After the FRCA – what next?

The early years of obstetric anaesthesia

The Scottish Standing Committee
Ultrasound Training Courses 2009

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

Advanced Ultrasound Guided Regional Anaesthesia

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

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

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 in 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.

Fee: £350.00 / £450 (A) (two-day courses) includes VAT, lunch, refreshments and course materials
£250.00 (one-day courses) includes VAT, lunch, refreshments and course materials.

(A) - Anatomy based courses / with cadaveric projections.

To register or for more information contact:
Jes Greasley
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As an introduction to my first report as Honorary Secretary: my name is Les Gemmell, I am a consultant anaesthetist/intensivist in the North Wales Trust; I have an interest in major upper GI surgery and Critical Care Outreach and Aftercare. While a Council member I was Chair of the Safety Committee for 3 years; patient safety is my passion.

The extremely efficient Editor of Anaesthesia News has established a roster of reports from Executive members of the AAGBI Council. Therefore, knowing my slot would come as the new Honorary Secretary, I began this piece on the English Riviera where I took over the reins from William Harrop-Griffiths. Torquay was an appropriate place for the start of my term in office as it was the place where I also started my anaesthetic career - long, long ago in the dim and distant past. This coincidence has caused me to reminisce over the years from my anaesthetic infancy to the present day. Oh so many changes! One can take one’s own personal favourite (or worst) change over the years; from the drugs we use to the advance of our monitoring equipment. The most irritating aspects of change are the rapidly enforced managerial changes. These changes are often without evidence and introduced as a knee-jerk reaction to the mantra of modernisation.

My choice of a defining moment of change would be Devolution. The reason for this choice is the hybrid nature of my upbringing: born in Scotland; educated in South Wales; medical school in London; most of my medical training in England and consultant post in North Wales. Because of my truly British experience - I AM NOT A GREAT FAN OF DEVOLUTION. It has resulted in an impressively rapid divergence of healthcare in the devolved nations and there are clearly four differing NHS systems. This may have no benefit to patients in the four devolved nations and, indeed, may act as a hindrance to those patients who live on the borders. It may also impede the flow of doctors, especially trainees, through these differing systems.
The four healthcare systems face common challenges; they must ration resources in life-and-death situations and to do this they must rely on articulate, intelligent, often unmanageable professionals to implement their actions i.e. you and me! Therefore from anaesthesia’s point of view there must be a consistency of approach and of values. What we must insist on is patient safety; above all the rest of our professional colleagues, we are the champions of patient safety.

The AAGBI promotes consistently high standards of care to guide anaesthesia throughout the four devolved nations to enable individuals to aspire to excellence. The very fact that the Association from its inception has included our Irish colleagues gives the Association a unique ability to ensure consistency across varying healthcare systems.

The Association has been steered through a period of necessary change in its Constitution; crafted and implemented by my predecessor. There are a few consequences of the changes which Council must still explore, such as:

- Does the membership wish to vote on matters using an electronic format?
- How should the Annual Members’ Meeting be conducted?
- What topics would the members like to have for discussion in the Meeting?

The Association’s membership needs to inform Council of their views on these questions and others that will come up in the future development of the AAGBI. This will help enable an acceptable and successful future for the AAGBI. The Council is always keen for an increased dialogue with the Association’s membership and welcomes views on all related matters. In a recent article on the Constitution changes, William Harrop-Griffiths stated:

"...we plan to increase the amount of information we make available to our members, to make the governance of both organisations more open and transparent, and to give members a greater sense of involvement in the AAGBI’s overall strategy."

It is important that we take these ideas forward and Council wishes to do that with the help of the members.

However, the stated aims of the AAGBI have not been changed by this process and they are:

- to promote the development and study of anaesthesia
- to promote and ensure the maintenance of the highest standards and provision of safe anaesthesia
- to foster research into anaesthesia and allied subjects
- to encourage and support world wide co-operation amongst anaesthetists
- to represent and protect the interests of its members

These aims provide a consistent theme for individual anaesthetists in their ever-changing working environment. It is important to note some of the measurable benefits that the AAGBI has provided, and will continue to provide, in pursuit of these aims:

- The Association will donate £1 million funding for research projects over the next five years via the National Institute of Academic Anaesthesia: this will help the development of anaesthesia.
- There will be changes to the AAGBI website which will herald a new approach to education and engagement with members.
- The Safety Committee was established in 1974 and continues to ensure patient safety matters are of the highest importance on the AAGBI agenda. A forthcoming meeting on Human Factors in Patient Safety (2nd April) will take place prior to the launch of the new AAGBI Foundation.
- The protection of members’ interests has seen an increasing amount of activity, including activity against AXA PPP’s contractual changes, the publication of the Welfare resource pack, advice for the SAS grades in their new contract negotiations and highlighting the error of the increasing trend of criminalisation of medical mistakes.
- The AAGBI will take steps to ensure that the Revalidation process is fair and not burdensome.

The Council is committed to the “core business” of the AAGBI and the production of the ever-popular “Glossy” remains a priority in the Association’s business plans. The next few months will see the production of the following “Glossies”: Pre-hospital Anaesthesia; Interhospital Transfer; DNAR decisions in the perioperative period; the SAS Glossy and Intraoperative Cell Salvage. The Events Team will be busier than ever; there will be an increase in venues for Core Topics in 2009, as well as the usual meetings.

The Council hopes that the continued and increased measurable output from the Association demonstrates the commitment of the AAGBI to provide increasing value for money for its membership.

Les Gemmell
Honorary Secretary, AAGBI
The NHS was founded by the Labour Government in 1948 and has provided free universal healthcare for the population of the UK for the last 60 years. Originally budgeted at 3.1% of GDP, this has risen to around 7.6% in 2007/8, and this year the NHS in England will spend £105 billion, almost £1800 for each member of the population.

There is much to celebrate - dramatically decreased waiting times, particularly for cancer referral and treatment, better access to advanced diagnostics and an expanded, highly skilled consultant workforce are some of them. The challenges are also significant. An increasingly elderly population with chronic disease, a finite clinical capacity, patient safety, expensive genetically designed drugs, more complex surgery and hospital acquired infections are current concerns. Although spending on the NHS has trebled since 2000, at 7.6% of GDP we remain behind several of our European neighbours. The effectiveness of the increased spending has been debated, with the Audit Commission suggesting that although activity has increased, much of the increased funding has been absorbed by pay rises. The consultant contract has often been singled out - unfairly in my view.

Freely available universal healthcare, regardless of means and funded from taxation remains an amazing social concept. The complexity of the task is enormous and centralist control and political management is often beset by local implementation difficulties. The direction of increasing local autonomy with Foundation Trusts and emphasis on local agendas in the Darzi report feel optimistic, although the reality may differ. The internal market, payment by results and competition are recent innovations designed to improve efficiency within the service. They are becoming embedded slowly but their long-term effect is unknown. This year has been a good one financially for many acute Trusts: the 18 week target has produced surpluses, while deficits are more of a problem in Primary Care Trusts. Watch what happens as the new tariff is rolled out - some adjustments will be made, and next year may be more challenging for acute services.

What about anaesthesia and the NHS? At the foundation of the NHS in 1948 the Association of Anaesthetists of Great Britain and Ireland was 15 years old and had around 670 members. Our elders fought hard to ensure anaesthesia had an equal place with other specialties within the NHS, a crucial negotiation which resulted in many long-lasting benefits. In 2009 we have a strong specialty with over 12,000 medical anaesthetists, many of whom have further specialised into intensive care and pain medicine. We have an impressive number of specialist societies, all of which have further refined anaesthesia into one of the most popular and successful medical specialties in the NHS. High quality training organised by the Royal College of Anaesthetists and work by both organisations in the field of safety and equipment ensures that patients undergoing anaesthesia and surgery in the United Kingdom are remarkably safe, with an estimated mortality from anaesthesia alone of around 1: 180,000. Early work by AAGBI members assisted the development of international standards for equipment.

