fairy lights – these are an electrical safety hazard, and a trip hazard, and are expressly forbidden.

Singing of carols – banned within the Trust’s “Diversity in the Workplace” policy as they exclude patients and staff who are not Christians.

Visits from Father Christmas – allowing a strange adult to visit children on hospital premises is in breach of our Child Protection Policy.

Mince pies (hot) – these represent a burn/scald hazard, and are expressly forbidden.

Mince pies (cold) – these represent a choking hazard and are expressly forbidden.

Brussels sprouts – cause emission of greenhouse gases in breach of the Trust’s environmental policy, and therefore banned.

Christmas television – the Trust is pleased to announce that individual pay TV will be introduced for all patients from Monday December 22nd. All existing ward televisions will be removed on this date. The normal charge will be £1 per hour, but we have a special bargain Christmas rate of £8 per day. Please ensure all patients have purchased their tokens before December 23rd, as the office will be closed for the holidays thereafter.

Advent Calendars – discriminate against the innumerate, and therefore banned.

Raffles for Christmas hamper – in breach of the Trust’s anti-gambling policy.

Mistletoe – banned, as may lead to sexual harassment claims.

Wearing of tinsel, jolly flashing earrings, reindeer antlers, or fairy wings – staff engaging in these practices will be in breach of the Trust’s uniform policy.

Ward nights out – in breach of the Trust’s anti-alcohol policy.

Exchange of presents – in breach of the Trust’s Financial Policy, subsection 12 (iv) – “emoluments”.

Chocolates – in breach of the Trust’s anti-obesity policy.

Consumption of turkey – in breach of the Trust’s animal welfare policy.

Christmas crackers – may exceed the Trust’s defined acceptable noise limits.

Display of cards – infection hazard.

Hanging decorations – up a ladder? What are you thinking?

The Trust offices will close at lunchtime on December 23rd. In case of emergency during the Christmas period, please contact us when the offices re-open on Monday January 5th. The management of Lesser Gradgrind NHS Trust would like to wish all its staff a Happy non-denominational Winter Solstice-related Festival.

Editor’s note: This is of course a spoof – however a number of these items have genuinely been banned at various Trusts. If your Trust has banned any of these enjoyments, or indeed anything else this Christmas, let Anaesthesia News know and we will publish the list of shame in the New Year.