SPA time: A joint RCoA / AAGBI statement

Linkmen: A new charter

Letter from America

Drug and equipment licensing processes explained
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8 – 9 January — Newcastle (A)
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9 – 10 September — Liverpool
3 – 4 December — Nottingham (A)

Introductory Ultrasound Guided Regional Anaesthesia
8 – 9 February — Hitchin
17 – 18 May — Hitchin
5 – 6 July — Hitchin
22 – 23 November — Hitchin

Ultrasound Guided Venous Access
4 February — Hitchin
15 April — Hitchin
10 June — Hitchin
22 July — Hitchin
9 September — Hitchin
11 November — Hitchin

Ultrasound Guided Chronic Pain Management
12 May — Hitchin
22 September — Hitchin

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Editorial

Consultant’s contracted time for supporting professional activities (SPAs) is the subject of a joint statement written by the Presidents of the Association of Anaesthetists and the Royal College of Anaesthetists. This statement is important for two reasons. Firstly, it is vital that consultants do have adequate time in their working week to conduct the essential professional tasks that are required of them (other than direct delivery of clinical care to patients). These tasks are of fundamental importance to the delivery of safe, high quality care, but they may easily be targeted in cost-cutting exercises. Secondly, it is important that the Royal College of Anaesthetists and the Association of Anaesthetists work cooperatively on those issues where there is an overlap of interests. Members may not be aware of the considerable degree of behind-the-scenes communication and work which takes place between the two organisations to ensure that important issues are dealt with without needlessly duplicating effort. This statement is one of the more tangible fruits of this dialogue.

Ellen O’Sullivan, our Honorary Membership Secretary, issues a ‘call to arms’ for linkmen in her report of last autumn’s annual linkman conference. The proposed new charter sets out clearly what is expected of a linkman. This is surely an important role worthy of recognition as SPA time!

Victor returns to our pages this month by popular request. I find his views to be somewhat disagreeable, but he makes me laugh nevertheless, and I think it is important that potentially specious bodies are scrutinised. Caveat emptor!

We publish two articles relating to the regulatory control of drugs and equipment this month. Dr John Mackenzie writes a thought-provoking article about the off-label use of medicines, and Mr Paul Sim (Deputy chairman of BAREMA - a trade association for manufacturers of anaesthetic and respiratory equipment) asks whether we should use equipment and devices ‘off-
label’. Whilst I believe we should not be deterred from using medicines and devices ‘off label’ when we consider this to be necessary for the care of our patients, we should at least be aware of their regulatory status and should consider following the advice regarding informing our patients of such use.

David Bogod’s account of ‘Sutcliffe v Aintree’ makes truly spine-chilling reading, especially for an obstetric anaesthetist. This case, and the drive to eradicate healthcare acquired infection, have raised questions about exactly how one should prep the back (or other body part) prior to regional anaesthesia. The ideal approach (in the absence of an antiseptic that is not neurotoxic) would seem to me to include preparing the skin in such a way that the possibility of spilling any antiseptic solution on the sterile field or regional block equipment, or of drawing it up and injecting it by mistake is eliminated. For example, the antiseptic could be applied by a third party or using a separate sterile field or a closed application system. An agreed, national approach would be helpful. Drs Scott et al posed a question about antisepsis prior to central neuraxial blockade to the authors of the NAP3 report, and their response is measured and useful in this respect [1]. The advice given is to use 0.5% chlorhexidine in 70% alcohol (an off-label use) and to be meticulously careful to avoid contamination of gloves and equipment, letting it dry before starting. I have started recording brief details of the skin prep solution and technique I have used, and making a comment to the effect that no spillage has occurred. Perhaps this is unnecessary, but I can’t see any harm in it.

References
Antiseptic solutions for central neuraxial blockade: which concentration of chlorhexidine in alcohol should we use?
The AAGBI and RCoA view of time for supporting professional activities (SPAs)

At the inception of the new consultant contract in 2003 it was decided that a consultant’s job plan was to be a minimum of 40 hours a week made up “typically” of 7.5 programmed activities (PA) for direct clinical care and 2.5 programmed activities for supporting professional activities (SPA), each PA equivalent to 4 hours [1]. Over the last 2 years the “typical” 2.5 SPA time has come under increasing scrutiny and has been reduced in an increasing number of hospitals. SPA time has implications for both service provision and training within a department and so it is important that both the AAGBI and RCoA make comment on this trend.