We must remember that none of these
developments have happened by chance. A strong feature of the NHS is that consultants work not just as direct service providers, but are expected to lead and develop the specialty towards greater safety and efficiency. Research into outcomes and new methods of anaesthesia have permitted the steady expansion of surgical techniques with outcomes in 2008 unimaginable 60 years ago. To meet the challenges of medicine in 2009 and beyond, the NHS will need to become more efficient at the routine, more imaginative in its care of long term conditions, and continue to meet the demands that NICE - approved treatments and drugs place on the budgets. The recent top-up concept must not be allowed to remove the NHS responsibility for comprehensive care.

Workforce predictions in the NHS generally and more particularly in anaesthesia have proved very difficult, swinging between concerns about major unemployment and shortages. We all believe that there must be a better way of planning this, but predicting the number of doctors needed five, ten or fifteen years ahead will remain very difficult, not only for healthcare planners, but also for those choosing their careers. An excess of UK - trained doctors would be safer for patients than a shortage, but would be poor for the individual doctors concerned.

Academic anaesthesia is under great pressure, with research grants difficult to obtain unless pharmaceutically sponsored. In reality, we need many more independent, focussed outcome studies – elderly colorectal patients deserve the best technique for their high-risk procedures, but we still cannot even be sure if epidurals are beneficial. The formation of the National Institute of Academic Anaesthesia in 2008 – a partnership among the AAGBI, the journal Anaesthesia, the Royal College of Anaesthetists and the British Journal of Anaesthesia - will help promote the research agenda, but the NHS must continue to contribute in the broadest sense.

I am a passionate believer in the NHS – it belongs to all of us, not just the politicians and managers. We are all consumers and contributors. The leadership shown by our seniors 60 years ago should inspire us to show the same efforts and leadership today. With the NHS increasingly focussing on a market approach, we must not let anaesthesia slip into a purely service orientated specialty. Politicians must be held to account, and despite the many difficulties faced, free healthcare to all funded by taxation should remain a reality. Let’s celebrate the good and work to fix the bad. Most of all, let us look out for the trainees. They are the enthusiastic future of the service – and we shall need them to look out for us.

Iain Wilson
Honorary Treasurer, AAGBI

Help for Doctors with difficulties

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help (www.bma.org.uk/doctorsfordoctors). To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor*. A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

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

*The doctor advisor scheme is not a 24 hour service
If you are considering a career in pain medicine, then this article outlines what you need to know and should expect.

**Background**

April 2007 heralded the formation of the long awaited Faculty of Pain Medicine within the Royal College of Anaesthetists (RCoA). With this came a review of standards and prerequisites for advanced Pain Medicine training in line with modern educational theory and competency-based medicine.

A team comprising the Regional Advisers from around the country have spent the past two years devising a rigorous programme of competencies to be achieved by the end of the twelve month training period. These have been trialled over the past year by current trainees in its pre-pilot format and will be more formally trialled in an extended pilot over the coming year. This will allow feedback and review of the assessment and appraisal process by both trainee and trainer.

From September 2008 all trainees completing Advanced Pain training will be required to apply for Fellowship by assessment.

**What will the programme entail?**

The scope of Advanced Pain Training covers the management of acute, chronic and cancer pain. There will be a broad, balanced range of multidisciplinary clinical experience over a recommended twelve month full time equivalent period, although it is understood that the training programme is competency based rather than time based.

**The Standard**

Information about the syllabus in terms of knowledge and competence is easily obtained if you spend time exploring the diverse opportunities available. The specifics are highlighted on the RCoA website [http://www.rcoa.ac.uk/index.asp?PageID=1080](http://www.rcoa.ac.uk/index.asp?PageID=1080)

You may find that your department does not cover all the aspects recommended. This should not be viewed as a hindrance but rather as an opportunity – networking within Pain Medicine is so good that there is undoubtedly ample scope to visit other units, where different methods may be practised or other complex procedures performed.
Assessment Tools

Until now you, like me, may have had little or no experience of these tools, but they are becoming increasingly common and are now part of all training modules.

The tools are based on a quality improvement assessment model. This implies a systematic process for ‘measuring’ or comparing a trainee’s progress or achievement against set standards. It utilises a rating scale allowing comparison against a doctor who is ready to complete a pain fellowship programme. It is therefore expected that early in one’s training the scores should be low, but that these will improve over time and with experience. With each assessment you and your assessor will discuss and identify agreed strengths, areas for development and an action plan. The aim is not that numerical values of these assessments are added together to produce an average over time, but that spacing creates a continuum to allow a profile of development.

My experience of this over the past year has been varied in that there has been little education or guidance on the use of these tools for assessors or trainees. This is however being addressed, with training days aimed principally at Local Pain Management Educational Supervisors (LPMES) and other interested individuals. The written guidance has also been made more explicit.

The faculty has recently produced a calendar outlining when these assessments should take place, and also specifying the subjects to be covered. Further details are available on the College website at http://www.rcoa.ac.uk/index.asp?PageID=1079

Mini-CEx (clinical evaluation exercise)

This is a clinical evaluation exercise which is designed to provide feedback on skills essential for the provision of good clinical care. It is a ‘snapshot’ observation of your interaction with a patient during a clinical encounter. The assessment should cover history taking, examination and feedback and advice to the patient. Subjects that should be covered include acute post-operative pain, acute non-post-operative pain, neuropathic pain, chronic musculoskeletal pain, chronic pain with complex psychological issues and cancer pain.
In reality this is what we have been doing throughout our training, but it has now been formalised. It is an invaluable tool to enhance one's technique by getting feedback from an experienced third party. The biggest difficulty is allowing time for proper feedback within a busy and time-pressured outpatient setting. One needs to identify a possible case early. Ideally this should be done at booking in order to allocate the time (possibly a double appointment) necessary for this. This requires some forward thinking.

**DOPS (Directly Observed Procedural Skills)**

DOPS is a tool whereby one's practical skills are evaluated for competence. The procedure performed should be appropriate for your stage of training. There are a range of procedures to be covered: the simpler trigger point injection or lumbar steroid epidural, through sympathectomy and on to more complex procedures including possibly implanting spinal cord stimulators. These should not be difficult to achieve, but your range of experience will depend on the units in which you have worked.

**CBD (Case Based Discussion)**

This tool is designed to evaluate clinical practice. It allows in-depth discussion of various aspects of clinical care including clinical reasoning and judgement together with interpretation and application of evidence based knowledge in the decision-making process. It also enables discussion of ethical and legal issues in practice and evaluation of the quality of record keeping. The complexity of the cases should be again appropriate to the stage of training. It should not be seen as an excuse for a viva, but formative reflective learning. Although many units were already doing this, it has now been formalised through written record of discussion.

As a trainee, I found these the most useful. Although formalised, it allowed free discussion on a multitude of aspects of care, beyond clinical boundaries, which adds to overall experience. One needs to book a suitable time with your chosen assessor as this is not a quick process if done properly to provide maximum benefit.

**Written Case Report**

The current stipulation is that an Advanced Pain Trainee is required to submit four written case reports during their year of training. Each of these should be made available to the Educational Supervisor prior to the assessment interviews. There is guidance on how these should be structured on the RCoA website. At the time of assessment the trainee will be required to present the case.

