Launch of national critical incident e-reporting system

How to make a poster

Reports from Liverpool

GAT committee update
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
These courses are organized by Regional Anaesthesia UK – RAUK (formerly ESRA UK & Ireland) the official UK national regional anaesthesia society affiliated to ESRA, in conjunction with Sonosite Ltd. This two-day course is aimed at anaesthetists wishing to improve their skills in UGRA and comprises of didactic lectures covering all commonly used regional techniques, clinical and cadaveric anatomy demonstrations and practical hands-on workshops. Further information on the faculty and content of this course can be found on the RAUK website www.RA-UK.org, these courses are also recognized for the ESRA diploma.

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

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 models, 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.

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

Fees:
- £350 / £450 (A) (two-day courses) includes VAT, lunch, refreshments and course materials.
- £250 (one-day courses) includes VAT, lunch, refreshments and course materials.
(A) – Anatomy based courses / with cadaveric prossections.

For the full listing of SonoSite training and education courses, dates and to register go to:
www.sonositeeducation.co.uk

If you have any questions or should need further information please contact:
Jes Tiller, SonoSite Ltd, Alexander House, 40A Wilbury Way, Hitchin Herts, SG4 0AP
Tel: +44 (0) 1462 444800 Fax: +44 (0) 1462 444801 E-mail: education@sonosite.com
As another year draws towards its conclusion, I am moved to consider the highlights, the big events and the low points of 2009, and (respectful of the fact that predicting the future really can make fools of us all) to look forward to 2010.

This year saw the official launch of the Association's new charity, the AAGBI Foundation. This event provided all of us with an opportunity to re-evaluate the nature and role of the Association, and to focus on the charitable activities that form such a large part of its work. The AAGBI Foundation focuses on safety, education and research, and is premised on the presumption that that which is good for our patients is good for our profession.

At the time of writing it is unclear whether swine 'flu was the 'Disease of the Year' or the 'Damp Squib of the Year'. After years of careful planning for Pandemic 'Flu, there was an air of almost feverish excitement amongst the healthcare disaster planners across the UK as news came that Mexican 'Flu was on its way to Europe. Plans were dusted off, intensive care units were braced and respirator masks were fitted to intensivists and anaesthetists throughout the country. Some areas have been hit hard; others have seen little 'flu activity. The predicted 'surge' in late September did not come to pass, and many are now saying that the whole crisis has been rather over-egged. However, as I write, I am sitting only a few metres away from our intensive care unit in which a woman who contracted swine ‘flu in late pregnancy lies critically unwell. For many patients and their doctors affected by swine ‘flu, it was by no means a damp squib. I can only hope that the predictions are wrong and that we will now see an ebbing away of the disease.

In May we published a debate about the proposal ‘Consultants doing first on call is part of the solution to EWTD’. Whatever the merits of the arguments, it is clear following the advent of the EWTD in August 2009 that consultants are undertaking resident on-call...

Welcome

Editorial

Teetering on the brink?

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duties as part of the solution to EWTD. The Association is working with Linkmen to monitor developments and changes in consultants’ working patterns, and a Working Party is preparing a document that will provide consultants with advice on the contractual issues surrounding changes to consultants’ working arrangements.

The ‘WHO checklist’ will surely be something that 2009 will be remembered for. Though many of us will have initially railed against this (superficially at least) ‘box-ticking’ activity, I am sure that we will look back and wonder why we made such a fuss. For very little cost, a great improvement in team-working and a real advance in patient safety is possible. The background to the development of the Safe Surgery checklist is outlined in the WFSA Newsletter (page 20). Also in this edition Les Gemmell and others inform us (in an article that will also be published elsewhere) about another ‘box ticking’ initiative - a new national e-reporting system for critical incidents in anaesthesia in England and Wales, which is expected to ‘go live’ this month. This has the potential to facilitate further big improvements in patient safety, and the AAGBI has given its full support to this initiative.

Looking forward to next year, I find it difficult to be optimistic about the economic outlook for the NHS. The combined impact of the recession, the credit crunch and the government’s response to these mean that 2010 is likely to be a tough year for the NHS, whichever party is in power. The government will demand greater “efficiency”, and I fear that many managers will focus on issues around the consultant contract – and on SPA time in particular. We published a debate on this issue in September’s Anaesthesia News. In August, the AAGBI Council decided that in view of the financial situation the AAGBI would not increase membership fees and fees for our courses and meetings have also been held at what are now very competitive rates.

Revalidation is, of course, going to be a big change for 2010. I think it is entirely reasonable for the public to expect that doctors should undergo scrutiny from time to time; the challenge will be to ensure that the processes for achieving this are not so time-consuming that our productivity falls. If we use revalidation as an opportunity to optimise our learning and develop our potential then it will be to the benefit of both our patients and ourselves. The AAGBI is ensuring that both our past and future academic meeting programmes will be mapped to revalidation CPD objectives, to facilitate the process.

WSM London (January 20th-22nd 2010) is an excellent opportunity to ensure your CPD portfolio is up-to-date.

I was rather captivated by Rob Lenoir’s photograph illustrating his life after anaesthesia (page 30), and also by listening to Nick Toff’s talk at annual congress in September in which he compared and contrasted his two professional roles – commercial airline pilot and consultant anaesthetist. I think it does us good to look outside anaesthesia sometimes, and I’d like to hear from other members who have taken up different careers or hobbies. I was also delighted to receive a letter from a member in New Zealand, meticulously penned in green ink. Unlike our GAT correspondent (page 12) I have never visited the antipodes. Dr Cosh’s letter conjures up a lost world of afternoon tea, ‘proper’ letters and extreme civility, which I will make it a personal priority to visit soon. More letters please! Dr Cosh asks for ‘Victor’ to write a regular column. Victor must have struck a nerve; I have received many requests for more. However, in the interests of fair play I have decided to print a riposte from ‘Sister Hitler’ this month. I think that our quandary may not have been completely understood by Sister H; she seems to assume that we choose to eat in theatre rather than the coffee room out of cussedness; whereas surely we eat in clinical areas (if we do) when the choice is eating or not eating as we are unable to leave the clinical area either way.

I’ll end with Season’s Greetings. I am fortunately not rostered to work on Christmas day this year, but thank you to all those who are – I hope it is quiet for you. Thanks also to our colleagues in the armed forces who have to spend the festive season far from home. I wish all readers a very happy, very successful, very efficient, very ‘flu-free, very healthy and acceptably prosperous New Year.
The history of critical incident reporting dates back to World War II when both the military and industry recognised the value of having a voluntary reporting system. In particular, it was the work of Colonel J. Flanagan that resulted in the present day critical incident reporting techniques. The concept arose from studies carried out as part of the Aviation Psychology Program. In 1976 the Aviation Safety Reporting System (ASRS) was established by the National Aeronautics and Space Administration (NASA). The ASRS collects, analyses and responds to voluntarily submitted aviation safety incident reports in order to reduce the likelihood of accidents. Information is shared by the publication of a monthly safety bulletin. It is well recognised that there are usually a number of events leading up to an accident and that the same pattern of failures will precede a near miss. Organisations that consistently operate under very challenging conditions and manage to minimise the impact of unexpected events are referred to as high reliability organisations (HROs). The latter routinely look for events within and outside the company and seek information that can be shared in the interests of safety and quality improvement. These industries have well-developed reporting systems because of the human, environmental and financial consequences of actual incidents. Voluntary reporting systems are important to help reduce adverse events. It is not only important to record such occurrences but also to collect data that enable the organisation to identify the factors that lead to such incidents.

Critical incident reporting techniques were first used in medicine when Blum in 1974 used the incident analysis technique from aviation to analyse anaesthetic incidents. Cooper et al. applied critical incident techniques in anaesthetic practice to analyse errors and equipment failure. Critical incident reporting has been adopted in nearly all branches of medicine over the subsequent years. One of the largest studies is the Australian Incident Monitoring Study which in 1993 reported on the findings from analysis of 2000 incident reports.

The National Patient Safety Agency (NPSA) began recording patient safety incident reports in 2003. Since then the NPSA has encouraged all healthcare staff to report to the database to help the NHS understand why things go wrong, and how to prevent them happening in the future. By January 2009, three million incidents had been uploaded to the RLS. One of the priorities set out in the NRLS strategy of 2008 was to review reports of serious incidents and to prioritise those which require urgent action.

The document Safety First was commissioned by Sir Liam Donaldson, Chief Medical Officer, to reconsider the organisational arrangements currently in place to ensure that patient safety is at the heart of the healthcare agenda. After the report, the NPSA embarked on a series of programs to increase clinical engagement in patient safety issues. Anaesthesia is the largest single hospital specialty in the NHS, with anaesthetists seeing around two thirds of all admitted patients. There has been a longstanding tradition of incident reporting in anaesthesia; the specialty being the first profession in healthcare to introduce incident reporting. The development of a partnership between anaesthesia and the NPSA was highlighted in the RCoA’s Bulletin and the AAGBI’s Anaesthesia News. The articles announced the projects that were to be carried out by the partnership of the NPSA, AAGBI, RCoA, AfPP and the COPD. One of those projects was the development of a national reporting system for patient safety incidents.

The NPSA’s Reporting and Learning database [NRLS] began recording patient safety incident reports in 2003. Since then the NPSA has encouraged all healthcare staff to report to the database to help the NHS understand why things go wrong, and how to prevent them happening in the future. By January 2009, three million incidents had been uploaded to the RLS. One of the priorities set out in the NRLS strategy of 2008 was to review reports of serious incidents and to prioritise those which require urgent action. The document Safety First was commissioned by Sir Liam Donaldson, Chief Medical Officer, to reconsider the organisational arrangements currently in place to ensure that patient safety is at the heart of the healthcare agenda. After the report, the NPSA embarked on a series of programs to increase clinical engagement in patient safety issues. Anaesthesia is the largest single hospital specialty in the NHS, with anaesthetists seeing around two thirds of all admitted patients. There has been a longstanding tradition of incident reporting in anaesthesia; the specialty being the first profession in healthcare to introduce incident reporting. The development of a partnership between anaesthesia and the NPSA was highlighted in the RCoA’s Bulletin and the AAGBI’s Anaesthesia News. The articles announced the projects that were to be carried out by the partnership of the NPSA, AAGBI, RCoA, AfPP and the COPD. One of those projects was the development of a national reporting system for patient safety incidents.

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of a specialty specific e-reporting tool to allow enhanced reporting of near misses and patient safety incidents arising during the perioperative period.

The RCoA introduced a reporting form for critical incidents in the late 1990s, which was replaced by a modified form in 2000, with the expectation that this would lead to a centralised reporting system for anaesthesia. The formation of a national reporting and learning system was announced in 2002 and plans at the RCoA to develop an electronic reporting system did not proceed. The RCoA, along with the AAGBI, expressed interest in developing a reporting system to improve patient safety in anaesthesia, which integrated the information required by anesthetists with the RLS and allowed the RCoA a role in analysis and subsequent dissemination. A workshop was held in September 2007 to discuss the development of a specialty specific reporting package linked to the NRLS, attended by the NPSA Chief Executive and Medical Director and representatives of the RCoA and AAGBI. Consensus was reached on the purpose of a reporting system. The Safety First report highlighted, inter alia:

“There is little evidence that data collected through the national reporting system are effectively informing patient safety at the local NHS level. Despite the high volume of incident reports collected by the NPSA to date, there are too few examples where these have resulted in actionable learning for local NHS organisations”.

The Specialty Specific Reporting Tool pilot tried to address some of these issues. The purpose of the Tool was to:

- Allow RCoA and AAGBI to provide rapid feedback through networks on previously unknown ‘high priority’ incidents
- Provide a constant reminder on severe incidents that occur rarely but are known
- Permit peer comparison through provision of benchmarking data
- Learn from near misses
- Engage the anaesthetic profession in reporting patient safety incidents

The intention of the pilot was to develop and test a web based electronic form (e-form) that would be completed by members of the anaesthetic team (anaesthetists, nurses and operation department practitioners (ODPs)) to record anaesthesia related incidents within the surgical pathway. To achieve this it was necessary to achieve the following objectives:

- To design a specialty based reporting form;
- To test a data classification system/taxonomy to support the way in which anaesthesia related incidents are reported to the NPSA;
- To develop data analysis and reporting tools for incidents reporting on the anaesthetic e-form.