The clear aim of these reductions from the NHS point of view is to save money. It has been estimated that SPA time may account for up to 1% of the NHS budget. The reason it is under attack is that it is perceived by some that consultants do not require 10 hours a week within working time to perform so called ‘additional activities’ and that this is a cost the already financially stretched NHS can ill afford. There are differences emerging between the devolved nations. Wales has a 7PA to 3SPA split but the first reduction of the typical 7.5 to 2.5 split came in Scotland, where we now hear of 9 to 1 contracts. This does not mean in anaesthesia that 9 fixed clinical sessions are worked, more normally 6 or 7 as on the old contract, but importantly only 1 SPA is given. This trend is now starting to spread to England where the majority of NHS consultants work; it is becoming particularly attractive to Foundation Trusts. There is growing evidence of consultants taking up posts with job plans including 1.5 or even 1 SPA.

So what is our view of this? One myth that we need to dispel is that 2.5 SPAs is a contractual obligation: it is not. Clearly both clinicians and management accept that time is required on a weekly basis for a consultant to update themselves on new and evolving improvements in their chosen specialty, especially with revalidation looming. No one, as far as we are aware, has suggested removing SPA time altogether and we are vehemently opposed to any Trust/hospital giving differing SPA time to different specialties as this would be wholly inappropriate and professionally divisive. We believe that any additional activity benefiting the Trust/hospital or wider NHS should be added to this basic 1 to 1.5 SPA time.

What sort of activity should count? More enlightened departments have come up with a whole host of posts/jobs which might require additional SPA time - clinical director, rota organiser, governance lead, audit lead and so on. It is difficult to be generic about this because different directorates in different hospitals work slightly differently, but the principle is the same. We believe that any additional activity should have a set tariff of SPA time agreed by the clinical director and accepted by hospital management. This is happening in some Trusts/hospitals and indeed we know of some who are giving up to 3 SPAs for individuals with high administrative or research/teaching activity. This may occur in smaller departments where the number of ‘lead’ posts is such that the majority of the consultant staff is responsible for a particular area. In major teaching hospitals with 50 or more consultants it may clearly be difficult for them all to be in ‘lead’ posts but the emphasis there should be on specialty teaching both of postgraduates and undergraduates.

We support the original view that “typically” a consultant should have 2.5 SPAs in his/her contract. Clearly, though, this has to be justified but we believe it can be for the majority in our specialty. It is imperative that accurate records of additional activity be presented at the annual job plan review.

Richard Birks, President, Association of Anaesthetists of Great Britain and Ireland

Peter Nightingale, President, Royal College of Anaesthetists
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PLACES ARE LIMITED
The Truth, the Whole Truth?

“Mother paralysed after being injected with cleaning fluid during childbirth” ran the headlines in the Daily Mail in February 2008, ruining the breakfast of any anaesthetist foolish enough to subscribe to the bible of little Englanders. Further reading would have revealed the sad case of Angelique Sutcliffe, who presented for her second elective Caesarean section in 2001, the first having been carried out uneventfully under spinal anaesthesia some nine years earlier.

The sequence of events that followed can best be appreciated by looking at the admirably detailed judgment handed down by the High Court in 2007, along with the contemporaneous notes. Angelique’s skin was prepped with iodine followed by 0.5% chlorhexidine in 70% alcohol, and then allowed to dry. The antiseptic solutions had been poured by the ODP into pre-formed wells in a tray on the sterile field. The anaesthetist may or may not have ‘handed away’ the tray, before infiltrating the skin at L2/3 with lignocaine and inserting an introducer. Either at this point, or upon passing the 25-gauge pencil-point spinal needle, Angelique complained of pain at the insertion point, and this was not improved with further injections of lignocaine, utilising at least one more 2-ml vial of the local anaesthetic; between two and four attempts were made. The anaesthetist then moved one space lower and successfully inserted the spinal needle through the introducer, injecting 2.8 ml of 0.5% hyperbaric bupivacaine alone. The resultant block was recorded as ascending to T4 bilaterally and surgery got under way.

All went well until shortly after delivery, when Angelique became increasingly restless and complained of a severe headache, but denied feeling any pain. Midazolam had no useful effect, and at one point she pulled out her intravenous cannula. The anaesthetist induced general anaesthesia and the operation was concluded without further incident.

I first read of Angelique’s subsequent deterioration in 2003 when I was instructed by her solicitors to prepare an expert report, and I still recall the sleepless night that followed. By the time she left hospital ten days later, after a stormy postpartum course, she had abdominal, back and leg pain. She was readmitted the day after discharge with urinary retention and severe constipation and, after several failed attempts to restore bladder function, went home self-catheterising two weeks later.