This promises to be an involved and time-consuming process if it is to be completed properly. I can only advise that you agree on an appropriate patient with your LPMES early in order to complete this task in a timely manner.

My personal view is that to produce four written case reports in one year in addition to the other requirements for learning is an enormous undertaking, and I worry that this may detract from pursuing other additional projects which could add to a trainee's overall learning.

**MSF (Multi-Source Feedback)**

This is also known as a 360 degree evaluation. It is a questionnaire-based assessment allowing anonymous feedback from a number of different sources including colleagues and co-workers, and self assessment. Each source offers a different perspective on skills, attributes and other job relevant characteristics which allows a more accurate picture than from one source alone.

The broad areas covered are *Professionalism*, encompassing clinical competence, attitudes, behaviours, ethical and legal issues and probity, and *Communication and Collaboration*, or effective working with colleagues. All of these are evaluated in order to improve performance in a goal directed way and increase individual self-awareness of strengths and areas that need development. Each trainee is required to undergo an MSF exercise at seven months, only to be repeated if there are outstanding issues. The current recommendation is for 15 assessors, chosen by the trainee. It is also useful to ask those evaluating you to please write comments as these are more useful than any out-of-context number on a scale.

**Conclusion**

There is a great deal of paperwork but don't let this put you off. Although the programme may seem rigid there is still ample opportunity to develop your skills, knowledge base and clinical experience in a way that suits your personal style.

It is not an easy year. To begin with, you will find that there are many times you will feel that discomfort and awkwardness experienced as a junior doctor on a steep learning curve. This can be contrasted to the relative comfort of your current anaesthetic training with the confidence and competence of a senior trainee.

I am however sure that I am not alone in saying that you will probably find it one of the most rewarding years of your training and well worth the effort.

**Delia Hopkins**

Specialist Registrar in Anaesthesia and Pain Medicine
Southampton General Hospital

**References**

1. [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
This year’s prestigious Welsh Woman of the Year 2008 is Professor Judith Hall. The award was announced to over 700 people including prominent politicians and public figures in Cardiff’s International Arena on 21st November.

Professor Hall, head of Anaesthesia and Intensive Care at the School of Medicine at Cardiff University also won the “Women in the Community” category in recognition for her outstanding and pioneering work in establishing the educational charity “Mothers of Africa”. The charity was founded in 2005 after Professor Hall had been moved by an impassioned lecture to the World Congress of Anaesthesia, given by an anaesthetist from West Africa. He described the high maternal mortality that exists in sub-Saharan Africa where women are 100 times more likely to die during childbirth than women in developed countries.

The aim of the charity (which received early support from the AAGBI’s International Relations Committee) is to work towards one of the Millennium Development Goals, that of reducing maternal mortality in developing countries. The charity is attempting to educate healthcare workers to better recognise sick mothers, resuscitate them more effectively and provide safer anaesthesia. Since 2005, the charity has established courses and sent healthcare workers and teachers from a number of hospitals in South Wales to Benin, Togo, Ethiopia and Liberia. These activities have been supported by a large number of extremely active fundraisers who have organised events including the well-attended concert, “Cardiff sings Classics”, held earlier this year in Llandaff Cathedral, Cardiff.

The Welsh Woman of the Year Awards is sponsored by the Western Mail and was established to promote the role of women in the workplace and community, and to celebrate the ever-expanding achievements of women working in Wales.

Professor Judith Hall, (front row, 4th from left) with fellow trustees & fundraisers of Mothers of Africa celebrating at the awards ceremony
Can job planning be made interesting?

Job planning: tedious annual tick-box exercise, or opportunity? I had much sympathy with the former view until I attended the inaugural seminar on Leading Job Planning, held at 21 Portland Place in June. Led by the able trio of Jonathan Fielden, Ian Wilson and Mark Porter, the meeting was aimed at consultants with a lead role in job planning within their own departments, but would be of use and interest to anyone wanting a better understanding of the reasons behind the requirement for all consultants to undertake job planning.

Having recently been tasked with job planning for my eighteen colleagues, I was interested to know whether I was doing it correctly: the timetable part was easy, but what else was involved? The faculty, with their combined wealth of knowledge on all matters relating to the consultant contract, the role of senior clinicians and the demands on the service we provide, guided us expertly through the purpose of job planning so that we understood what the process is intended to achieve; in particular, the opportunity for the job plan to highlight the consultant’s own objectives and balance these with the wider service objectives of the trust in which they work.

We learned strategies to reach agreement by a partnership approach. Particular emphasis was placed on the importance of supporting professional activities as being the key to development of the service provided to patients and therefore how and why SPAs should be protected robustly, while achieving a balance with the pressures we all face to work ever harder.

Ian explained the practicalities of agreeing flexible models of working, such as annualised, part time, or team job plans, and we were guided to resources to assist us in the process. We were given the opportunity to practise our own negotiating skills with a role-play scenario between a clinical director and a consultant, involving setting and delivering objectives and attempting to reach a mutually acceptable compromise – not so easy!

Throughout the day, the delegates challenged the faculty with both broad and specific questions. The seminar ended with a job planning “clinic” giving us further opportunity to seek the experts’ advice on any tricky job planning issues we had encountered, which resulted in some lively debate and discussion!

I will admit to having begun the day with apprehension, wondering how such a potentially turgid topic could possibly keep me awake for six hours; I was more than pleasantly surprised at the way the faculty engaged us, and the food for thought that the seminar provided. Don’t be put off by the subject matter; this was a very worthwhile seminar: I highly recommend it.

Dr Caroline Fairley
Winchester

There will be another seminar on job planning on April 1st 2009.
See www.aagbi.org/events/seminars for details
Can job planning be made interesting?

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• All podcasts are reviewed by Royal College of Anaesthetist examiners

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How to make the most of post-FRCA training

Becoming an SpR3 is an important milestone. The hard work required for exam success is behind you but consultant interviews still seem a long way into the future. It is a time therefore to relax and contemplate your future. You may start thinking about developing a specialist interest, planning for a year abroad or even turning your attention to matters outside of the workplace. It is a golden opportunity to buff up your curriculum vitae and to get to grips with all the non-clinical aspects of future consultant life. Application for a Consultant post may seem to be on a distant horizon, but will come round frighteningly quickly.

The competency based CCT in Anaesthesia includes six core areas of non-clinical competencies (Table 1). The competencies are not a syllabus, but rather a “...guide to trainees and trainers of what might be covered”. The expectation is that they enable the trainee “...to acquire many of the other clinical, practical and managerial skills necessary to be a successful consultant anaesthetist.” [1]

Trainees during their final months will have covered the area of knowledge laid out in the “Healthcare Management and Professional Life” section by attending short management courses. Whilst knowledge acquired by these courses may stand some individuals in good stead at consultant interviews, real understanding of the machinations of hospital management acquired by ongoing interest in the workings of the trust gives a far better message to the interview committee. We feel that spending time exploring these issues will be helpful not only in obtaining a consultant post but also at the start of one’s consultant career.

The remainder of this article gives some useful pointers on what may be achieved by using the objectives from the non-clinical competencies as a guide.

Courses

Many courses covering healthcare management, topical NHS issues and overviews of all aspects of the UK healthcare system are available nationally. These courses are tailored to consultant interviews and are widely advertised in the BMJ and Anaesthesia News, but do browse the RCoA and the AAGBI websites for alternatives. Local Universities and further education colleges are also useful resource.