Once the e-form had been developed, the anaesthesia specialty based reporting system was piloted in a small number of acute trusts in England and Wales. This has now been completed and evaluation of the project has been completed by the NPSA. The evaluation indicated a positive response to the reporting tool from the pilot sites. The NPSA now wish to encourage anesthetists and operating department personnel to use the reporting tool throughout England and Wales.

The RCoA decided that it was necessary to form a specific group to analyse the data from the e-reporting project. This group will be able to produce rapid response to any reported adverse incident and to produce regular reports on trends noted in the data set. The SALG includes core members from the RCoA, NPSA and the AAGBI.

The incidents will be reported to, and processed by, the NPSA

- Incidents will be classified as:
  1. Those requiring a rapid response (e.g. deaths associated with positioning of patients for a specified procedure, previously unknown side effects of a new drug or a new piece of equipment).
  2. Those requiring a periodic response (e.g. reports of retained throat packs, errors during drug administration, adverse drug effects).

The rapid response will be in the form of:

1. Initial immediate consultation among relevant parties – NPSA, RCoA, AAGBI.
2. Depending upon the circumstances

- further consultation with the relevant bodies:
  a. Trust Risk Management
  b. MHRA
  c. Specialist societies (ICS, ACTA, SCATA, DAS etc)

3. Written documentation of the problem, and possible solutions (these may not be at hand – hence sometimes the solution may be raising awareness of the problem and possibly recommending further work, research, national audit, working party for recommendations or guidelines).

4. Early wide dissemination of the response (alert) to all concerned (Trusts, all practising anaesthetists through College and Association links, journals and Newsletters, websites, NPSA mechanisms, all appropriate committees).

- The periodic response will be in the form of
  1. Trend analysis by NPSA, RCoA, AAGBI.
  2. Root cause analysis (consulting with specialist societies as required).
  3. Written documentation of the reported incidents, underlying problem, and possible solutions (these may not be at hand – hence sometimes the solution may be raising awareness of the problem and possibly recommending further research, national audit, working party for recommendations or guidelines).

4. Periodic response (3-6 monthly) to all concerned (Trusts, all practising anaesthetists through College and Association links, Journals and Newsletters, Websites, NPSA mechanisms, Committees as appropriate).

- The above will generate material for developing/informing national audits, research, and guidelines and recommendations.

- The effectiveness of these responses will be crucial for the success of this project, raising awareness of patient safety issues nationally, and ultimately making anaesthesia even safer.

The group should comprise:
  1. Core members, including:
     a. 2 RCoA members (one of them to be the Chair)
     b. 2 AAGBI members

Safe Anaesthesia Liaison Group

The RCoA, along with the AAGBI, expressed interest in developing a reporting system to improve patient safety in anaesthesia, which integrated the information required by anesthetists with the RLS and allowed the RCoA a role in analysis and subsequent dissemination. A workshop was held in September 2007 to discuss the development of a specialty specific reporting package linked to the NRLS, attended by the NPSA Chief Executive and Medical Director and representatives of the RCoA and AAGBI. Consensus was reached on the purpose of a reporting system. The Safety First report highlighted, inter alia:

“...
• 2 NPSA members
  o Co-opted members including:
  • Individual consultants with a track record on issues related to patients safety or national audits
  • Named individuals representing ODPs and Nurses
  • Named individuals from specialist societies
  • Named individuals from PLG, MHRA, Trust Risk Managers

The Group will report to the appropriate committee or council for each partner organisation.

THE FUTURE

The NPSA have agreed to roll out the e-reporting tool and it will be part of Patient Safety Direct. Patient Safety Direct builds on the work of the National Reporting and Learning Service (NRLS) by streamlining the reporting and learning process.

To improve reporting and learning:
• reporting systems need to be simple - there are currently multiple reporting routes which can be confusing and complex;
• the value of reporting needs to be demonstrated via the provision of feedback to those who report;
• learning has to have clinical relevance.

To address these challenges and improve reporting and learning, Patient Safety Direct will provide:
• a simplified reporting of patient safety incidents via a single route
• Improved feedback and information
• A ‘one stop shop’ for accessing leading patient safety information, tools and resource needs via a dedicated web ‘portal’
• Customised clinical incident specialty reporting forms
• Improved system for reporting and learning from the most serious incidents

The Improvement Through Partnership project in the specialty of anaesthesia has produced and tested successfully an e-reporting tool which can now be used as a model for other specialties to follow. The recently published Health Select Committee Report states

“We welcome the NPSA’s recognition of the need to address under reporting by doctors by developing reporting systems that are appropriate to different specialities (such as general practice and anaesthesia). We recommend that work on this be treated as a major priority by the Agency”.

The AAGBI and RCoA will provide support for the roll out of the specialty specific reporting tool in the Patient Safety Direct program. Both organisations, along with the NPSA, will seek to engage clinicians to use the e-form and encourage local champions to improve incident reporting rates. Both organisations support the development of a “safety” culture in the NHS and an environment in which healthcare professionals can freely report patient safety incidents. It is important that SALG continues to provide feedback from incident reports and ensure that there is “actionable learning for local NHS organisations”. Anaesthesia must, once again, take the forefront in reporting incidents that occur in everyday practice. As individuals and in our departments we must work together to ensure that the culture of incident reporting delivers benefits to patient safety.

Dr Les Gemmell, Hon Sec, AAGBI
Professor Ravi Mahajan, Council Member
RCoA and Chair, SALG
Mrs Joan Russell, NPSA

The Association of Paediatric Anaesthetists of Great Britain and Ireland in conjunction with the Canadian Pediatric Anesthesia Society

Annual Scientific Meeting, Glasgow
Radisson SAS Hotel, 13th- 14th May 2010

Mini-Symposia
Burns in Paediatric Anaesthesia
Paediatric Dental Anaesthesia
Anaesthesia and the Obese Child
Human factors and Error
Special Journal Session
Trainee session
Anaesthesia in the Developing World
Free Papers and Posters
Trainee prizes

9th Jackson-Rees Lecture
Dr Larry Roy, Toronto

State of the Art Lecture
Neuroprotection
Dr Robert Tasker, Cambridge, UK

Thursday and Friday Workshops
Local techniques and ultrasound
Advanced regional techniques
TIVA, Airway management

This meeting has attracted an unprecedented faculty of leading national and international experts to take part in workshops and lectures. Book early!

For further information and registration contact: APA website www.apagbi.org.uk or contact: AAGBI Specialist Society Events Team, 21 Portland Place, London W1B 1PY or E-mail: apa2010@aagbi.org or Tel: +44 (0)20 7631 8804
An Update from the GAT Committee

Anaesthesia News, being the mouthpiece of the Association, lends itself well to an update for our members on what the GAT Committee has been up to since I took to the Chair in July. Our current GAT Page editor and Honorary Secretary, Susan Williams, has been made an assistant editor of Anaesthesia News, continuing to ensure that the GAT voice features prominently.

The GAT Committee, with its six new elected members, has been unable to meet since our ASM in Cambridge due to a number of factors, but communications continue by e-mail and through representation on multiple committees at the AAGBI, RCoA and others. Please see our website for a full list of these, including our representatives on AAGBI Working Parties. Unfortunately, after many years of representation as a co-opted member of the RCoA Council, GAT has been removed from this position over the summer. Negotiations over this continue, as we feel this should remain a vital part of our work and, indeed, is the main reason for the existence of our elected Vice Chair position.

The 9th Edition of our GAT Handbook should have found its way to your doorsteps by now, and I’m sure you’ll agree it looks very impressive. Thanks again to Drs Mark Hearn and Alex Ward for all their hard work in putting it together. Our new publication, the “Core Survival Guide” edited by Liz Shewry, will also be out shortly, and our booklet “Your Career in Anaesthesia” is in the process of being rewritten to reflect changes in the training pathway post-MM. The remaining copies of the previous edition were given away at our joint AAGBI/RCoA/ICS stand at the BMJ Careers Fairs in London and Birmingham in early October. Representatives from GAT spent time at the London BMJ Careers Fair promoting our specialty to medical students and Foundation doctors, and were delighted at the amount of interest expressed in careers in both anaesthetics and ICM.

The GAT ASM 2010 in Cardiff (June 30th to July 2nd) is in the advanced planning stages under the stewardship of Professor Judith Hall and the Local Organising Committee. The Royal Society of Medicine will be present on the first day, and the GAT Committee have organised a session on peri-operative optimisation with three experts in this field. It has all the makings of an excellent meeting so book your study leave now! Our 2011 ASM is in its early planning stages and will be held in Leeds.

Rob Broomhead had taken over as co-ordinator of our GAT seminars. These
continue to be popular ways of gaining experience and education in different areas of our specialty, and the Consultant Interview seminar remains particularly popular. Look out for the advertisements within the AAGBI Seminars programme published each month, and please let us know if you have any ideas for future topics.

GAT has recently written to the RCoA Training Committee expressing concerns over the integration of training with the demands of the introduction of full EWTD compliance. We have also been in contact with the RCoA Advisor for less-than-full-time training in an attempt to clarify the position regarding time-in-lieu for study leave taken on non-working days. This issue is still open for debate. One of our major functions is to write to appropriate people on your behalf regarding key concerns and issues, so if there is anything else that we should be following up on your behalf then please let us know.

We have been actively promoting the use of the WHO Surgical Safety Checklist and the Patient Safety First project ‘SAVED’, which took place during Patient Safety Week in September. Hannah Gill, one of our newly elected members, has been appointed to the role of Patient Safety Link, liaising with the NPSA on such matters. She is also involved in the writing of the Patient Safety Curriculum in conjunction with the RCoS and PMETB.

Susan Williams is an active member of the AAGBI Welfare Committee and has co-ordinated the recent survey of stress amongst trainees. Some of this data was presented in an excellent talk at the AAGBI Annual Congress in Liverpool entitled “Trainee stressors”. Thank you to everyone who took time to complete this important survey; more information will be available regarding the results in due course. Also, thank you to those who completed our Annual Training Survey at the Cambridge ASM. These results were presented in an article in the October issue of Anaesthesia News by the co-ordinator, Liz Shewry. The results from our Annual On-call Survey will also be available shortly; please do keep helping us with data collection – we try to limit the numbers of requests for your help in completing surveys, but we cannot properly represent you if we do not know what your views and opinions are and without hard data to back up any claims we make on your behalf. We do not allow others access to our e-mail database to distribute individual surveys, and following an incident at the GAT ASM this year, we do not allow distribution of surveys other than our own Annual Training Survey at our ASM.

Our web-pages are our main communication tool with you and we are extremely proud of them and their content and endeavour to keep them updated regularly. However, we are currently in the process of redesigning them in conjunction with the whole AAGBI website project so please bear with us during the transition process.

The GAT Committee continue to work hard on your behalf and are always happy to be contacted on gat@aagbi.org for any ideas, questions or comments. Please encourage all anaesthetic trainees who are not yet members to sign up – membership of GAT is automatic for trainees on joining the AAGBI, and the large number of benefits available can also be found on our website. We will continue to keep you updated about all relevant GAT issues.

Felicity Howard
GAT Committee Chair
HAS MOVED

The Association of Paediatric Anaesthetists has moved offices

Effective
14th September 2009

Our new address is:
Association of Paediatric Anaesthetists of
Great Britain & Ireland
21 Portland Place
London W1B 1PY

Tel: 020 7631 8887
Fax: 020 7631 4352

Email: APAGBladmin@aaagi.org
www.apagbi.org.uk

Honorary Secretary
Dr Jane Peutrell

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The RAF values every individual’s unique contribution, irrespective of race, ethnic origin, religion, gender, sexual orientation or social background.
The AAGBI Annual Art Exhibition never fails to impress with the sheer variety and artistic skill of the entries, and this year was no exception. Original art-works, photography, poetry and hand-made jewellery were all there to be enjoyed. The exhibition is unusual in that all of the work is executed and judged by amateurs – all those visiting the stand are encouraged to vote, and presumably mostly do so in terms of what they like rather than critical acclaim. First, second and third prize, and a number of ‘highly commendeds’, are all awarded simply on the basis of popular vote. It is quite impossible to predict the winner, everyone and no-one is an art critic and this promotes an air of anticipation, fun and excitement.