Three days later, she was back with extreme lethargy, nausea, low back pain, headache and confusion. Post-natal depression was suspected and a psychiatric referral made. Two weeks passed, during which time she developed frank signs of raised intracranial pressure. An MRI scan showed obstructive hydrocephalus, and a ventriculo-peritoneal shunt was inserted. Her condition continued to deteriorate, however, and she developed progressively more severe sensory and motor loss in her legs. An MRI scan of her spinal cord showed severe adhesive arachnoiditis. CSF – obtained with great difficulty from a cisternal tap after a dry lumbar puncture – was sterile.

A repeat MRI scan seven months later showed marked deterioration, with a fluid-filled syrinx in the cord extending from the cervical to the mid-thoracic region; a neuroradiologist described it looking as if the cord had been split apart. A further episode of raised intracranial pressure necessitated further surgery, and Angelique is now completely confined to a wheelchair and with limited use of her arms.

What can have caused this appalling outcome? Those consulted, myself included, agreed that the spinal injection must have been the precipitating factor. Was there a syringe swap? Could blood in the CSF as a result of a traumatic puncture have caused a progressive arachnoiditis? Was there contamination of the bupivacaine? Had Angelique suffered an idiosyncratic reaction? A number of anaesthetic medico-legal experts, instructed in turn, tended to prefer the last two explanations but, stressing that there was no indication of poor practice on the
part of the anaesthetist or ODP, could not identify any aspect of Angelique’s care that fell below an acceptable standard. In short, they were of the view that, notwithstanding the outcome, there was no evidence of substandard practice, therefore no negligence.

Unlike some other countries, the UK does not have a no-fault compensation scheme for the victims of medical accidents so, without a case for negligence, Angelique would not receive any financial compensation, despite her terrible injuries and the inevitably high cost of her care. The solicitors ‘shopped around’ for further experts, understandable in the circumstances even if not strictly within the spirit of the law, and found a favourable opinion.

And so, six years after the events in question, the High Court – in the form of the Honourable Mr Justice Irwin – sat to consider the actions of those who had cared for Angelique, and to determine whether they had “…acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art”, the well-known Bolam principle. The Court heard the evidence of the expert neurologist that “the meningitic reaction, arachnoiditis and subsequent neurological injuries suffered by Angelique Sutcliffe after the spinal anaesthesia of 22nd January 2001 were not the consequence of any coincidental idiopathic pathology, were not the consequence of any idiosyncratic response to the procedure normally performed or medications appropriately given and were not the consequence of the leakage of blood into the subarachnoid space or the inadvertent injection of an infection into the subarachnoid space but more likely were the consequence of some chemical contamination of the spinal anaesthesia either with some cleansing agent or with some medication inappropriately administered.”

The judge was persuaded that, in view of the huge number of spinal anaesthetics carried out every year without incident, it was very unlikely that a simple bupivacaine – lignocaine syringe swap would result in the sort of damage suffered by Angelique, and nor would minimal contamination by “a tiny smear quantity” of antiseptic contaminant. He concluded that the chlorhexidine was the likely contaminant, since iodine in the syringe would have been detected as it was so dark, and there was a case report in the literature suggesting that large volumes of epidural chlorhexidine could have this effect. Furthermore, it must have been “a measurable quantity”, with a volume of 0.1 ml suggested. In the meantime, the expert retained by Angelique’s team had carried out an experiment in his kitchen which seemed to show that this degree of contamination could occur if liquid to liquid contact through a Luer-sized orifice took place. Thus, if the syringe, with no needle attached, came to lie in a pool of chlorhexidine spilt when, perhaps, someone bumped into the trolley, the necessary degree of contamination might occur.

The judge concluded: “Next, I find that liquid to liquid contact should not have happened and that procedures which these high quality and responsible clinicians adopted were designed specifically to avoid such contamination. That is the point of those procedures. I therefore find that this conscientious clinician and this conscientious ODP, who were truthful and operated to a very high standard, on this occasion permitted some breach of procedures that allowed the contamination to take place. In summary, there is a probability that contamination through a lapse or breach of duty, which I cannot further specify, permitted liquid to liquid contact, the injectate was contaminated and the damage sustained as a result. Hence, there will be judgment for the claimant.” He was later supported in this view by the Court of Appeal.

For those of us accustomed to the rigour of scientific proof, this process of laying speculation upon conjecture upon guesswork may seem little short of ludicrous. But this is how the law, in its less enlightened moments, tends to work, and it is also probable that the Courts were influenced, however subconsciously, by the need to provide some financial relief to a very deserving woman. None of which is any succour, I am sure, to that “conscientious clinician” to whom the judge referred.