Table 1 Core Non-Clinical Competencies

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<td>Healthcare Management</td>
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<td>Understanding the Responsibilities</td>
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<td>of Professional Life</td>
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<td>Information Technology</td>
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<td>Teaching and Medical Education</td>
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<td>Independent Practice</td>
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<td>Medical Ethics and the Law</td>
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A perusal of our own trust’s website revealed a variety of relevant courses available to all staff. Examples include a half-day session on Root cause analysis, a lunchtime session on Confidentiality and the Caldicott principles and a one-day course entitled Diffusing anger, aggression and conflict in the workplace. Consider a refresher course in Child protection, Diversity training, Mental health issues or Faith group courses. In addition there are numerous sessions organised by the information technology department such as Advanced PowerPoint and an Introduction to Excel. These local courses are generally short (half or full day), free of charge, are often repeated and should not eat into your study leave time or budget. The European working time directive (EWTD) and the shift...
"Giving some thought to your third year of training as an SpR will reap multiple rewards."

pattern of working allows you to use your time more efficiently and enables you to ask for leave to attend these courses.

Who’s Who?

On arrival in a new department it is sometimes not easy to determine which consultant performs which role in the department or even which roles exist. In some hospitals, anaesthesia is merged with other areas into ‘super-directorates’ such as critical care. Once you have gained an idea of the structure of a clinical department it is then easier to begin to understand the requirements of each role. Figure 1 demonstrates a typical anaesthetic directorate structure. Different hospitals may have different names for the same roles which can also be confusing. A good way to start working out who does what is to talk to the department secretarial staff.

In Theatre

At this point in your career you don’t relish sitting in the operating theatre and discussing the mechanics of desflurane vaporisers or the structure and metabolism of local anaesthetics with a consultant colleague. So, unless the case is particularly challenging, conversation tends to resort to holiday destinations, hobbies, aspirations and who will take the first coffee break! However, consultant lists can present opportunities to display enthusiasm for finding out about the running of an anaesthetic department and to mentally tick off some of those non-clinical competencies. Again, in light of the EWTD, it is vital that every training opportunity is utilised. For example, if the senior colleague next to you happens to be the lead clinician for day case anaesthesia, paediatric anaesthesia, or the College tutor, ask them what these roles entail or what the current issues and problems are in these areas. Older consultants are very likely to have filled many of the departmental roles in the past and may have had experience at a national level. They will have a vast experience in many issues, such as how to manage a ‘failing’ colleague, procurement, conflict etc. - in fact, many of the issues which are frequently covered at consultant interview. Moreover, they will probably have conducted many consultant interviews and have a very good idea of what is required for interview success.

Topics such as the consultant appraisal process, clinical excellence awards and job planning have taken up many column inches over the last few years. Informal chats in theatre are good opportunities for gaining insight into these and other local political problems. Finally, the practicality of independent practice is a topic about which trainees often have little knowledge. Again, a friendly informal chat in theatre is a good chance to find out how it actually works. Senior ODPs and theatre practitioners can be invaluable in ensuring you stay up to date with such topical issues as infection control and manual handling.

Committees

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<td>Medical Staff Committee</td>
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<td>Blood Transfusion Committee</td>
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<td>Risk Management Committee/Obstetric Risk Management Committee</td>
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<tr>
<td>Theatre Users Group</td>
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<td>Local Negotiating Committee</td>
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<td>Drugs and Therapeutics Committee</td>
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<td>Trust Medical Board</td>
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<td>Anaesthetic Directorate Meeting</td>
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Most consultants will have been involved in committee work at some point during their careers. Again, a consultant-led theatre list is an excellent opportunity to find out more about committee structure, membership and function. Table 2 lists some of the commoner committees.

Attending one or two committee meetings as an observer may be enormously useful in gaining insight into the running of the hospital. The easiest way of going to a meeting is to find out who is the departmental representative on that committee and ask to attend with them. The drug and therapeutics committee, theatre users’ group or the local negotiating committee will help your understanding in business planning, procurement and local healthcare politics. Chronic pain meetings are useful even if you do not have a specialist interest in this area as they give insight into problems encountered by other specialties, such as waiting list targets and outpatient throughput, which are of huge importance to the trusts but easily overlooked by anaesthetists during training.

All anaesthetic departments will have their own regular directorate meetings, and asking politely if you can attend one of these would also be useful. An alternative is to shadow the chief executive, medical director or your own clinical director for a day. Ask to attend the monthly trust board meeting which is also open to the public. They are an opportunity not only to discover the hot topics in your trust but also to gain an understanding of the roles of the chairman, directors (executive and non-executive) and issues relating to other departments (e.g. finance and human resources).

### Odds and Ends

You should also consider developing your own management skills by undertaking a few management roles such as preparing the on-call rota, organizing a journal club or an informal lunchtime morbidity and mortality meeting. Organise a timetable for viva practice for ST doctors about to take examinations. Register to be able to teach and examine for DOPS and Mini-CEXs for the Foundation Year and ST doctors. It will make you feel less like a dinosaur and keep your skills up to date! Or you could arrange a lecture to the department, for example from a medico-legal lawyer or from an anaesthetist who has experience in military or anaesthesia in the developing world. Again, you are demonstrating enthusiasm as well as improving your own credentials locally.

Creating local clinical guidelines and then seeing them through the process of acceptance by the relevant committee is yet another way of raising your profile. Ask to observe ST or locum appointment interviews to get a taste of being on the other side of the interview table. Now is also a good time to begin creating a folder of interesting articles pertaining to non-clinical issues from medical and non-medical publications.

### Summary

Giving some thought to your third year of training as an SpR will reap multiple rewards. As consultant interviews approach, there will be less of a panicked rush to cram knowledge and attend courses, and you will have a genuine understanding of wider issues within a hospital. You’ll also have developed some of your own opinions, including ways in which things could be improved. To anyone reading your curriculum vitae, it will be clear that you have given thought to non-clinical issues for several years and not just in the last six months. Finally, consultants in your department will have seen you as a trainee with independent thought, who has enthusiasm for a consultant career and as a possible future colleague.

Frank Swinton, SPR Southampton
Kate Donovan, SPR Swindon
Belinda Cornforth, SPR Salisbury

Recommended reading: - The Specialist Registrar and New Consultant Handbook by John Catrell and Tony White (Radcliffe Publishing Ltd.)

### References:

1.) The CCT in Anaesthesia IV. www.rcoa.ac.uk accessed 9/6/2008

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**Figure 1 A Typical Directorate Hierarchy**

Clinical Service Director

- Lead Clinicians
  - ITU
  - Risk
  - Daycare
  - Paeds
  - Obs

- Educational Supervisors

College Tutor
The Mersey Selective Course

14.00 Sunday 1st – 16.00 Friday 6th March 2009

As has been the case since its inception some eight years ago, this course is designed to cover those aspects of the FRCA Basic Sciences syllabus which are not well explained in the available texts. As such and as always, the course is suitable for both Primary and Final FRCA candidates.

USUAL PROGRAMME

- Physics Revisited
- Measurement Revisited
- Electricity Revisited
- Pharmacodynamics
- Pharmacokinetics
- Oxygen & Carbon Dioxide Fundamentals
- Acid Base Conundrums
- Cardiovascular Physiology
- Respiratory Physiology
- Metabolism Physiology
- Renal Physiology
- Muscle Physiology
- Statistics for the FRCA Examinations
- Physiology of Altitude
- Physiology of Depth
- Physiology of Exercise

Plus

MCQ Techniques

LIMITED TO 30 PLACES

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Candidates will be sent a Revision & Preparatory Homework Syllabus on Confirmation of Application

Further Details & Application Form – msoa.org.uk
Can you imagine an airline allowing a pilot to fly a plane they have never flown before, into and out of an airport they are unfamiliar with? It is patently ludicrous (and frankly embarrassing) that this is permitted within anaesthesia – a specialty that prides itself on its forward-thinking approach to safety issues.