This year, the winning entry was a stunning photograph entitled ‘Still Life with Bamboo, Water and Glass’ taken by anaesthetist Paul Hayse-Gregson on a visit from South Africa. Paul, who also won third prize with another photograph entitled ‘Damskraal’, was able to collect his well-deserved medal at the award ceremony on Friday morning. The second prize was taken by ex-Editor-in-Chief of Anaesthesia and Vice President, David Bogod, with another photograph, ‘On the Shoulders of Giants’ – a wonderful shot of a family of elephants enjoying the water. The best artwork was by Mary Follows, a pencil drawing of a reclining figure, and both Ruth Spencer and Samantha Shinde received ‘highly commendeds’. Sam for a piece from her dazzling collection of handmade silver jewellery.

It is fair to say that very few individual works received no vote at all, such was the diversity of taste, and over all, each of the exhibitors collected a comparable number of votes. This should provide encouragement to anyone out there wondering if their work is good enough for Harrogate in 2010. The answer is – of course it is! And if you are generous enough to let us exhibit it, we can guarantee many folk will appreciate it!

Of course at no point should we lose sight of the fact that the main aim of the exercise, apart from displaying the dazzling artistic talent we nurture in our midst, is to raise money for two very deserving charities: the AAGBI’s Overseas Anaesthesia Fund and the Royal Medical Benevolent Society. Funds raised by the sale of artworks, Christmas Cards and raffle tickets are all donated in full to these two charities. We can announce with great pride that this year a record amount in excess of £1,000 was raised. Our heartfelt thanks go to all those who donated or bought a picture and to long-suffering delegates who visited the stand, sold tickets and generally did as they were told (mostly helpfully!)

We look forward to Annual Congress in Harrogate in 2010, and we have some new ideas to ensure that the 2010 Art Exhibition is just as successful. There would be no exhibition and no funds raised, however, without your help. Please consider contributing your art and craft work. The exhibition is not limited to pictures. Ceramics, sculpture, jewellery, needlework, indeed anything you have made that is beautiful and/or interesting and can be hung on a wall or displayed on a stand would be welcome. So get cracking – you have a nearly a whole year to be creative!

Stephanie Greenwell and Di Dickson
This September I represented GAT at the 68th National Scientific Congress (NSC) of the Australian Society of Anaesthetists (ASA); definitely the furthest I have ever travelled for a conference! The ASA was founded in 1934 as a voluntary association and represents Australia’s anaesthetists, similarly to the AAGBI in the UK. They also have a trainee group - the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT). The GAT Committee maintains a link with GASACT, which gives us the excellent opportunity to exchange information and share experiences.

The National Scientific Congress of the ASA.

The NSC was held in ‘the Top End’ of Australia for the first time, in the newly built Darwin Convention Centre which is located on the Darwin waterfront. It was the 68th National Scientific Congress but 2009 marked the 75th anniversary of the ASA, and there was an impressive turnout of over 700 delegates from throughout Australasia and a number who had travelled as far as me. The conference was held in September over 4 days starting with welcome drinks on Friday night and ending with a farewell lunch on Tuesday. In contrast to British conferences, all social events were included in the congress price and there was a great turnout for these. Many delegates brought their partners and families, who benefitted from an organised sightseeing programme and the opportunity to participate in the NSC social events. Darwin appeared to be a rather appealing venue for a conference!

The NSC Scientific Programme covered a wide range of topics with strong sessions on cardiovascular disease, perioperative medicine, neuroanaesthesia, obstetric anaesthesia, modern airway management, pain medicine and paediatrics. There was also an excellent programme of non-plenary sessions, including oral and poster presentations. Fifteen different workshops were held, ranging from ALS, TOE, to Remote Anaesthesia, while ‘Problem Based Learning Discussions’ included topics such as sleep apnoea, pulmonary hypertension, coronary stents and Suboxone. A number of Quality Assurance Sessions were also held and many Special Interest Groups hold their annual meeting at the conference.

After an address from ASA President Dr Elizabeth Feeney, the opening session consisted of a ‘Welcome to Country’ from the Koolpinahy-Larrakia Nation, a local aboriginal people. This was followed by traditional aboriginal dancing from ‘One Mob Different Country’. This was quite different to the opening of most conferences I’ve been to!

The opening ‘Kester Brown’ Lecture was presented by Professor Norman Director of The Robinson Institute at The University of Adelaide, who is a subspecialist in reproductive medicine and endocrine biochemistry. This was a fascinating insight into ‘How we are heading to Reproductive Extinction’, regarding how our lifestyles affect our reproductive outcomes which left many in the audience rather concerned.

GASACT

During my time in Darwin I sat in on the GASACT Committee Annual Meeting representing GAT, which gave me a fascinating opportunity to compare the anaesthetic training arrangements between the two countries. In October 2001, the inaugural annual GASACT meeting was held in Canberra in conjunction with the current National Scientific Congress. This
meeting proved successful in leading to
the formal establishment of the GASACT
Committee. Compared to GAT, which
was established in 1967, GASACT is still in its
infancy and there are substantial differences
between our societies.

One major difficulty in the running of the
GASACT committee is the geographical
challenges within Australia. Flights between
many of the major cities are 4-5 hours and
the committee is only able to meet once a
year at the NSC. Each state has a state
representative and many have both senior
and junior representatives, all of whom are
elected. Because the training in Australia is
two years shorter than our training and ends
soon after the FANZA examination (FRCA
equivalent) it is difficult for anaesthetic
trainees to become involved in the ASA
for an extended period and one year is the
standard term. Unlike GAT, GASACT
have not yet considered organising their
own seminars or conference, though after
our meeting they are keen to develop a
separate trainee session at the NSC.

Training is not centralised in Australia and
there are significant differences between
states. Interestingly, many existing trainee
issues within the UK appear to arise in
Australia, perhaps a few years later. For
example, the discussion about anaesthetic
practitioners had recently begun. They
were interested to hear about the EWTD
(European Working Time Directive)
as similar regulations do not apply in
Australia. Many of the larger hospitals have
significantly higher numbers of anaesthetic
trainees working on rota and so out of
hours work does not appear to
affect training as much.

I also had the opportunity to meet with
the Canadian Anaesthesiologists Society
trainee representative Dr Andre Bernard.
Their training in contrast to the UK is a lot
shorter but the supervision is much greater.
When they qualify as a consultant they are
literally thrown into the job and have no
supervision.

Their training in contrast to the UK is a lot
shorter but the supervision is much greater.
When they qualify as a consultant they are
suddenly on their own. They also appear
to qualify with big debts and then earn an
even bigger salary! I am keen to maintain
and extend our international connections
in my role as GAT Vice Chair and thank the
AAGBI for their help.

Session highlights

There were many fantastic and informative
sessions during the conference; I was
particularly fascinated by a session on
Northern Territory (NT) Medicine. In
general the NT is a world away from the
UK; the population of 220,000 is spread
out over an area 6 times the size of Great
Britain. The NT has many hazards that we
are unfamiliar with including the wild
weather (itself the subject of a lecture) and
many native animals. It experiences a
variety of extreme weather conditions and
Darwin has been flattened four times, three
times by cyclones in 1897, 1937 and 1974
and once by air raids during World War II.
Cyclone Tracey struck Darwin in 1974 and
flattened 80% of the city with its 175mph
gusts. Darwin has since been rebuilt with
cyclone-proofing in mind! There are 2
seasons in Darwin; ‘the dry’ (or winter) and
‘the wet’ (summer) with tropical cyclones
and monsoon rain. It was building up to ‘the
wet’ during the conference and the ASM
dates had been changed to accommodate
this. Apparently as the humidity gets higher
and higher the population gets more and
more short tempered until it finally rains in
December!

There is a high trauma rate in the NT,
particularly from road traffic collisions. It
has a young population with large distances
between settlements and a high risk of
animals straying/jumping into the roads.
The recent introduction of a speed limit on
the Highways is aimed at reducing this.

There was an excellent session on the role
of the Northern Territory in mass casualty
management. Funding for a National
Critical Care and Trauma Response Centre
was allocated in 2005 and the Royal
Darwin Hospital was chosen to host the
centre following its involvement in the
management of the victims of both Bali
bombings and the riots in East Timor. This
centre is being established to ensure that
Australia has an effective capacity to receive
and treat casualties in northern Australia,
with increased capability for mass casualty
reception in the event of a major incident
in the region. There was also discussion of
the problem of refugees arriving by sea
into the NT, often in extremely precarious
vessels. The local team had been involved
in a number of rescue attempts including
boats catching fire with multiple casualties.

Finally a fascinating session on ‘Crocs
and Crocs’ introduced many of us to the
local paper NT News (which can be found
online at www.news.com.au). It is truly a
fascinating read, full of tales of Crocs and
the local population. Recent headlines
include ‘I drink 3 slabs of beer a day’,
‘42,000 drunks locked up this year’ and ‘A
6m 1000kg croc found’!!

Crocosaurus Cove

Sunday evening was spent at the world-
renowned Crocosaurus Cove which was
definitely a highlight for some and a scary
experience for others! There were some
rather large (up to 6 metres long) Northern
Territory saltwater crocodiles and serious
adrenaline junkies could enter the ‘Cage of
Death’ alongside them. The Annual ASA
Congress Dinner was held on the Monday
night with a fantastic turnout and some
great entertainment.

If you are interested in a year of out-
of-programme experience in
Australia or another
developed country please consider
reading the recent
GAT publication ‘Organising a Year
Abroad’ which is
also available online
at www.aagbi.org/gat/publications.htm

Finally I’d like to thank the AAGBI and ASA
and their events team for supporting my trip
to the ASA NSC. I hope that this relationship
will continue into the future. The 69th ASA
National Scientific Meeting will be held in
Melbourne from 2-5th October 2010.

The GASACT team, GAT representative Elizabeth Shewry and Canadian trainee rep Dr Bernard
# MERSEY MENU

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<tr>
<th>Event</th>
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<td>Primary MCQ Course - Unlimited Places</td>
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<td>Final FRCA &amp; FCARCSI MCQ Course - Unlimited Places</td>
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<td>Final FRCA &amp; Final FCARCSI (Booker) Crammer Course</td>
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<td>Final FRCA SAQ &amp; Final FCARCSI E&amp;SAQ Weekend Course*</td>
<td>26/02/10 (Fri) – 28/02/10 (Sun)</td>
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**THE SAQ WRITERS' CLUB FOR FINAL FRCA**

**THE E&SAQ WRITERS' CLUB FOR FINAL FCARCSI**

Open to Enquiry

David.Gray@aintree.nhs.uk

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*Note*

There are two stagings of the *Final FRCA SAQ & Final FCARCSI E&SAQ Weekend Course* for the convenience of trainees who intend to attend the Booker Course. The two courses are identical and there is no point in any trainee attending both courses.

Further Details

www.msoa.org.uk
Permissive hypotension or aggressive fluid resuscitation: identifying the best approach for pre-operative care of the bleeding trauma patient

The Wylie Medal is awarded annually for the best essay concerning anaesthesia or associated clinical practice written by a medical student attending a University in Great Britain or Ireland. We are delighted to publish this year’s prize-winning essay.

Introduction

The implementation of ATLS® guidelines and other structured approaches in trauma care over the last few decades has allowed the implementation of a systematic management approach to victims of acute trauma. The optimisation of early fluid resuscitation in haemorrhage and haemorrhagic shock is an area of contention within the approach to trauma patients. Traditionally an approach of rapid pre-operative fluid resuscitation has been encouraged aiming to achieve pre-injury systolic blood pressure. Increasingly, however, a management approach that tolerates the existence of a degree of carefully monitored hypotension during the period before definitive surgical bleeding control, using fluid input to maintain this hypotensive set point, has been touted as providing better survival outcomes in trauma victims. This approach in the management of trauma patients is known as permissive hypotension.

A careful assessment of the potential merits and drawbacks of these contrasting approaches to trauma care is warranted in light of the prevalence of trauma as the leading cause of death worldwide in under-35 year olds (Murray, Lopez).