Finally, as scientists, what should we do with respect to skin preparation before neuraxial block, and should we be influenced by the judgment in this case? Probably nothing and no, respectively. It is true that the Summary of Product Characteristics for Chloroprep, comprising 2% chlorhexidine in alcohol, states quite clearly that it should not be used for lumbar puncture and that “contact with the brain (and) meninges….must be avoided”. However, no such warning appears to exist for the 0.5% solution, and the manufacturers of Chloroprep have indicated that they may be changing this warning to “do not bring into contact with the meninges”. What we do know is that there is high quality evidence regarding the antiseptic properties of chlorhexidine, and that an American Society of Regional Anesthesia and Pain Medicine Practice Advisory Panel considering ‘The Infectious Complications Associated with Regional Anesthesia and Pain Medicine’ concluded that chlorhexidine is the most effective of the choices available (see http://bja.oxfordjournals.org/cgi/eletters/102/2/179#4350 for a more detailed discussion).

Angelique’s Sutcliffe’s injuries may not be due to antiseptic contamination of the anaesthetic, but her case does serve as a useful reminder that, however careful we are, we are using powerful neuactive drugs in the most neurologically sensitive part of the human body. There may be, to paraphrase that great thinker, Donald Rumsfeld “…known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we now know we don’t know. But there are also unknown unknowns. These are things we do not know we don’t know.” We don’t know what happened to Angelique, but at least now we know we don’t know.

David Bogod
Anaesthesia records have changed considerably in our 25 years in the specialty. When some old notes are examined from the early 1980s, just before oximetry and capnography became standard, very little information was recorded. The record may just have “GOH” on the back with no recording of any physiological variables. In the 1960s, the anaesthetic record was frequently a scribble on the back of the drug chart, no useful information appeared for future anaesthetists to interrogate.

Many departments in the U.K. have subsequently developed their own charts, which may now also be electronic. In Peterborough the anaesthetic chart is a development of the record used throughout the Leicester Hospitals, where there was a regular review of the record keeping process when RG was a trainee in the early 1990s. New information has been added and the process made easier by a tick box approach so that long hand is seldom required. There is also a section for anaesthetic consent, which also employs the “tick box”.

The problem with the recording of the information about an anaesthetic episode is the vast number of variants of anaesthetic charts that are in existence in the NHS. We have both become aware of this whilst trying to tease data from photocopied records for the latest NCEPOD investigation into perioperative deaths in the elderly. We both appreciate that if the information has not been recorded that is a failure of the individual conducting the anaesthetic but when such vital information, such as ASA grade may not even have a space on the record it must be time to standardise.

The potential advantages of the “national” record would include the ability to extract information quickly, ensure that it was easy to photocopy, make an audit of records easier and enable trainees and locum doctors to be familiar with the chart when they move hospitals. The record should not be made of cheap photocopy style paper but should be manufactured from good quality paper, or card, that is likely to survive in the patient notes.

There will be individuals in anaesthesia departments in the UK who are fiercely proud of the record in their part of the world, possibly now on ‘version 38’. However, it is surely about time that the organisation with the longest track record in patient safety in anaesthesia in the UK, the AAGBI, in collaboration with the NPSA, pushed for a mandatory, single hardcopy and electronic anaesthesia episode record.

Richard Griffiths, AAGBI Council member
Alex Goodwin

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Anaesthesia has the second highest number of part time trainees, previously termed ‘flexible’ but now “less than full time” (LTFT) trainees. In 2007 9% of anaesthetic Specialist Registrars were training flexibly [1]. The national average across Medical specialties is 6.6% [2]. Anaesthesia has a well-deserved reputation as a ‘family friendly’ speciality - 10% of the Consultant workforce practice part-time - this may explain why anaesthesia attracts more trainees seeking LTFT opportunities.

Currently, around 40% of anaesthetic trainees are female, and this is likely to increase since there are now more female medical students than males. In 2008, the ratio of females to males at the University of Bristol’s Faculty of Medicine and Dentistry was 1.6 [3].

There are wide regional variations in the numbers training flexibly, for reasons which may relate to accessibility to funding, or how well individual Deaneries manage their programmes locally. The highest total number of LTFT trainees is found in London, but in proportion to size, our own Severn Deanery comes top [2] with 13% training flexibly [4]. Locally Bristol is known as being supportive of LTFT training, and trainees find the application process to be a well trodden path. Historically the Southwest has always had large numbers of LTFT trainees which may date back to the introduction of Calman training since regions with higher numbers of existing part-timers were better placed to continue funding for their numbers.