The induction process for new trainees is the best opportunity that departments get to assess a new member of staff’s competence before they anaesthetise patients without direct supervision. It should therefore, be focussed on patient safety to protect patient, trainee and trust against avoidable mishaps, and allow new staff to familiarise themselves with a few of their new department’s procedures, equipment and logistics.

Both the recent reports in Anaesthesia News (November 2008) about trainee inductions are accurate, frustrating, yet paradoxically reassuring that my own experiences are not unique. Induction processes are generally dreaded by both Consultants and trainees, and are widely thought of as lacking purpose, time-wasting and generally misdirected.

The reason it is so crucial to anaesthetic practice is the fundamental dynamic nature of anaesthesia, where disasters may be anticipated, and those that aren’t may be treated, but only with thorough knowledge of associated equipment or local protocols. The easiest and quickest way to impart this information to an intake of new staff is through a group induction process.

A survey of all the hospitals in the South West in 2007 showed that there was variation in quality of the induction process, which could potentially lead to serious consequences [1].

The problem is there are two parts to the modern induction process – a trust-wide section, and a departmental section, which should be the most useful and interesting part. The trust-wide section has been designed by the NHS Litigation Authority and suggests a standardised, nationalised framework. Every new staff member, regardless of profession or background should have this induction. It is convenient to put doctors through induction together, as the majority intake is in August each year. Unsurprisingly, this process is tedious and covers non-clinical material. Some hospitals have reduced this by using on-line software, and even pre-first day exams to cover essential material, thereby reducing the monotonous lectures and providing hard evidence of ‘competence’. It still doesn’t have the same impact as having to request the first x-ray or blood test, but does reduce the amount of time listening to often familiar lectures.

The anaesthetic department induction however, should be a much more useful event. Trainees are generally keen and full of anticipation about their new department, colleagues, organisation and willing to get stuck in and learn new ways of doing previously familiar (or unfamiliar) cases. As well as providing a friendly, social meeting, it can also be used to get trainees working effectively within the departmental team as soon as possible.
There appear to be two ‘categories’ of items to be covered – organisational aspects (such as annual leave, educational supervision, rotas, changing rooms, coffee rooms etc), and patient safety aspects – e.g. lines of supervision when on call, specific paediatric or obstetric anaesthesia policies, cardiac arrest or trauma team responsibilities.

Clearly the organisational aspects – annual leave, rotas etc are best done in a non-clinical environment. There cannot be a better way to welcome new staff than to sit down in a reserved space and time, with plenty of refreshments, and informally run though a selection of the department’s favourite procedures. This should provide a welcoming atmosphere, allow time for questions and comments, and allow the new staff to immediately feel part of their new department. Some topics are best done on a tour of the department – e.g. changing room access, coffee room etc etc, and this should be included, as it takes most people a few trips round the block before they find their own way successfully.

However, when considering more detailed topics, one-to-one attention will improve concentration and retention of important knowledge. This needs to range from an overview of the anaesthetic machine, which might be markedly different to ones previously used by relatively inexperienced staff, to discussing the location, contents and use of the kit on the difficult airway or defibrillation trolley, which might be needed at any time. Some of the early studies of errors in anaesthesia highlighted unfamiliarity with equipment as an important factor, and simulation studies have shown that trainees make fewer mistakes if they are familiar with the equipment they are using [2,3,4]. This familiarisation could easily be achieved on the trainee’s first supervised training list. However, without an aide-memoire, it is likely that some essential items may be accidentally omitted.

Our recent survey of South West hospitals [1] would suggest that the organisational items are covered well by departments, but patient safety issues are much less well covered, and omissions here are the most crucial. For example, only 27% of hospitals included any discussion about the difficult airway trolley, and only 55% remembered to tell trainees which emergency teams they were part of (see chart) – there doesn’t need to be a full run-down of each Consultant’s favourite gadget on the difficult intubation trolley, but a brief pointer and reminder to come back at a spare moment and familiarise oneself with the equipment might just save a life one day. One would have imagined that seasoned trainees would think to ask about cardiac arrest teams, but on conducting the survey it was surprising how many had forgotten their existence, and one even had been called but didn’t know how to respond when also anaesthetising a patient alone in theatre.

These matters have been thought of before. The AAGBI itself has produced some guidance in an appendix to Risk Management [5], however it also declares it outdated and has no plans to update it. The College has an ‘audit-recipe’ on induction processes, but this doesn’t give definite standards of what should be included. Which leaves individual departments back in square one of thinking of (or omitting) each subject for themselves.

There are simple ways to improve this. Our survey was published in a regional journal, but the benefits of MMC and a forced relocation prevented the survey being repeated to show any difference. We also suggested a checklist (yes, another piece of paper, but hopefully a useful one) which departments can use to ensure they include most of the useful stuff, and each trainee can sit down with a Consultant to quickly run over pertinent kit. Nobody is advocating a longer induction process, but the time allocated at present could be put to much better use.

Adrian Clarke
ST3 Anaesthesia
University Hospital Wales

References:
THROUGH TROUBLED WATERS — the turbulent history of obstetric anaesthesia

Queen Victoria received chloroform during the births of her youngest children
On 19th January 1847, a little over three months after William Morton’s historic public demonstration of general anaesthesia, James Young Simpson administered ether for childbirth for the first time, to a pregnant patient with a malformed pelvis. So began the turbulent beginnings of obstetric anaesthesia. At the time Simpson was 36 years of age, and practised as Professor of Midwifery at the University of Edinburgh. Following his initial success, Simpson employed ether inhalation for numerous obstetric interventions, including “turning,” and “employment of forceps,” as well as for natural labour and delivery (1). The use of ether in obstetric practice spread throughout the UK and Europe, and from here news spread across the Atlantic. In April of the same year Nathan Keep described in a letter his administration of inhaled ether to a labouring woman without impairment of consciousness or hindrance to labour (2). Simpson was delighted to have found a method of relieving pain during childbirth, and although he continued to use it, he searched for other agents with fewer unpleasant effects than ether. Towards the end of the year he had been using chloroform with better success and had published several case reports in the Lancet (3).

**Confrontation from all fronts**
The early enthusiasm was met with strong opposition on several fronts – medical, church, and public concerns came forth. It is interesting to note the mid-nineteenth century viewpoint on the role of pain. Unlike today where pain and suffering can be alleviated, views held by professionals and public were very different then. It was these attitudes as much as anything that were responsible for the reluctance in accepting anaesthesia in obstetric practice (4). The medical profession regarded the maternal pain felt during labour as an indispensable guide to the progress of labour and to their interventions. Removing such pain, they argued, would hinder the progress of labour and the work of obstetricians would be effectively blind. In London, Robert Barnes was lecturer in Midwifery. He vehemently opposed Simpson’s practice. In response to Simpson’s publication in the Lancet, Barnes wrote a (very) critical appraisal of Simpson’s paper. Pointing out errors in Simpson’s statistical analysis, Barnes firmly believed the labour pain revealed invaluable information about the progress and nature of the labour (5). In Simpson’s defence, James Moffat replied to Barnes with equal vigour: “Surely Dr Barnes can teach his pupils much more certain means of making out such matters of diagnosis by the use of their fingers, than by insisting upon the patients continuing to shriek in order that he and his pupils may make it out by the use of their ears.” (4). In the USA, Professor Charles Meigs, chair of obstetrics at Jefferson Medical College in Philadelphia also took a firm stance against the use of anaesthesia in obstetrics.