Normotensive fluid resuscitation

In the latter half of the twentieth century, intensive fluid resuscitation to normalise blood pressure was the accepted wisdom in the treatment of trauma causing haemorrhage (Shires, Coln). Animal experiments performed during the 1950s and 1960s are partially responsible for the emphasis placed on the normotensive resuscitation approach. Experimenters removed controlled amounts of blood from animal models via vascular cannulae before using different fluid regimens to replace the lost volume, with the outcomes of the treatment being measured in terms of mortality (Wiggers). General survival rates in animals treated with isotonic fluids were vastly improved compared to controls which did not receive any fluid and the fluid resuscitated animals showed fewer signs of organ damage. The origins of the 3:1 rule (ratio of recommended crystalloid fluid: blood loss) associated with the ATLS approach to trauma lie partially within these animal experiments that appeared to emphasise the importance of early fluid volume replenishment.

In physiological terms, the traditional resuscitative approach aims to maintain vital organ perfusion and function while diagnostic procedures are performed prior to a definitive surgical resolution to the bleeding. As well as research from animal models normotensive resuscitation is supported by evidence suggesting increased mortality and morbidity amongst patients with prolonged hypotension. In their 1992 study Chestnut et al. found hypotension (defined as systolic blood pressure <90mmHg) to be associated with a 150% increase in mortality in trauma victims stating that “resuscitation protocols for trauma victims should assiduously avoid hypovolaemic shock on an absolute basis” (Chesnut, Marshall).

Despite being the accepted dogma for some time, the theory behind normotensive resuscitation has not been without criticism. Evidence accumulated from early animal models has been somewhat discredited due to the controlled nature of blood removal in these studies which provides an inaccurate representation of the potential for uncontrolled blood loss in genuine trauma scenarios.

There is apprehension that overly vigorous fluid replacement in uncontrolled haemorrhage may lead to unnecessary morbidity and mortality through disruption of haemostatic mechanisms. Crystalloid fluids have been cited to cause disruption of clot formation; by both reduction of the clotting factor concentration in the blood and also through the consequences of prematurely increasing blood pressure back to physiological levels and subsequently “popping the clot”. Fluid related breakthrough bleeding from an unstable clot has been demonstrated in contemporary animal studies (Stern, Dronen).
Perhaps surprisingly, given the current degree of debate surrounding the area, the observation that over-zealous fluid resuscitation in uncontrolled bleeding from trauma can potentially increase mortality was described nearly a century ago by Canon et al., in their paper discussing the management of wounds in the First World War (Cannon, Fraser). In 1918, surgical resolution to internal bleeding would have been frequently unachievable, thus it would often be more appropriate for the physician to rely on the body’s own clotting system to control bleeds. In such circumstances, while fluid infusion may temporarily stave off shock and maintain blood pressure, without surgical treatment the subsequent dilution of clotting factors and disruption of physiological clotting mechanics may well be counterproductive to reducing mortality, by reducing the likelihood of the haemorrhage being controlled.

Recent experimental studies have used techniques that inflict vascular injuries to produce uncontrolled haemorrhage in animal models to provide a more functional model of trauma. Stern et al. found that using crystalloid fluids to restore pre-operative blood pressure in the injured animals to between 40-60 mmHg, improved survival compared to animals whose blood pressure was restored to the baseline mean of 80mmHg. Importantly survival was also improved compared to those animals which were not infused with any fluids (Stern, Wang). The findings of this model correlate well with the theoretical benefits of permissive hypotension i.e. maintaining a low but stable blood pressure in order to avoid compromising haemostasis.

The potential benefits of permissive hypotension in pre-operative management of patients with penetrating trauma were demonstrated by Bickell et al. in their quasi-randomised controlled trial of around 500 adults suffering from gunshot or stab wounds, presenting with a systolic blood pressure <90mmHg. Two cohorts were formed; one group received no fluid resuscitation pre-operatively while the other group were treated with immediate standard crystalloid infusions. Patients were randomised to the alternative cohorts based on the day they arrived in hospital with the contrasting protocols being used on alternate days. The group receiving no fluid resuscitation until reaching the operating table had significantly improved survival at 70% compared to the 62% survival (p=0.04) seen amongst those who received standard fluid infusions. The delayed resuscitation also experienced fewer measured post-operative complications (adult respiratory distress syndrome, sepsis syndrome, acute renal failure, coagulopathy, wound infection, and pneumonia) than the standard care group however this difference was not statistically significant (Bickell, Wall).

Further analysis of the data in Bickell’s study by Lessard et al. addressed concerns that injury severity was less in the delayed resuscitation group. They found that the benefits of delayed resuscitation were even more profound in patients with an injury severity score of 25 or higher with 61% survival in the delayed resuscitation group compared to 48% survival in the standard treatment group (Lessard, Brochu).

A 2003 Cochrane review assessed the effects of early versus delayed, and larger versus smaller volume of fluid administration in trauma patients with bleeding. Data from Bickell’s study and two smaller trials were included in the review, however, the authors found no conclusive evidence to support or contradict the use of early or large volumes of fluid in pre-operative resuscitation of trauma patients (Kwan, Bunn).

**Discussion**

In the management of trauma victims with bleeding, it is clear that expeditious surgical resolution of the bleeding along with subsequent volume replacement is of paramount importance to survival. The consensus on optimal fluid management of patients prior to the operative environment is far less clearly defined. Increasingly opinion appears to favour discarding of the traditional principle of administering liberal fluids to achieve normotension, in favour of more conservative measures of titrating fluids to a lower blood pressure e.g. 90mmHG or even eschewing pre-operative fluids altogether. Hemodynamic theories, contemporary animal studies and a small number of randomised clinical trials add weight to the theory of permissive hypotension, however, the current evidence is inconclusive.

The importance of getting fluid management “right” and optimising outcomes cannot be overemphasised in light of the aforementioned scale of young lives lost to trauma. Moreover yearly deaths from injury are predicted to rise from 3 million in 1990 to 8.4 million in 2020 (Murray, Lopez). Many lives may be saved in coming years by even marginal improvements in efficacy of the resuscitation of trauma victims. From an ethical perspective the physicians guiding principle of ‘first, do no harm’ is highly relevant to the debate. It is of course highly undesirable to implement a treatment that has more potential to damage than to benefit patients. The significance of this point is highlighted by a meta-analysis that found a significantly higher mortality in trauma patients attended by paramedics (RR 1.26 p=0.03) compared to those not seen by paramedics, even accounting for differences in injury severity. This suggests that efforts to vigorously increase blood pressure by paramedics may be harmful to some patients (Nicholl, Hughes).

The strength of conviction amongst some trauma specialists of the benefits of permissive hypotension is encapsulated by the views of Kenneth Mattox MD (Chief of the Surgery Service and Chief of Staff at Ben Taub General Hospital):

“Within no less than 10 years, probably even less than 5 years, any paramedic, nurse, flight personnel, EC personnel,
Anaesthesiologist that raises the blood pressure to higher than \( \frac{3}{4} \) the pre injury level, especially if using crystalloid solutions will be severely criticized as violating one of the indicators, whether the injury be penetrating, blunt, elderly, child, or one’s own self or family.

“those of you who believe in two large bore IVs, Rapid infusers, intraosseous and sternal infusers, the 3 to 1 rule, and cyclic hyper resuscitation (will be cited) as causing unnecessary complications, deaths, and costs.” (Mattox)

Summary

In order to provide evidence based care for trauma patients with bleeding, the optimal approach to fluid resuscitation urgently needs to be established with further large scale randomised controlled trials. These trials require greater breadth of focus in order to address the management of specific types of trauma e.g. whether early fluid requirements differ in blunt trauma to penetrating trauma. Studies also need to expose any potential long term negative sequelae from delayed fluid resuscitation associated with hypoperfusive organ damage.

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daniel.odriscoll@stcatz.ox.ac.uk

Reference:

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A Description of a Unique Scavenging Reservoir for Jackson Rees Breathing Circuits

The Jackson Rees modification of the Ayre’s T–piece breathing circuit is still used extensively in paediatric practice. Its simplicity, familiarity and minimal resistance to breathing are well known features. One major drawback is the lack of scavenging, known to cause pollution of anaesthetic gases which exceed operating theatre standards1.

In order to add scavenging, several devices have been described including the “double bag”, where the T–piece reservoir bag is contained within a much bigger plastic bag2 and the “Scavenging Dish”, an open scavenging device which works by suitable positioning of the bag3. Other modifications of the standard circuit include connection of scavenging via a syringe body on the distal end of the bag3, a second paediatric circuit4, or an APL valve onto the distal bag opening5,6.

Ancillary devices have the potential to increase airway resistance and pressures. Increased bulk and complexity of the circuit makes displacement of the circuit more likely and with extra ancillaries the potential for equipment failure is greater.

I describe below a novel scavenging device, manufactured by myself, which shares the advantages of the “double bag system” and the “scavenging dish”.

The construction is based upon a 5l breakfast cereal container (fig. 1, The Scavenging Reservoir). The sealing circular lid is removed, leaving a 10cm hole allowing easy passage of the reservoir bag. Simple attachments are added to the side to facilitate fixation to the operating table and a 22mm hole cut in the bottom to allow insertion of a standard 22mm scavenging pipe (with multiple extra holes to prevent occlusion).

The device allows the anaesthetist to use the standard T–piece easily and safely during induction and positioning of the patient. The bag with standard length tubing can then be suspended in the scavenging device. Direct observation of the bag during spontaneous ventilation is possible through the translucent container sides. For controlled ventilation the bag is withdrawn from within the container and the distal bag end directed into the top opening.

In practice the device is safe and easy to use and the T–piece operates in the usual manner. The most salient safety feature is that withdrawal of the bag from the scavenger leaves the anaesthetist holding the standard T–piece with no modifications, which he/she will be familiar with.

Informal gas sampling (Datex-Ohmeda Gas Analyser) around the top of the container demonstrates that scavenging using the container is successful with undetectable levels of anaesthetic agents.

Dr Thomas Cowlam
Anaesthetic SpR (Leicester) Leicester Royal Infirmary

Dr William Russell
Consultant Anaesthetist Leicester Royal Infirmary

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2. Chan MS, Kong AS. T-piece scavenging – the double bag system. Anaesthesia 1993 Jul;48(7):647
5. S. S. Dhara1 and H. L. Pua. A non occluding bag and closed scavenging system for the Jackson Rees modified T-piece breathing system. Anaesthesia, 2000, 55, pages 450-454

In the past, anaesthetists commonly modified anaesthetic equipment and even made their own devices. This is uncommon today, and there are definite problems with doing so, of which more in a future edition. Meanwhile, this article describes a simple modification of a device which is very much in the spirit of the past; I think it appeals to me because it seems simple and fills a perceived clinical gap, but also because of nostalgia for the past. However, please be warned, I do not think you should rush to work carrying your cornflakes box, as the world has moved on…
The iPhone and Muscle Relaxants

From our correspondent Scoop O’Lamine

The NHS Innovations in Patient Monitoring 2009 prize has been won by Dr Richard Clever from the Society for Computerised Anaesthesia Monitoring (SCAM). Dr Clever explained that his application designed for the iPhone can be used by anaesthetists to monitor their patients during anaesthesia.

“The application works by using the ear phones attached to skin electrodes using a special connector found in electronic shops (Special part number Malpin BL-244UTA-77K). This connector allows the iPhone circuitry to drive a higher inductance loop resulting in a voltage similar to that found in normal peripheral nerve stimulators.”

The application was written by Dick and his partner Sophie T ware and carries a fully functional PNS. By using the accelerometers found in the iPhone, the application can detect the amount of movement resulting from stimulation, calculating the Train Of Four ratio and other parameters.

The figure demonstrates the PNS iPhone in use on a patient and displays the TOF ratio.

At the ceremony in London where Dick was presented with a cheque by the judges, he explained that he was keen to see his work in the NHS, and that the first 100 anaesthetists who wished to use the application could download it free of charge from the Society website – www.aagbi/scam/freedownloadpns
The WFSA has had a productive year working with the World Health Organization on the **Safe Surgery Saves Lives** project, led by Atul Gawande which resulted in the Safe Surgery Checklist. Several WFSA member societies have championed the use of the checklist and in a number of countries, such as the UK, the checklist is being introduced to all hospitals. This work has now led on to the **WHO Global Pulse Oximetry Project** aiming to facilitate the provision of pulse oximeters and training in their use to every operating theatre in the world. Specifications have been produced for a low cost WHO oximeter, and it is hoped that following the tendering process an oximeter was selected and tested. The WFSA have been particularly involved in producing training materials for the project which will be tested at the All Africa Anaesthesia Meeting in Nairobi in September. This educational work has been led by our President Angela Enright. Special thanks are also due to Isabelle Murat for the French translation of the WHO oximeter manual, Gonzalo Barreiro for the Spanish edition and to Rafael Ortega for his superb instructional video.

A major effort to raise the profile of this lifesaving project is required to ensure that demand for oximeters is realized in parts of the world where anaesthetists work without them. This will result in hospitals and ministries of health "oximeterizing" health systems and thus improving perioperative safety. Major donors will be sought to support the project. Please email iainhwilson@mac.com with any suggestions you may have to ensure the success of this initiative. Without doubt this project is the largest anaesthesia safety initiative ever started, and all WFSA societies will need to put energy into this project to ensure its success.

An account of the oximetry projects in Uganda, Vietnam, India and the Philippines run by a collaboration from the WFSA, AAGBI and GE Healthcare was published in the journal *Anaesthesia* along with an accompanying editorial in October 2009. These projects did much to inform WHO of the practical aspects of the global programme.

The WFSA has also assisted the work of WHO through our contact Dr Meena Cherian of the Clinical Procedures Unit. We provided input into the new WHO guideline on the Clinical Use of Oxygen which details indications for oxygen, different ways to administer oxygen and how to monitor patients receiving oxygen.

Countries seeking advice about how to improve anaesthesia services will benefit from a joint WFSA / WHO blueprint describing the essential components of a national anaesthesia service. This will provide guidance in organizing a service, personnel who may provide anaesthesia, training recommendations, equipment required and ways of working to support safe practice. It is anticipated that this guideline will complement the WHO Emergency and Essential Surgical Care (EESC) program. Improvements in training methods will be coordinated with WHO.

The WFSA has some experience with training masterclasses run by Mike Dobson, Shirley Dobson and Lesley Bromley from the UK with their team – “Training the trainers”.

Following participation of WFSA members in a meeting organized by WHO Essential Health Technologies Department on anaesthesia equipment, WFSA and WHO have started work on generic specifications for anaesthesia machines that can operate reliably in resource poor areas of the world. This work is important as many anaesthesia machines in poorer countries remain unrepaired due to shortages of spare parts and maintenance facilities.
Primary Trauma Care (PTC)

PTC is supported by the WFSA and WHO and has run 34 courses during 2007-9 in different regions of the world. The WHO manual Surgical Care at the District Hospital includes the PTC material. The Chairman Douglas Wilkinson, and his international teams, are to be congratulated on this amazing achievement.

Publications Committee

The role of the Publications Committee is to further the work of the WFSA by providing appropriate educational materials for anaesthetists working without up-to-date published materials. The vision is challenging as clinical conditions vary from one country to the next, anaesthesia providers differ in their educational level and communicate in multiple languages. Modern texts which are almost exclusively written for advanced practice may be too expensive and impractical for some settings.

Update in Anaesthesia is the official CME publication of the WFSA. It is designed for anaesthetists working in resource poor settings and is edited by Dr Bruce McCormick. Each English edition is now translated into Russian, Chinese and Spanish. We are working to achieve French and Portuguese language editions. The Spanish edition is published on the internet, English and Russian editions are in paper format and on the internet.

In 2008 two editions have been produced – see www.anaesthesiologists.org. The second edition was a 200 page review of Basic Science applicable to anaesthesia. This was a significant undertaking for the editorial team and has received very positive reviews. We were extremely fortunate that the Association of Anaesthetists of Great Britain and Ireland (AAGBI) funded half the costs of production to assist the work of the WFSA. In 2009 we intend to produce another special edition – Emergencies in Anaesthesia.

WFSA Anaesthesia Tutorial of the Week was started in 2005 as an on-line weekly tutorial with a number of UK based editors. The tutorials provide material for trainees as well as experienced anaesthetists, and are particularly of interest for those anaesthetists working in isolation without access to CME, both medical and non-medical. The tutorials vary in complexity and are divided into basic science, general anaesthesia, paediatric, obstetric, regional and intensive care. The Tutorials are designed to encourage reflective learning by including questions and self-assessments and may be used for self study or teaching in the classroom. Tutorials are issued once a week and are currently hosted on the WFSA website, and are also sent out weekly to hundreds of anaesthetists by email. The archive on the website has around 140 tutorials at present containing a wide variety of material useful for the full range of clinical conditions which has proved popular for trainees in all countries. Since the system is based on the Internet, it is low cost and flexible, although limited where the internet is not available. The website www.frca.co.uk also publishes ATOTW.

Book donation programs continued during 2008-9 to centres in sub-Saharan Africa, Thailand, Fiji, Pacific Islands, Mongolia and Moldova. We have been working collaboratively with the AAGBI, which has a major book distribution program, mainly in sub-Saharan Africa.

In particular Understanding Paediatric Anaesthesia (R Jacob) has been printed in India in both English (1000) and French (2000) and distributed widely by the WFSA. Special thanks go to Isabelle Murat for organising the French distribution.

During 2009 the American Society of Anesthesiologists is planning to fund and distribute a Spanish translation of this book – a fantastic gesture costing around $15k. In addition, the Association of Paediatric Anaesthetists of Great Britain and Ireland are planning to sponsor 1000 copies of the English version for distribution by the WFSA ($6000).

The AAGBI Overseas Anaesthesia Fund receives donations by members and supports a major book donation program which is hugely appreciated. An Obstetric anaesthesia manual “Anaesthesia for Obstetrics in Developing Countries” is currently being edited by Dr Paul Clyburn in the UK and will become available for distribution in 2010. This is a joint venture between the WFSA, AAGBI and the Obstetric Anaesthetists Association. The manual will be published by Oxford University Press.

Dr Iain Wilson
Chairman WFSA Publications Committee
Trauma Series

In an interesting series of leading articles, the British Journal of Surgery is currently half way through a review of all things trauma, with several points of interest for anaesthetists. The series kicks off with a review of the epidemiology of major trauma, follows with ‘lessons from the battlefield’, and continues with the diagnosis and management of coagulopathies following major trauma.

British Journal of Surgery 2009; 96: 697-8

Deaths from late sepsis and multiple organ failure following trauma are in decline (less than 10% of fatalities, the majority being due to CNS trauma or thoracic aortic trauma) and are increasingly confined to the elderly population with less severe injuries but more comorbidities. This has lead to the creation of a subpopulation of those with ‘geriatric trauma’. Whist this population maybe declining as a proportion of the total fatalities, these are the patients likely to come to the ICU with potentially treatable multiple pathologies.


The military has introduced many innovative treatments and strategies for the management of haemorrhage. These include the early use of limb tourniquets, clot activating bandages, intraosseous cannulation drills, aggressive warming, 1:1 blood to plasma administration, and whole blood administration. Also, for battlefield limb trauma, ‘damage control surgery’ is often performed; that is operating on an unstable patient to affect limb salvage (such as vascular or nerve repair) and then performing definitive surgery once fully resuscitated in a critical care environment.

British Journal of Surgery 2009; 96: 963-

Coagulopathies following trauma are common (25%) and serious (fourfold increase in mortality). However, diagnosis is at present difficult; the laboratory tests are not sensitive, and near patient tests and predictive scoring systems are unvalidated. Empirical treatment is therefore common, and again the early use of plasma therapy is promoted though the effect this would have on civilian blood supplies is acknowledged. The article concludes with a look to the future; more appropriate tests of coagulation, non-plasma based coagulation correction, and specific therapies based on genetic variations in coagulation proteins.

Occasionally, the BJS has something of interest to anaesthetists. This is an easy to read series of articles giving an overview of the current and future direction of trauma treatments. I unfortunately have not seen the topics that are yet to be covered in the remaining three articles, though I will definitely give them a look.

Harry Murgatroyd

Su L, Rauff M et al. Carbetocin vs syntometrine for the third stage of labour following vaginal delivery – a double-blind randomised controlled trial. BJOG 2009; 116: 1461-1466

This trial was carried out in Singapore, and compares syntometrine with the long-acting oxytocin analogue carbetocin for the prophylaxis of primary post partum haemorrhage (PPH) following vaginal delivery in low-risk women. Syntometrine is already known to be more effective than syntocinon alone for this indication, but it is associated with significant side-effects and is contraindicated in approximately 10% of parturients. Following intramuscular (IM) injection pharmacokinetic studies show that carbetocin acts within 2 minutes, and lasts for about 2 hours. Subjects were randomised to receive either (n= 370) 100 μg of carbetocin IM or a mixture of oxytocin 5iu and ergometrine 500μg IM in a randomised double-blinded manner. The primary outcome (PPH requiring additional uterotonics) occurred equally frequently in both groups, confirming similar efficacy for the two treatments. The risk of nausea and vomiting, both moderate and severe, was much lower in the carbetocin group.

<table>
<thead>
<tr>
<th>Oxytocin IV</th>
<th>Carbetocin IV</th>
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<tbody>
<tr>
<td>Onset Time</td>
<td>&lt;1 min</td>
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<tr>
<td>Half life</td>
<td>4-10 min</td>
</tr>
<tr>
<td>Duration</td>
<td>16 min</td>
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</table>

I have not seen or used carbetocin personally.

In box 1, you can see the BNF data regarding carbetocin and (for comparison) that of other uterotonics in common use.

<table>
<thead>
<tr>
<th>Pabal® (Ferring) Injection , carbetocin 100 micrograms/ml 1-mL amp = £17.64</th>
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</thead>
<tbody>
<tr>
<td>Syntocinon® (Alliance) Injection , oxytocin, 5 units/ml, 1-mL amp = 76p; 10 u/ml 1-mL amp = 86p</td>
</tr>
<tr>
<td>Syntometrine® (Alliance) Injection , ergometrine maleate 500 μg, oxytocin 5 u/ml 1-mL amp = £1.35</td>
</tr>
<tr>
<td>Hemabate® (Pharmacia) Injection , carboprost (tromethamine salt) 250 μg/ml 1-mL amp = £18.20</td>
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Previous studies have demonstrated the superiority of carbetocin compared with intravenous infusion of syntocinon in terms of need for additional interventions (2,3). From other studies it appears the risk of side effects is similar to those of oxytocin, but it’s prolonged duration of action make it an alternative to syntocinon infusions(4,5). With the cost of consumables added in a Syntocinon infusion is still about a third of the price of carbetocin. Further studies are needed to compare cardiovascular side effects of carbetocin.

1. British National Formulary 58

Ryan Hynd, SpR 4, Northern Schools of Anaesthesia
MESSAGE FROM MERSEY

We take this Opportunity to Wish

All Candidates of the Mersey Courses

Past – Present – Future

Our Very Best Wishes

for

The New Year 2010

Our List of Alumni now contains more than
Five Thousand Names

We relish the Camaraderie which has been engendered among so many of those trainees who have passed through our courses.

We greatly value the support we receive from our alumni and recognise that, without that support, our courses would not be what they are.

And we will always appreciate the encouragement, advice and support we have received over the years from the many Senior Members of our Specialty who have contributed selflessly and without individual recompense to the MSA and its Courses.

We are very grateful.

THANK YOU

“If you feed the children with a spoon, they will never learn to use the chopsticks”

MSOA.ORG.UK
Don’t miss out on our premier conference this December in London. We will be bringing together key opinion leaders and international experts to speak at the most important ICM meeting of the year. It’s the perfect opportunity to keep ahead of all the latest developments in the field of intensive care, network, catch up with colleagues and go for a spot of Christmas shopping!

The meeting will be dedicated to state of the art topics of relevance to intensive care medicine with a choice of clinical practice and research forums.

CPD accreditation: 10 points pending

Key Note Speakers: Prof Djillali Annane, Paris France, Prof Simon Finfer, Sydney Australia, Prof Michael Matthay, San Francisco USA, Prof Laurent Papazian, France and Dr Leo Van de Watering, Netherlands.

Register now and take advantage of our special early bird rates!