The clergy also voiced their opinion. “In sorrow thou shalt bring forth children” was the divine will as written in Genesis 3 v16. Some members of the clergy believed that removal of pain in childbirth was against the will of God. These views may appear erroneous when viewed retrospectively, but they were held with genuine belief in the light of the knowledge at the time. Simpson addressed this in a letter of 1848 (6) and subsequently a pamphlet. Simpson’s arguments, however, did not have the scientific backing to allay his opponents. He compared the opposing views to those that had been placed against many new developments in medicine. Specifically he cited views held a century before on the introduction of the smallpox vaccine as a prime example of the reluctance.
to accept change (6). While Simpson’s dismissive attitude did little to convince physicians to change their views, the scientific methodology of John Snow did much more.

**Royal and public support**

Snow also had experience in using chloroform for obstetric anaesthesia, but he disliked Simpson’s unrefined technique of administration, even suggesting it to be dangerous. With careful record keeping he experimented on when to give anaesthesia for labour and how much to give. He was able to delay administration until the second stage of labour, and titrated the dose to provide analgesia without loss of consciousness (7).

Snow worked closely with several obstetricians in London, some of whom attended Queen Victoria. Initial reservations over the administration of anaesthesia to the Queen were dropped following discussions between Snow and her obstetrician, possibly as a result of a request from Prince Albert, and Snow famously administered “the blessed chloroform” to the Queen on 7th April 1853 for the birth of her eighth child, Prince Leopold, and subsequently for her ninth, Princess Beatrice, four years later. It is said that after this first administration of chloroform to Queen Victoria, opposition to obstetric anaesthesia all but disappeared. Furthermore, Snow’s scientific method allowed him to speak with some authority on the subject of obstetric anaesthesia. These factors in combination led to a changing public attitude to the treatment of pain in labour, guiding this sub-specialty through turbulent waters into the calmer seas of the late nineteenth century.

_Sunjay Bhadresha_
Northampton General Hospital
NHS Trust

**Accreditation for the Anaesthesia Museum**

The Anaesthesia Museum has recently been officially accredited by the Museums, Libraries and Archives Council (MLA)

MLA’s Museum Accreditation Scheme sets nationally agreed standards for all museums in the UK. The Anaesthesia Museum’s award proves that it measures up, meeting standards on how it is run, how it looks after its collections, and the services it provides its visitors.

Staff and volunteers of the Anaesthesia Heritage Centre have worked throughout the summer of 2008 to ensure that this has been recognised.

Andrew Motion, Chair of MLA, said: “Being awarded Accreditation is an impressive achievement. It recognises the high standard and service that the Anaesthesia Museum provides and acknowledges the hard work of the staff.”

**References**


3) Simpson JY, A new anaesthetic agent more efficient the sulphuric ether. Lancet 1847 (2), 549 – 550

4) Farr AD, Early opposition to obstetric anaesthesia, Anaesthesia 1980, (35) 896 – 907

5) Barnes R, Observations on Dr Simpson’s anaesthetic statistics

6) Royal College of Surgeons of Edinburgh – James Young Simpson papers, www.rcsed.ac.uk (ref J.Y.S. 233)

## The Mersey Spring into the April Final

### FINAL FRCA SAQ Weekend Course

**An Introduction to The Mersey Method**  
**plus**  
**Four 12 Question Papers - Examination Conditions Analysis & Revision**

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### FINAL FRCA MCQ Course

**NOT a Course of MCQ Practice**  
**A Course of MCQ Analysis**

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*Discount Course Fee for Candidates attending Both Courses*

**DETAILS & APPLICATION**  
WWW.MSOA.ORG.UK

There Are No Places Available On The Mersey Final FRCA (Booker) Crammer Course 30th March – 4th April

**NB:** The Autumn RCA Final SAQ & MCQ Papers are scheduled for September 1st

The Next Mersey Final FRCA (Booker) Crammer Course  
Sunday 16th - Friday 21st August  
Applications Accepted
The Scottish Standing Committee meets three times a year, twice in Perth, a place equidistant for all committee members and once in Stirling; the established venue for our AGM and Open Meeting.

The Scottish Standing Committee was established in 2001 following devolution in Scotland. Since then, the divergence of health care across the four UK nations has moved at a grand pace ensuring a place for the Standing Committee – keeping the AAGBI abreast of all the changes in the NHS in a devolved Scotland.

We have six elected members, plus AAGBI Council members resident in Scotland, a GAT representative and an SAS representative. In addition the Committee has representation from the Chief Medical Officer’s Advisor, the Scottish Board of Royal College of Anaesthetists, the Scottish Society of Anaesthetists, the North British Pain Society and the Scottish Intensive Care Society.

The Committee has the right to co-opt to its membership and does so to reflect the topical issues in Scottish health care. Examples include Scottish Audit of Surgical Mortality (SASM), the Physicians’ Assistants in Anaesthesia (PA-A) steering group, the Scottish Consultants’ Committee of the BMA and a representative on Scottish Parliamentary matters.

The activities of the Standing Committee have been many and varied. Notable has been its involvement in the development of the Core Competencies for Anaesthetic Assistants, which will allow all anaesthetic assistants in Scotland (including those already performing the role) to have a nationally recognised skill set. The published competencies are the outcome of collaborative work between anaesthetists, nurses, ODPs and NES (NHS Education for Scotland). Implementation is being co-ordinated by SMAAD (Scottish Multidisciplinary Anaesthetic Assistants Development Group) which has SSC representation. Their task is huge, recruiting trained mentors to undertake supervision of anaesthetic assistant trainees all across Scotland.

Following the introduction of the Anaesthetic Practitioner role and the training programme in England, the Scottish Government requested a similar programme to be evaluated in Scotland. The University of Edinburgh delivers the syllabus mainly through an e-based programme. This is underpinned by committed local supervisors who provide in-theatre and tutorial-based teaching and experience. The first cohort have completed their training and final examinations. Employment begins in January 2009. The evaluation will then begin in earnest to decide whether the role will continue to be rolled out in Scotland.

As well as promoting service delivery in Scotland, the Scottish Standing Committee embraces its educational role by organising and delivering the annual Open Meeting in Stirling every February. This meeting has become an established part of the Scottish CPD calendar. It is welcomed mostly because of its eclectic mix of education, clinical and political presentations which attract delegates from all corners of the country. Scone Palace, home of the Stone of Destiny, is the setting for Seminars in Scotland. The elegant surroundings provide a stunning backdrop for the high quality presentations delivered. Always a sell-out (standing room only for the last cardiac conditions seminar) it is expected that we will return to Scone in 2010.

Kathleen Ferguson
Convenor, Scottish Standing Committee

This year’s Scottish Standing Committee Open Meeting is in Stirling on February 20th.

See http://www.aagbi.org/aboutaagbi/scotstanding/meetings.htm for details
Dear Editor...

GAT or Congress – do we need both?

I am a final year Specialist Registrar and have recently attended the AAGBI Congress for the first time. I was surprised by how few trainees attended this meeting and suspect it reflects the popularity of the GAT Annual Scientific Meeting as well as the squeezing of study budgets for trainees.

Having also attended a GAT meeting I am in a position to compare the two. The Congress was academically more interesting and stimulating with higher profile speakers and a wider variety of topics, with the parallel sessions allowing a choice. There were many topics such as training, manpower, and legal issues which are of relevance to trainees, in addition to the clinical topics. The large industry exhibition was also of great interest. There were surprisingly few trainees attending and those who were generally had posters or presentations. I would highly recommend it to all trainees. The GAT ASM was an enjoyable and pleasant meeting and is a great opportunity for trainees across the country to meet. However, it attracts neither the speakers, sponsorship nor academic weight that the Annual Congress does.