Hot topics include:
- ARDS and ALI Update – ARDSnet, new treatments and strategies for ALI.
- ‘Less is More’ – The impact of oxygen, fluids and technology will be considered.
- Veterinary Intensive Care – Taking lessons from animals to humans.
- Ethics – Research issues and ethics of ICM practice.
- Lecture Tracks – Sessions including Organ Donation, Nutrition and Renal Medicine will question current practice.

Keep an eye on our website. More topics will be added as they are confirmed. Registration, abstract submission, a full programme and further meeting details are available at www.ics.ac.uk
How to make a poster

Congratulations!
Your abstract has been accepted. The email from the conference organisers should be welcome news; you are going to the conference and you may even get a publication out of it!

In the past, verbal presentation was the preferred vehicle for research and other short submissions to conferences and posters were a ‘second best’. Today, almost all major meetings direct presenters to poster sessions or “poster discussion” with either no verbal sessions or presentations reserved for a selected sub-group. Any how, a poster it is - so now you have to make one.

Who is going to make the poster? There are choices. You can do it yourself (see below), use a commercial print shop (possibly slick but expensive) or make friends with the staff in the nearest hospital or university medical illustration/graphic departments. If you choose the latter then go and see them in good time. If you are there 6 weeks before the meeting then everything will be possible. If you are the rude doctor who turns up 36 hours before a meeting and hammers the table then expect a frosty reception! Most of use choose a combination of ‘do it yourself’ and a professional department. Whatever you do, it is always worth having a chat with a professional, they do this everyday and you should avoid the typical doctor thing - don’t reinvent the wheel. They know lots about which colours work together, choice of fonts and size, how much stuff you can get on the page etc. Go on, ask them!

Software. Here you have several choices. Virtually everyone has access to Office software and within this Powerpoint is very suitable. If you thought Powerpoint was just for making slides then look again and read some of the sections of the help menu. Publisher is an excellent alternative but it doesn’t come as part of the basic Office software and it isn’t worth buying it specially. If you haven’t got Office or simply can’t stand Microsoft then Open Office can be downloaded freely from the web and contains similar functionality. Professionals use complex desktop publishing (DTP) packages. Don’t go anywhere near these, using them will add nothing to your poster but will definitely give you a headache and certainly cost you money if you go out to buy one. You definitely do not need this stuff, instead, put a cold flannel on your forehead and go back to Powerpoint.

Content and Layout. Scientific meetings are driven by data and the best posters present this (in appropriate quantities) together with interesting selected information about the research question, methods and results finishing with some moderate and defendable conclusions. In contrast the advertising industry goes for style over substance and can fill huge spaces with vacuous sentiments and precious few facts. If you doubt this take a look at any advertising hoarding! Remember you are trying to present yourself as a scientist and act accordingly.

What am I going to include? You have already written an abstract for the meeting and had it accepted. As a minimum you could simply cut and paste the contents of the abstract and dump it onto the poster. Plenty of people do this but it is a bit of a cop-out, you can do better than this. Your poster is your opportunity to present some visually interesting and selected outcomes from your research. You have got space for several graphs (we call them Figures in the world of scientific publication) and, one or more photographs or tables. There is also room for more text but don’t go crazy with this, people viewing posters tend to...
concentrate on the figures and only browse the text. If you write an essay on your poster you can be sure that the only person who reads it will be you and your mother, no one else is going to bother.

Read the instructions. Posters are rectangular in shape, and may be oriented with the long axis horizontally (landscape) or vertically (portrait). This will be clearly stated in the instructions together with the size of the poster that you are allowed. Check this out and then do so again. If you make your poster the wrong shape then you are going to be the person with a pair of scissors cutting it up on the floor 5 minutes before the poster session (this really happens, do try not to be that person).

Before you begin faffing about with Powerpoint or other software you need to sort out what you are trying to put into the poster. This is best done in a plain text document (Word or similar). Similarly, get together any tables (Word), pictures or graphs (Excel or similar). It is a complete waste of time starting to plaster stuff into the poster if you have no idea before you start what it is you are trying to achieve. If you set yourself a target of around 700 words and between two and ten items from the table/graph/photo category then you are in the right territory.

Made up your mind? If you are using some one from medical illustration or similar, now is the time to take your stuff to them. They don't want you to present it half formatted or messed about with. If you do this then they will simply have to spend time undoing all the 'clever clogs' stuff that you have attempted. What they like are plain text files graphs and tables in the native file format from the programme in which they were created and photos in the largest (uncompressed) version that you have. On a technical note, the preferred picture format is .tiff, .jpg is a “glossy” format which uses compression and some of the clarity of the photograph is lost. If a .jpg is all you have then don't worry but the bigger the file the better. Also, don't edit, alter, crop or mess about with the picture. Rather, take it along as it was originally acquired and then tell them what you would like to do.

Layout. There are lots of ways of doing this. Basically get the title at the top and then the names of the authors, in the middle put the stuff from the abstract, other text and the figures where it is justified and at the bottom remember to credit your financial backers, non-author helpers and advisers. Also, every institution has a logo and some are very picky about requiring employees to use it and then telling you how your poster should look. Decide whether you are going to take any notice of this or simply ignore it (it is you who might get the sack, not me!).

Printing. Now it is time to print your poster, and you need to find the person with the big A2 printer. Definitively check this on screen with them before you print it. It is an absolute certainty that you made one or more mistakes and large format printers run on a rich mixture so don’t waste your money at this stage. Print out the poster, roll it up, buy or borrow a poster tube and book your tickets . . .

On the day. Hopefully you have done a reconnaissance, especially if you are going to a large congress. The congress centre in New Orleans is one mile (yes really, one mile) long from one end to the other. 5 minutes before your poster session isn’t the best time to work out where Hall E, Zone B, Line 9 is. Turn up early; if there are registration staff say hello and then set about getting your poster in position. For this you will need ‘Blu-Tak’/pins/double-sided Velcro. They have probably told you which in the instructions but it doesn’t hurt to have some ‘Blu-Tak’ and pins in your pockets, just in case.

Turning Up. It is an extreme discourtesy to your hosts to not present your poster or simply to stick it up and not be alongside it at the appointed time. Don’t be that person, be there and enjoy it. Poster sessions are a great opportunity to meet people and your key tools are a smile, a handshake and some business cards (these are cheap, you can order them off the web and can sometimes get them for free). Introduce yourself and actively market the poster. If somebody walks past and pauses to look at it, don’t wait to be asked, say “can I tell you about our project?” and then get going. Because posters are typically grouped together by topic this an excellent chance to meet other people with research interests in the same area, big names in the academic world may be cruising past. Play your cards right and you could wangle yourself an invitation to visit, a collaboration or maybe even a fellowship. If you haven’t turned up you can be certain that none of these things will happen!

Although a little daunting the first time you do it, poster sessions are actually great fun. Don’t be frightened, do promote yourself and your institution, network like crazy and be sure to come away with some contacts (and follow them up!), some ideas and some new friends. Go on, do it, you know you want to!

Presenting a poster - getting the most out of the day
• Turn up on time
• Stay by your poster
• Promote yourself and your institution
• Approach people
• Photocopies of your abstract
• Business cards
• A smile and a handshake!
• Figure legends
• Poster printer
• Don’t forget to read the instructions
• and re-read them

Robert Sneyd
Peninsula College of Medicine and Dentistry, Plymouth
Three years ago we introduced a new series of one-day meetings labelled “Core Topics” which aims to bring well-organised one-day AAGBI meetings to the regions. We are now busy preparing the 2010 series, and the programme has been extended this year to ten meetings.

Our aim with Core Topics is to offer you high-quality CME at regional venues and, where possible, to have an AAGBI Council member present to allow an open-forum discussion of current topics and to provide an avenue for exchange of information between the Council and our members.

Revalidation is just around the corner and the topics presented at all future meetings will fit into the continuing professional development matrix, which is currently under development by the Royal College of Anaesthetists. Core Topics offers an opportunity to stay up to date, hear from a mixture of well-known national speakers and also to promote emerging talent from your own region.

Our one-day registration fee of £150 for AAGBI members represents great value for money. We are committed to supporting our trainees and to this end offer a rate of £100 for AAGBI members who are in training posts.

The dates for 2010 are listed below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
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<tbody>
<tr>
<td>25 Feb</td>
<td>Chester</td>
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<tr>
<td>18 Mar</td>
<td>Newcastle</td>
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<td>29 Apr</td>
<td>Exeter</td>
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<td>28 Oct</td>
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<tr>
<td>24 Nov</td>
<td>Manchester</td>
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AAGBI Member: £150
Non- Members : £200
Trainee: £100

www.aagbi.org/events/act.htm

Richard Griffiths
Chair, AAGBI Events Committee

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GAT Prizes at Cardiff 2010

**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.

**The Anaesthesia History Prize**
The Association of Anaesthetists and the History of Anaesthesia Society will award a cash prize 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 cash prize and an engraved medal will be awarded for the best entry.

**CLOSING DATE – FRIDAY 16 APRIL 2010**
Full details can be found on the AAGBI website http://www.aagbi.org/grants/trainee.htm

If you have any additional queries, please contact the AAGBI Secretariat on 020 7631 8807 or secretariat@aagbi.org

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**Society for Education in Anaesthesia (UK)**
Annual Scientific Meeting

**REVALIDATION & MEDICAL EDUCATION IN ANAESTHESIA**

**Monday 15th March 2010**

The Mercure St Pauls Hotel & Spa
SHEFFIELD

- The GMC perspective
- The Royal College of Anaesthetists’ perspective
- Dealing with the failing doctor
- Human factors in anaesthesia
- Plus
- Abstracts invited for Free Papers.
- Trainee Prizes of £150 and £300.

Submission deadline Friday 29th January 2010
Posters welcome - deadline as above. Prize £150

Cost: £125 for members/£150 for non-members (including one year membership))

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

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www.aagbi.org/events/act.htm
Scousers, deep-fried jam sandwiches and tortoises on bricks

The 2009 AAGBI Annual Congress in Liverpool

Will Harrop-Griffiths, VP

With more than 600 registrants this year, the AAGBI’s Annual Congress is the UK’s biggest ‘general’ anaesthetic conference. For some, the main attraction may have been the location: the BT Convention Centre in the modern dockside redevelopment in Liverpool. For some it may have been the weather: the sun always seems to shine on the Annual Congress. However, for all, it was certainly the interesting and comprehensive programme put together by Rob Sneyd and his Education Team at the AAGBI. The mix of topics covered is something unique to the AAGBI’s meetings: keynote lectures on important and topical subjects, ‘state of the art’ scientific sessions produced in cooperation with specialist societies, ‘core topic’ update sessions, workshops, case presentations, and time devoted to subjects important to AAGBI members such as welfare, health, revalidation, management, Specialty Doctors and independent practice. In addition to these, there were scores of posters on show and three sessions devoted to free paper presentations. No other meeting offers this breadth of topics. All this was laced with a large industry exhibition, art prizes, debates and dramatisations. There was quite literally something for everyone. Rather than go through every session in detail, I will report what for me were the highlights of the meeting.

Professor Sir John Tooke delivered the eponymous John Snow lecture. With a measured tone and careful delivery, his talk held all transfixed. He ably argued the importance of academia to medicine and highlighted the fact that hospitals with a strong academic basis performed better from the clinical point of view than those without. He lamented the decrease in funding for academic medicine and called for its rapid reversal. A key slide showed that the numbers of lecturers and senior lecturers were in decline – a worrying trend in that these people are the academic leaders of the future. He did not comment on the line in the graph that seemed to indicate that the number of professors is steadily – if slowly – increasing. All in all it was a thought provoking if rather concerning talk that was appreciated by all.

Karen Domino, the lead for the Closed Claims Analysis programme of the American Society of Anesthesiologists (ASA) gave a detailed and fascinating talk on morbidity and mortality as revealed by analysis of closed medicolegal claims in the US. Advances in monitoring introduced in the 1980s and 1990s seem to have been associated with decreases in mortality and major morbidity having their origin in cardiorespiratory problems. However, two recent issues of concern were emerging: an increased proportion of claims relating to chronic pain management procedures and MAC, an American acronym that stands for Monitored Anaesthesia Care. Although pulse oximetry is becoming almost ubiquitous in the context of monitored sedation, capnography is far from universal. Sedation with a combination of opioids, benzodiazepines and propofol with oxygen therapy but in the absence of capnography is leading to a situation in which airway obstruction or apnoea is being recognised.
too late as a decrease in oxygen saturation and, in the absence of the necessary airway management and resuscitation skills ad equipment, patients are suffering. Dr Domino translated from her American experiences to the UK situation well, although many were slightly foxed by her description of “awake neurosurgery with propofol sedation and a laryngeal mask airway”; I can only presume that the word ‘awake’ has a much broader definition on the other side of the Atlantic. All in all, it was an excellent presentation.

For me, the keynote lecture highlight of the conference was the Intavent Lecture delivered by Dr David Bogod who, after six years at the helm of what is arguably the world’s best clinical anaesthetic journal – the AAGBI’s own Anaesthesia – is standing down. He gave a masterful guided tour through the peaks, the troughs and the plain daft of medical publishing – in his own words the Good, the Bad and the Ugly. There was much insight and humour in his talk, culminating in the funniest mental image most of us had enjoyed for some time. He recalled meeting with some veterinary anaesthetists and being told that the only way to diagnose pregnancy in a tortoise is with an MRI. He asked how one sedated or anaesthetised a tortoise in order to keep it still enough to get good MRI images. In response, he was told that anaesthesia was not necessary; one simply ‘velcroed’ the tortoise to a brick. Cue prolonged guffaws throughout the lecture theatre.

The AAGBI’s Annual Dinner and Dance was held on the Thursday evening in the St George’s Hall, a magnificent Victorian monument to wealth and mercantile power. To the powerful melodies of a full-scale pipe organ (the Bach Toccata and Fugue in D Minor made my chest vibrate), diners sipped champagne before enjoying a very good three-course meal. Blue cheese on a fig challenged the taste buds of many but all were agreed that the meal was excellent. Mr Crisp, our usual toastmaster, was not present, his place as master of ceremonies being taken by yours truly. I cannot pass judgement on my own performance as stand-in compère and toastmaster, but I certainly enjoyed it!

As with all societies, annual meetings contain a certain amount of process and ceremony. I will not trouble readers with all the details but I will note some changes and awards. Dr Iain Wilson from Exeter became the AAGBI’s President Elect, Dr Andrew Hartle from London became our Honorary Secretary Elect and Dr Steve Yentis from London became the new Editor-in-Chief of Anaesthesia. I wish them all the very best of luck in their new roles; I fear that they will need it! Sadly, we had to say ‘adieu’ to some Council members: Alastair Cambers, Nick Denny, Judith Hull, Chandra Kumar, John McAdoo, Chris Meadows and David Whitaker; they were sent on their way with our best wishes and a framed Council Award that thanked them for their service to the AAGBI’s members. The full list of honours and awards made at the Annual Congress is available on the AAGBI’s website.

As all anaesthetists, intensivists and pain specialists face the upcoming challenge of revalidation, meetings such as the Annual Congress offer great opportunities to satisfy the new system’s demands for CPD across a wide range of subspecialties. Registrants at the meeting will have satisfied the requirements in a number of clinical areas: patient safety, vascular anaesthesia, burns and plastic surgery, obesity, renal disorders, cardiac disorders, paediatric anaesthesia, military anaesthesia, diabetes, difficult airways, regional anaesthesia, obstetric anaesthesia, e-learning and ultrasound – just to mention a few! Education Committee Chair Rob Sneyd has guaranteed that the Annual Congress and all meetings in the last few years that have been run by the AAGBI will have their lecture content mapped to the forthcoming RCoA CPD matrix that will form the core of recertification. In addition to this, the incoming Education Committee Chair, Richard Griffiths, has said that future AAGBI meetings will be prospectively mapped to CPD cells within the recertification matrix. Annual Congresses and WSM London meetings will, as a result, form a good value and interesting way to fulfil most, if not all, the recertification requirements of anaesthetists. It is estimated that all an anaesthetist will have to do is attend either the Annual Congress or WSM London every year, along with an AAGBI Regional Core Topics meeting, and even the GMC’s new processes will be satisfied.

This year’s Art Prize went to Dr Paul Hayse-Gregson with his bewitching photograph ‘Still life with water, glass and bamboo’. He narrowly beat former Art Prize winner and regular contender David Bogod, whose ruse to use the heart-string-tugging appeal of a picture of a baby elephant very nearly worked. However, he was narrowly pushed into second place.

The meeting ended with a dramatisation of a medicolegal case in which an anaesthetist (played by Isabeau Walker) was held to be negligent because she did not use ultrasound imaging to identify the internal jugular vein. Her needle encountered the carotid artery and the patient suffered a stroke.
In spite of the best efforts of her lawyer (me again) and an expert witness for the defence (Richard Griffiths), the verdict (delivered by Judge Andrew Hartle) went against her. David Bogod played the lawyer for the claimant and Rob Sneyd was the undoubted star as he played the completely convincing part of Professor Robert Hourly-Rate: academic, medical politician and serial clinical escapee.

Finally, I just need to provide an explanation for the title of this report. The ‘scousers’ need no explanation, and the tortoise has been explained above. There remains the not inconsiderable matter of the deep-fried jam sandwich, which was actually served with Carnation Milk ice cream. It was delicious – absolutely delicious – and was served by a delightful young waitress with a Liverpudlian accent so thick you could cut it with a knife in an excellent restaurant in a wonderful city during an extremely successful and enjoyable meeting. The taste will linger with me for months, the extra centimetre on my waist for years. Next year’s Annual Congress promises to be better than ever. It will be held in Harrogate on 22nd – 24th September 2010. Aficionados of Harrogate eateries will know that it is the home of Bettys Tea Room (Betty does not use an apostrophe). I can already taste the Warm Yorkshire Fat Rascal which, for the uninitiated, is a large, plump, fruity scone made with citrus peel, almonds and cherries, served with a lump of butter. It’s as good as deep-fried jam sandwich – almost!

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
AAGBI Christmas Cards

Sold in aid of the Overseas Anaesthesia Fund

The AAGBI is pleased to announce the choice of two designs of Christmas card available to purchase this year at a reduced price. Both cards have been exhibited at previous Annual Congress Art Exhibitions.

Proceeds from the sale of these cards will go to the Association’s Overseas Anaesthesia Fund, whose aim is to raise the profile of the specialty and promote safer anaesthesia in the developing world. For more information, go to www.aagbi.org/oaf.htm

If you would like to purchase the charity Christmas cards, please complete this form (which is also available on our website www.aagbi.org). The packs will be mailed to you from the AAGBI in London.

The cards are available to purchase as a minimum order of a pack of 10.

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Additional donation to OAF

Please tick this box if you are a UK taxpayer and wish for OAF to reclaim (via Gift Aid) 28 pence for every £1.00 of your additional donation

Total

Please pay by Sterling cheque drawn on a UK bank account and made payable to the AAGBI OR please debit my credit card (only Visa/VISA Debit/Mastercard/Maestro) or Switch

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Expiry date ....................... Start date/Issue no (Switch only) ............... Cardholder’s name ..............................................................

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Please return to: Christine Tabano, AAGBI, 21 Portland Place, London, W1B 1PY. Or fax: 020 7631 4352 phone: 0207 631 8812 or email the above details to secretariat@aagbi.org
Dear Editor

Like Doctors Seymour (Anaesthesia News, June, 2009) and Fletcher (Anaesthesia News, October, 2009), and being myself retired, I have been concerned about what I may do in terms of bystander first-aid. I am some way further down the road than Dr Fletcher, being over five years retired; also, I have chosen to take voluntary erasure from the GMC’s Register, rather than pay them £395 per annum, to nobody’s benefit other than to the GMC.

Incidentally, in the forty years I was working, I helped as a bystander on only three occasions, and I did nothing on these occasions that I wouldn’t do today.

However, I have been reassured by both the GMC and the Medical Defence Union that it would still be in order for me to help if needed as a bystander at an accident or major health problem, and the MDU say that they have discretion to help me if legal consequences ensue; I have been told that there have been no known actions yet taken against doctors acting as bystanders. I will, of course, be more reluctant to do much as I get older and my knowledge gets more and more out-of-date. Nevertheless, if someone were to be obviously dying if no help were given, I might even treat a tension pneumothorax, as in Dr Seymour’s example.

I cannot, however, support Dr Fletcher’s idea of limited prescribing rights. If I or my family get ill, they see a “proper” doctor! “A doctor who treats himself has a fool for a patient ...”.

Yours sincerely,

Peter Young

Dear Editor

There is nothing worse than a grumbly email from an ex-editor!

The dreaded ‘myself’ makes an ugly appearance in the President’s Report, instead of ‘I’. Did ‘myself’ really attended the Canadian meeting with Les and Ian, or did ‘I’?

I, [please note, not me or myself], would allow the President, a man with a standing very close to royalty, to have gone on his own and write that ‘We’ attended the said meeting, but ‘myself’ should be buried deeply and permanently somewhere unpleasant.

Robin Weller
Retired of Bristol [not Tunbridge Wells]

Mea Culpa; I didn’t spot this myself. Bill Bryson summarily dismisses ‘myself’ as follows: ‘Except when it is used for emphasis (‘I’ll do it myself’) or reflexively (‘I cut myself while shaving’) myself is almost always timorous and better avoided.’ (Bryson’s Dictionary for Writers and Editors. Black Swan, 2008). Ed.

Dear Editor,

“Victor” Harrop-Griffiths’ musings in the September issue struck a resonant chord on this side of the planet - not least because whatever the UK does at breakfast, New Zealand tends to adopt by afternoon tea.

Years ago, when I was still a child of the NHS, I worked regularly with an enlightened vascular surgeon. During long cases he would insist that I be provided with a mug of coffee, in theatre, on the anaesthetic machine. He declared that the bacteriological hazard posed by a mug of steaming coffee was negligible; it was of more concern to him that his anaesthetists should be adequately refreshed.

And to V.F.G.’s experiences I will add a Kiwi version. We anaesthetise in three small rural hospitals spread around the southern, wilder region of central North Island. One of the last units of the late 1960’s was a mixture of uncooperative small children and intellectually disabled adults. Some of the autistic teenagers are frightened, strong and aggressive - a thought-provoking combination.

Our usual strategy involves an oral ketamine/midazolam premed, which adapts to provide to a fairly safe (pros) and amnestic (for the patient) induction.

However, the onset of sedation from the oral cocktail can be unpredictable, and the ideal arrangement is for the patient, caretaker, and theatre delay to be placed in a quiet room. As soon as kids in the post op ward come out of central North Island.

Two weeks ago, in the third hospital, we had such a case - a 85 kg teenage autistic lad. However, hospital IT does not have any patient boluses in its day surgery unit, only conventional hospital beds. ‘Don’t ask me why ...’ We approached the Emergency Department: Yes, they had five boluses. Yes, they only had two patients. No, we couldn’t borrow a bolus; not even for an hour.

At this point my anaesthetic colleague/husband flipped into what I now recognize to be Melatonin mode, strode down to ED and physically removed a bolus. The ensuing kerfuffle was quite remarkable; not because ED was now aware with casualties and they desperately needed their bolus, but because the one held hijacked - a nice new model - had been flagged as an INFECTION CONTROL RISK.

Why? Because the bolus’s matters had - as is right and proper - a waterproof cover, and said waterproof cover was secured by a zip. Yes, gentle reader, a zip. Obviously a serious infection hazard. So the nice new bolus was kicked up into a corner, gathering dust until a safely zipped free matter arrives from overseas the UK, actually ...

I have heard of zip being dangerous - usually to a sensitive portion of the male anatomy, in the course of clothes sharp adjustment. But can anyone - up to and including the infection control SS - furnish reliable scientific data as to their potential for transmitting infection? We did ask. Sunday slapping horses ensued, but not much else.

All power to ‘Victor’s’ allow. Could this become a regular column?

Yours,

Heather Cash
Dear Editor,

Propofol (The Magic Milk) - It is not Bad, Dangerous or a Smooth Criminal!