It seems to me a great shame that we have two meetings that divide our main annual AAGBI meetings into one for trainees or one for non-trainees. Surely we should be striving to unite rather than divide these two groups? I fully understand the position trainees hold at the AAGBI as a result of the hard work of the GAT Committee, but feel that it would be best for these meetings to be held at the same time and place. The result would be a fantastic meeting for both trainees and non-trainees with access to great speakers, industry stands, greater competition for poster and oral presentations and an even wider programme (combining AAGBI and GAT resources) providing greater choice. There could be both independent and combined social events. I can see no negatives and I look forward to hearing the views of others.

Dr Guy Jackson
Specialist Registrar
North West London (Imperial) Rotation

Reply: Thank you for your insightful comments on our Congress and the GAT meeting. The Annual Congress has always been open to trainees and we are delighted to see those that choose to come. It is probably fair to say that we have not actively marketed Congress to trainees but this is something that we plan to put right in future. AAGBI is a large organisation with over 10,000 members. We try to offer an educational programme which offers events of different sizes and delivers them in different locations. This allows members to pick things that they like at locations which are convenient or attractive to them. The GAT meeting offers a distinct trainee-focused event with a strong social programme and we are reluctant to combine it with Congress as it might make a large event into an unmanageable one whilst also compromising the ‘special feel’ traditionally associated with GAT.

Study leave is also an issue - when several trainees are away at the GAT meeting it puts pressure on consultants to cover lost service work and vice versa for Congress. Running the two meetings at the same time might simply be too much and reduce attendance at both.

We will certainly discuss your suggestions at the Events Committee and look forward to seeing you at our meetings in the future.

Rob Sneyd, AAGBI Events Committee Chair
Chris Meadows, GAT Chairman

It’s definitely outside the M25…

I was disturbed when reading the address to which my copy of Anaesthesia (and Anaesthesia News) is sent, since instead of Glasgow, United Kingdom it now reads Glasgow, England.

Does the Association know something of Gordon Brown’s intentions which the rest of us don’t, or has it joined the anti-devolution movement? I think we should be told.

Yours in Hypnos and in Somnos
Jonathan Glasser
Consultant Anaesthetist
East Kilbride (also in Scotland)

Historical Veterinary Anaesthesia

Now the veterinary anaesthesia series has finished (Anaesthesia News September – November 2008), some examples from over 150 years ago may be interesting.

Charles Waterton in conjunction with the [Royal] Veterinary College, in 1814 injected a crude form of curare into a she-ass. After falling paralysed it was ventilated with hand bellows through an incision in the windpipe. It recovered and was given the freedom of the grounds of Walton Hall, Waterton’s home.

Early in 1847 the Pharmaceutical Journal had an advertisement by William Hooper, the celebrated instrument maker. It showed a Horse Inhaler to administer ether via large ‘vulcanised India- rubber bag’. Our veterinary colleagues may be able to tell us how often this was used. Dr David Zuck discovered recently that in late 1850 John Snow was called upon to anaesthetise a cheetah for an amputation and two bears for cataracts at the London Zoo.

Adrian Padfield
Sheffield
Put to the (underwater bubble) test

We recently discovered an endotracheal tube with a leak in a most unusual position – highlighted by the good old-fashioned ‘underwater bubble’ test as shown. One can see the bubbles originating from the distal tip of the pilot tube, beyond where the cuff is bonded to the tube. We speculate the pilot tube was cut inadvertently whilst machining the bevel.

The patient had been found previously to be difficult to intubate and was scheduled for a posterior craniotomy in the ‘park bench’ position. Despite checking the cuff beforehand we noticed a small leak, fortunately whilst still in the anaesthetic room. The ETT was successfully exchanged for a new one with no ill effects.

This highlights the fact that the process of checking the cuff prior to use is not foolproof.

Matt Turner, SpR Anaesthesia
William McFadzean, Consultant Anaesthetist
Morriston Hospital, Swansea

Getting guidelines off the wall

In the editorial (“In need of guidance”, Anaesthesia News, December 2008) about dog-eared guidelines on the theatre wall, you didn’t mention the use of the Trust Intranet.

Like the editor, I may need to get out more, as I have accepted the department responsibility for guideline publishing. These are now posted on a Guidelines page of the Critical Care section of our Trust’s Intranet, where they collect no dust and cannot be an infection risk. Thanks to the provision of terminals in all our theatres and anaesthetic rooms, ostensibly to expedite the theatre management system’s throughput monitoring, we have near instant access to the Trust Intranet as well as the World Wide Web. So seeing a department guideline is as easy as looking up the latest stock prices or the predicted weather conditions on fell or sea for the weekend. If you want a printout, it need take no longer.

Guidelines are listed with their last revision dates and may be updated as often as deemed necessary. Old guidelines will prompt the ‘publisher’ to demand revision or excision by their authors, the centralised listing prevents reduplication and redundancy, and new or revised guidelines may be published without circulating anything other than a notice to interested parties by email.

John Davies
Consultant anaesthetist, Lancaster
This is a very personal view and cannot be taken to represent the views or position of any of the Colleges, societies or bodies involved in the evolution of the United Kingdom Faculty of Intensive Care since I have not been involved in discussions in these bodies and because I, like most intensivists, have no clear view of what those positions are. I have, however, discussed the matter widely with influential members of the ICM community and know that my views are widely shared.

My involvement with Intensive Care in the UK started in 1985 when it was, where it even existed, largely the domain of the enthusiastic amateur often working in isolation. They were often anaesthetists by training, although with some physicians, the occasional physiologist and even a surgeon. The word ‘amateur’ is not derogatory but refers to the total lack of acknowledgement by their respective Colleges that they were specialists in any shape or form. All were struggling to demonstrate by example that critically ill patients needed far more than the occasional visit by a passing ventilator jockey and that speciality knowledge and its application made a difference to quality of care and to outcome.

As an Australian-trained intensivist with a recognised qualification in the speciality it was bizarre to find that there was no real recognition that the speciality existed and even subspecialty status was considered ‘gilding the lily’. How curious this is, since Sir Robert Macintosh was credited with saying, ‘Anyone can give an anaesthetic and that is the problem’, thereby recognising the need for the specialty of anaesthesia. Yet just a few years on, British anaesthetists were clearly conforming to Hegel’s view that mankind rarely learns from its history. Anaesthetists, as the most numerous group, were now cheerfully doing to intensive care what everyone had done to them. At a training meeting organised by the Faculty of Anaesthetists in 1985 the view was clearly stated that there was no need for a speciality. I know this because I was there and objected only to be told ‘we have to take things slowly’, a phrase still in common parlance today. The Diploma in Anaesthesia was founded in 1934 and the Faculty in 1948 but there was a World War to slow things down - it is already 10 years since our Diploma with no World War and no Faculty!

Nevertheless we have come a long way, largely through the endeavours and persistence of those heroic enthusiasts who pioneered the Speciality in such adverse conditions. The speciality is recognised and even has a CCT, there is a recognised intermediate and advanced training program, and there are several qualifications that individuals can acquire in the Speciality including the DICM. It has been advanced considerably and impressively by the Intercollegiate Board. This has input from all seven parent Colleges, allowing the speciality to dovetail with the Colleges’ requirements.
while controlling the management of training in the speciality. It has been a major, yet relatively unsung, success story, so why do we need a Faculty?