Recently I was anaesthetizing a 7 year old for an elective tonsillectomy. Dad was present in the anaesthetic room and, as we had discussed pre-op, I obtained intravenous access with little upset for the child. Having spent my training years in different parts of the country I understand describing propofol as the magic milk is a common practice among us anaesthetists, particularly in a paediatric setting. So I explained to the child that I was injecting the magic milk and soon he would be asleep. The operation was uneventful and when I met the dad later in the recovery he asked me whether the medicine I injected is the same one given to Michael Jackson just before his death. I said yes and he was surprised that this drug is still being used in clinical practice. With so much publicity surrounding the probable role of propofol in Michael Jackson’s death I understand public are really concerned if they come to know that propofol is being administered to them or their children. To allay the anxiety of parents in anaesthetic room about what is being given to their children maybe we should stop describing propofol as magic milk as people believe it is bad, dangerous and a smooth criminal.

Dr. SenthilKumar Vijayan, Specialist Registrar,
St. Marys Hospital, Paddington, London.
E mail  senthil14@doctors.org.uk

References
1. Doctor and his ‘magic milk’ at heart of the mystery over Michael Jackson’s last hours, www.timesonline.co.uk/tol/news/world/us/article6809936.ece
2. Los Angeles county coroner reports Michael Jackson had a lethal level of Propofol in his blood, www.guardian.co.uk/michael-jackson-death-homicide

Which needle do you use?

We all experience frequent changes in equipment, or drug manufacturers, often driven by purely financial considerations, with no concern for clinical performance.

Following the recent introduction of a new brand of drawing up needle, I discovered more than I had expected in a syringe of gentamicin. Initially I found the needle difficult to push through the bung of the vial, and on closer inspection of the bung I could see a significant hole where the needle had pierced the rubber. Looking at the syringe after drawing up the gentamicin, I noticed a small core of red rubber drifting within the solution. I discarded the syringe and drew up a replacement using a sharp needle, as there were no filter needles available. No particles of rubber were visible in this second syringe.

Only one of the hospitals I have worked in routinely provides filter needles for drawing up drugs. I have asked several colleagues which needle they use when drawing up from glass ‘snap’ vials or through rubber bungs, but could find no consensus. In the literature there are a few articles on related subjects but nothing specifically about drawing up needles. Should we not all have available, and be using filter needles for drawing up drugs, thus avoiding this potentially harmful problem?

Stephen Hill
Specialist Registrar in Anaesthesia
Calderdale Royal Hospital, Halifax

Propofol: A response

Before the recent intense media attention surrounding Michael Jackson’s death, most members of the public were blissfully unaware of the very existence of propofol. Sadly, as a result of the singer’s death, propofol may now be labelled as a drug of abuse with potentially lethal side-effects. Anaesthetists have always been aware of the potentially lethal side effects, but its use as a recreational drug will come as a surprise to most.

Propofol is the most widely used intravenous induction agent in the United Kingdom (more than 5.5 million units were sold in the year ending June 2009), and since its introduction into clinical practice in the 1980s, it has revolutionised the practice of anaesthesia. It came onto the market at very much the same time as the laryngeal mask airway, and this ‘match made in heaven’ has benefited countless millions of patients around the world. It is not an obvious candidate as a drug of dependence: it has a short duration of action and is not commonly associated with the euphoric phenomena seen with other substances of misuse such as opioids and ketamine. The number of case reports of propofol addiction in the literature is limited. There is only one report in existence of a member of the public abusing propofol, and misuse by healthcare staff is limited to a few sporadic case reports in one survey of Academic Anaesthesia Programmes in the US. In this survey, which covered over a 10-year period, only 26 cases of known propofol abuse were revealed. Many of those known to have abused propofol had also abused other substances, and in about a third of cases the abuse was only discovered with the individual’s death. Thus, if these small numbers of misuse are considered against the number of doses of propofol that are administered each year, it is not possible to say that the propofol misuse is a significant problem.

The US Food and Drug Administration (FDA) requires that propofol be administered by healthcare professionals trained in the administration of general anaesthesia - in the UK this is almost always anaesthetists or intensivists, although non-medically qualified people can give it under appropriate supervision. The death of Michael Jackson may be attributed to the fact that propofol was administered in combination with other sedative drugs in an environment that lacked monitoring and resuscitation equipment, and by an individual who may not have had the necessary training.

Therefore, given the limited of evidence of its misuse, and the fact that propofol is given in the UK only by individuals who are trained to do so in a controlled clinical environment, we can conclude that propofol is a safe drug, with limited addictive potential. Our role as anaesthetists should be to try to discourage the ‘villainisation’ of the drug, and to promote its use and safety to the public and our patients.

Dr Vijayan notes that many might think the drug ‘bad, dangerous and a smooth criminal’. I can only caution that it should not be used as a thriller, because if you can’t beat it, you will find that you are not unbreakable and, indeed, you are likely to be gone too soon.

Surbhi Malhotra
Consultant Anaesthetist & Honorary Senior Lecturer
St Mary’s Hospital, Imperial College Healthcare NHS Trust, London


The author of this response co-wrote a recent editorial about this issue in the BMJ: Hartle A, Malhotra S. Editorial: The safety of propofol. BMJ 2009; 339: b4024
Poor you, suffering from a mid-life crisis and turning to your two-wheeled friend with a huge engine for comfort and support, through what I can see must be a very distressing time.

However, perish the thought that I, Sister Hitler would allow the demanding standards I set in my theatre suite to drop for anyone, even for anaesthetists experiencing mid-life crises. My three line whip is clear. Food and drink containers littered around the anaesthetic room look unprofessional and can be very unkind to patients who have been fasting. This, I would argue, is reason enough not to allow the practice to occur. It has no evidence base, but is just plain common sense. Even if the picnic hamper with the flask full of steaming coffee were to be opened after the patient was safely anaesthetised and surgery was underway, I know that dirty cups and crumb-riddled surfaces will be left behind. I feel that I do not need to conduct some robust quantitative research to prove this point, a quick audit on any given day, in any theatre suite in the UK, will demonstrate that this phenomenon exists.

So let’s get to the nitty-gritty of producing the evidence for banning food and drink consumption in the anaesthetic room or theatre. In medicine and nursing many actions are unsupported by a controlled randomised trial. Can we prove that a patient has caught an infection from an anaesthetist who has eaten a bug-laden sandwich in the coffee room? It’s not killing off of a few anaesthetists that worries me. If an anaesthetist wants to eat his bug-laden sandwich in the coffee room, he is likely to take off his gloves and (one hopes) wash his hands or as a minimum put on a clean pair of gloves on return to theatre. If he is not made to go to the coffee room he risks contaminating the theatre environment with food, saliva and so on. Now I am not saying that all anaesthetists have slovenly habits, but the point I am trying to make is that eating in a clinical area poses a theoretical risk to the patient. For the anaesthetist, eating and drinking in a clinical area poses a significant Health and Safety risk to themselves.

This is well researched and written about in the literature. To manage the risk of infections to staff members who are handling tissue and body fluids it is recommend that food and drink is consumed away from clinical areas. Specific guidance in relation to the consumption of food and drink in clinical areas exists in the COSHH regulations 2002 (HSE) and the document ‘Infection at Work: Controlling the risks, Advisory Committee on Dangerous Pathogens 2003’. This clearly states that rest breaks and meal breaks should be taken away from the main work area.

Not only is this guidance, it is a legal requirement. So to all the Sister Hitler’s across the UK, here is the evidence you need for poor old Victor!


Linda Walker, Senior Nurse, UHW Llandough.
I am writing this to the AAGBI with much gratitude and appreciation for the efforts they are making to improve anaesthesia in the developing world and in Uganda in particular.

My story is just a small part of the greater good that the AAGBI have done and its starts in August of 2007. I had started my training as an anaesthesia senior house officer at the Makerere University Teaching hospital at Mulago and was completing my first year.

We were three students in my lot at the start and there hadn’t been a trainee for three consecutive years leading up to our admission.

As you may be aware, anaesthesia as a specialty has received a lot of negative criticism and is at the bottom of the barrel as far as post graduate training priorities lay. To make matters worse, trainee senior house officers across the board do not receive any remuneration or allowance for the service they give to the hospitals. As a matter of fact they pay tuition and other fees to the university. It is against this background that I applied for anaesthesia training.

It was a rather brave decision at the time because I had a fairly well paying job as a medical officer and had been offered an even better one by a big HIV research organization in the city. So in order to survive during my training I had to do long moonlighting hours at private hospitals around town. This only worked to make my training harder because I had no time to read and often times presented for my tutorials unprepared. This also conflicted with my call schedules at the hospital. Sometimes I would have a shift that was paying much needed money and at the same time a thankless one at the hospital casualty OR. As if that wasn’t enough our colleague dropped out, citing financial constraints.

So when I met Dr Sarah Hodges (who has been a really excellent tutor) in August of 2007 I was contemplating quitting the course, and had also written a letter to that effect. I didn’t tell her this because I felt that having given so much unpaid time to teaching us she’d be so disappointed and that would negatively affect my colleague (who was sponsored by a private hospital).

Mention of the AAGBI fellowship was of course very welcome news. I promptly tore up my letter and decided to fight on. This not only helped ease my personal life but it motivated me to involve myself in anaesthesia advocacy. In the last 2 years I’ve been able to help recruit 5 other trainees into the program. I constantly talk to whoever may listen about anaesthesia as a career, even if they are 3rd year undergrads because I believe that by doing so I am sowing a seed in each one of them. By staying in the program I have been able to take advantage of other training opportunities that have presented themselves and in so doing improve my skills.

All the above goes to show the knock on effect of helping just one person. Truth is we need a critical mass in both training programs (Makerere and Mbarara) in order to get anaesthesia organised in this country. It is much easier to recruit good quality trainees if they know that they won’t have to worry about survival outside the hospital. Now because of the support I got, quite a number of prospective trainees now seriously consider anaesthesia as an option.

There is always going to be the question of ‘brain drain’ in this situation. There is always going to be 20-30% who leave to practice elsewhere, but if we can convince them to continually support us from wherever they are everyone wins.

If we can achieve a training critical mass of 10 residents per year for the next 5 years, we shall have a big enough voice to be heard by policy makers. This means that safe anaesthesia will become a right for every Ugandan and not for a privileged few.

I would like to specially thank Drs Sarah Hodges, Isabeau Walker, and Iain Wilson for all the guidance they have given me through my training.

God bless you

Dr Arthur Kwizera
Preparation of Hot Beverages

Aims

- To understand the importance of tea in facilitating and enhancing social interactions within the department.
- To recognise the verbal and non-verbal communication concerning tea.
- To develop awareness of the varied ways in which consultants might express their need for tea.
- To learn the individual consultant requirements with regard to milk, sugar, and the strength of tea.
- Awareness of the potential dangers to individuals and the building of water and electricity when they come together in the proximity of a kettle.

Prerequisites.

As this procedure is potentially hazardous, the possession of the fire safety training Certificate, including evacuation procedures, is essential. Water is involved and proof of ability to swim 50 metres (without buoyancy aids) is required. The demonstration of a non-judgemental, non-discriminatory attitude to those non-tea drinkers who choose who choose to flaunt their abnormal imbibatory habits, in line with current equality and diversity training guidelines, is necessary.

DOPS

Foundation Doctors

Because of the limited time that Foundation Doctors spend in the Department, they will need to demonstrate:

- Safe kettle-filling technique.
- Awareness of threats and hazards when walking from the kitchen area carrying a teapot containing hot water.
- Completion of the dishwasher loading and emptying competency.

CT1 and 2 Basic competencies

Competencies as for Foundation Doctors. In addition:

- Knowledge of local emergency supplies of milk and sugar and opening hours (e.g., WRVS, theatre fridge).
- Awareness of current levels of supply and ability to prevent milk and sugar supply deficit.
- Trainees spending their EWTD-mandated rest period in the coffee room will have realised that consultants rarely enjoy such a luxury. The smooth running of the Department will be facilitated by senior trainees ensuring that there is a ready supply of fresh tea throughout the lunch period.

Super-advanced Competency test

There is a colour chart, indicating the strength of tea preferred by members of the Department (n=15) on the wall in the kitchen. Providing the tea—correct strength, correct person—at the Consultant business meeting will ensure an A3 embossed glossy certificate, the envy of all your friends, signed by the entire Department, which will impress any ARCP panel (should they ever look at it).

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Trainee assessment

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And how was it for you?