Felicity Hawker was the first Dean of the Joint Faculty of Intensive Care Medicine (JFICM), Australian and New Zealand College of Anaesthetists (ANZCA) and Royal Australasian College of Physicians (RACP) that was formed in 2002. To her, the formation of JFICM meant that there was one voice for intensivists whether they came from a background of anaesthesia or physician training. Moreover, moving to a Joint Faculty allowed the development of a single rounded training program so that Intensive Care trainees could have good training in anaesthesia and medicine in addition to intensive care. In Australia and New Zealand, intensivists have had clinical autonomy for many years, but the formation of FIC, ANZCA and later JFICM gave autonomy to the specialty of intensive care medicine. This meant that the interests of patients were looked after by those caring for them and not by third parties with potential conflicts of interest, many without the specific skills required to manage the complexities of intensive care. It encompassed all aspects of training, certification, policies and standards in intensive care, so that its whole future was now firmly in the hands of intensivists themselves. It also meant direct representation of the specialty with Government rather than by intermediaries. To be fair, in the United Kingdom the Intercollegiate Board can and does deliver most of these things to a lesser or greater extent so again, why a Faculty?

We are a large, well-organised and potentially very powerful Specialty, considerably larger than many other specialities. Indeed, the CCT programme has recently awarded its 200th CCT, and this in a period of less than six years since inception. The term subspecialty relates to the days when Intensive Care was a hobby for interested members of other specialities.) Intensivists may be dually qualified and most are, but our units are run by intensivists and not by anaesthetists, physicians or surgeons ‘with an interest’ and increasingly by intensivists with no other significant interest. While it is obvious that doctors from any number of different backgrounds can do basic ITU, it is clear that the gulf between specialist Intensive Care training and that of other specialties, including anaesthesia, has widened. Ventilator jockeys are ancient history. Given these observations, the fact that the specialty does not yet run its own affairs is in effect an indictment of those, in the past, whose responsibility it was to recognise and nurture the specialty, but failed to bring it to full maturity on their watch. That is history, and there are several lessons there, (including not writing articles like this) but now the scene is set for our specialty to achieve full Speciality status. To do so we need our own Faculty.

This needs to be defined. The purpose of the Faculty is to ensure the Specialty recognises the requirements of our patients in terms of standards, of training and qualification and governance, and then puts in place the mechanisms it needs to fulfil those requirements. It should be an autonomous body that is directly representative, so should have a majority of elected intensivists but also a smaller number of appointed parent College representatives, as no speciality exists in a vacuum. There are powerful and cogent reasons why a new Faculty would fail to thrive without the support and input of its parent Colleges. We do, of course, share common goals with the parent Colleges in terms of the delivery of patient care, but the skill set of intensivists has now diverged from all the parent specialities to a huge extent.

The two debatable issues currently appear to be what the Faculty should comprise - the destination, and how to get there - the route. The destination is easy, at least in my opinion. The Intercollegiate Board has done sterling work but is largely a non-elected body of appointed individuals and while most are practising intensivists there is still potential for conflict of interest arising from their disparate origins and their mechanism of selection. This issue is addressed simply by having the majority comprising practising intensivists who are elected by practising intensivists. The route is easy too. The Intercollegiate Board should organise elections to Faculty, based on the consultant membership of the Intensive Care Society at September 1st 2008 and then allow a seamless transition over time.

I have not yet mentioned the legal process and the Privy Council. This is the UK and the legal bits are both complicated and take time, but the clock won't start ticking till we get the road map and destination in place. The role and attitude of the parent Colleges in all this is important. At present perceived, rightly or wrongly, to be lukewarm about the initiative, they should seize the moment and recover the lost ground of the last twenty years by being seen to be keen, enthusiastic and helpful in the launch of a new autonomous Faculty. That may be happening but, if so, it seems to be a well-kept secret. This approach will engender a warm spirit of cooperation for the future and would be the ideal starting point for a young Faculty setting out on the road to independence with the blessings of its proud parents. Macintosh is remembered for a laryngoscope and the birth of a speciality and there is another Macintosh opportunity here. The future to me seems inevitable and bright and it is my fervent wish that we will get there by evolution rather than revolution.

Dr Neil Soni FJFICM - recognised as a specialist in Intensive Care since 1983 albeit 12,000 miles away. Consultant in Anaesthesia and Intensive Care, Chelsea and Westminster Hospital
British-Swedish Anaesthetists Society
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15TH ANNUAL PAEDIATRIC ANAESTHESIA UPDATE

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Manchester Conference Centre
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PROGRAMME

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MEETING CHAIRMEN Dr Mark Hamilton and Professor Monty Mythen
Dr. Ruxton noted with some sadness that as of November 2008, the Government’s new “points-based” immigration policy will exclude non-Europeans from many professions, including nursing and medicine. Whatever the political or social rights and wrongs, surely this is a time to reflect on and acknowledge the enormous debt that the NHS owes to non-European doctors and nurses, and the work still done for us by them.

As recently as 2006, about 30% of doctors registered in the UK had qualified abroad, three fifths of them from the Indian sub-continent. The majority say that they came to the UK in search of training in the NHS, and 88% of them spent five years or less here. Whether they have received adequate training, Dr. Ruxton cannot say, but he has no doubt that by their mere numbers they have propped up an NHS that could not have continued without them.

Of course, our ethereal anaesthetist may be biased, for his name was not always Buck Ruxton. Qualified as a doctor in Mumbai, or Bombay as the British Raj named it at the time, Bukhtyar Rustomji Ratanji Hakim came to the UK to work and study, and obtained further qualifications in Edinburgh. His successful general practice in Lancaster was a prototype for his successors in the NHS, but Dr. Ruxton has never sought to be a role model for his compatriots. That his patients signed a petition to the Home Secretary in their thousands for mercy from his sentence of execution for murder is a rare, pre-NHS example of appreciation for the service and benefit to the the patients of Great Britain given by our colleagues from the Indian sub-continent. As the door that allowed them to come here closes, we should at least say thank you.

Another news item has filled Dr. Ruxton with unearthly joy. Being in his second life, he has been outraged by hearing patients half his age addressed as ‘chuck’. This is a sin of doctors as well as nurses, so he hopes that the influence of new guidelines from the Nursing and Midwifery Council will spread throughout the hospital.

The NMC approved the document “Guidance for the Care of Older People” at the beginning of December 2008 and will deal with more than how patients are addressed. Although it will cover “a wide range of topics such as communication, personal hygiene and maintaining privacy and dignity”, the address issue has caught the eye of media editors and politicians as well as Dr. Ruxton. The response has been sometimes unexpected. Anne Milton, the Tory shadow Health Minister said, “This is ridiculous and does not do justice to nurses’ professionalism and understanding of patients’ needs” whereas the Guardian, that rightest-on of broad sheets, welcomed this return to conservative values and lamented that it could not be applied to the less courteous members of the general population.

In Dr. Ruxton’s previous life, respect and formality were universal. From that experience, he offers some advice to other anaesthetists, as he dare not do so to the nurses. He hopes that you all introduce yourself to patients, shake their hands at first meeting and make sure when they arrive in the anaesthetic room that you are recognised in the weird garb of the operating theatre. But despite the thorough identification and handover procedures that occur at that time, in preparing the patient for induction of anaesthesia, or performing regional blocks, he may forget their name. In this situation, he resorts to using ‘Sir’ or ‘Madam’, pronounced, “Ma’am”.

Using these titles could be taken as an ironic or exaggerated respect, that is disrespect, but he has always found it accepted either with satisfaction or an immediate request to use first names. Which is still uncomfortable for Dr. Ruxton, as he prefers his patients to use that name. After all, if the surgeon can hide behind a mask, why should he not be allowed to hide his identity?