**Returning to work**

The Association of Anaesthetists has published a Welfare Resource Pack [5] giving guidance on returning to work after a period of time off, for example after a period of ill-health, personal reasons, or suspension. It is not specific to maternity leave. Doctors who have been away for a “prolonged period” should undergo a formal, structured, return to work programme, tailored to their individual needs. It should incorporate all aspects of clinical practice such as reacquiring clinical skills, knowledge and demonstrating appropriate behaviour and team working. A summative assessment process can then be used to help decide whether the doctor is safe, or needs to undertake a period of retraining. The Resource Pack does not specify how long a “prolonged period” is but it can be argued that most periods of maternity leave would fall into this category.

The Medical Women’s Federation undertook research into part-time working, funded by the Government Equalities Office. The “Making Part-time Work” report [6] recommends that employers, medical directors and Deaneries should adopt a formal approach for the reacquisition of clinical skills after a career break and period of extended leave.

The Group of Anaesthetists in Training (GAT) have published details of “Keeping in Touch” days – up to 10 days which can be arranged on a mutually agreeable (to employee and employer) basis [7] in order to smooth the return to work. In practice, the reality on the shop floor is
considerably different. Freshly returned from maternity leave some find themselves on a couple of doubled-up lists, then straight back on the on-call rota, supervising junior colleagues and managing solo lists. There is the expectation that one returns to work “intact” professionally and just as skilled, knowledgeable and safe as one was before the period of leave (or life-changing event in the case of maternity leave).

In industry, as might be expected, the approach is slightly different. Corporate Mothers, a consultancy firm, recognises that welcoming women back into the workplace after a life-changing event requires a more businesslike approach. Since many companies invest heavily in “change management” this should be included in that process [8]. The Exemplar Employers project was commissioned by the Government in response to work published to address the gender gap [9]. Employers who undertake innovative work in this area are signed up to the scheme, to share their expertise with others.

One such firm is British Airways who have put in place seminars and structured support processes specifically for cabin crew staff returning from maternity leave; this has increased the rate of staff returning to work in the space of one year. In a similar fashion the Armed Forces retrain their staff as a matter of course – RAF staff are not allowed to handle weapons, or recommence flying until they have been retrained. Civil Aviation pilots would undergo “Sim Check” or Licence Skill Testing every six months also as a matter of course [10].

The Exemplar Employers Report makes recommendations based on what they have identified as best practice. Some seem unlikely ever to make their way into the public sector (a company gift on the birth of each child and a celebratory returner’s lunch), however induction programmes, tailored developmental objectives and self-appraisal toolkits perhaps should.

How far this should be taken into the anaesthetic workplace can be debated. Certainly our training emphases calling for help when needed, and a significant amount of self-policing and self-reliance. One colleague has described her return to work as a “crash landing”, while another detailed her trepidation at being on a senior on-call rota supervising her colleagues within days of returning after a year off. Self-reliant qualities are a good thing, but it might not be unreasonable to consider whether this could be done better or more safely.

Working life

The aim of a LTFT training programme is to establish a good work-life balance. Returning to work on a part-time basis can feel like a completely different experience to working full-time however. Many trainees experience a feeling of spreading themselves too thinly, and feel a pressure to keep up with their full-time colleagues. The “Making Part-time Work” research found that across all specialities over 75% of part-timers were working extra hours, whether it be clinical time, CPD (Continuing Professional Development) or research etc. The reason was often extra workload, but also a need to prove themselves as fully committed. In reality working 60% hours does not reduce emails, extracurricular projects and meetings by 60%.

A study in the Netherlands compared allocation of time between part-time and full-time doctors [11]. The balance between in-role (clinical care) and extra-role (admin tasks) was fairly similar, with the number of hours in total being proportionally higher for part-timers. A survey of flexible trainees in the Bristol region was carried out locally and found that the majority did between 4 and 12 hours extra per week. Attending courses on non-working days was a major contributing factor and almost all paid for courses beyond their very limited study budget, the costs of which could be as high as an extra £1000 a year.

Most flexible trainees have thought in depth about the arrangements needed to remain at work, and learn quickly how to juggle the competing aspects of their lives. Many say they feel more focussed at work, and motivated to make the most of the days they are there.

The recent changes with the European Working Time Directive have instigated many changes in the way departments organise their rotas. The balancing act between adequate training time and the need for rest time after on-calls is under even more pressure than before. The working arrangements of a flexible trainee are usually fairly fixed, and as a result so are the corresponding childcare commitments. Many trainees are therefore unable to participate in last minute rota changes, or to slot easily into fixed rota patterns. Reducing hours has the obvious effect of reducing training time, but also reduces opportunities to be involved in research and CPD.

A View for the Future

Traditionally part-time workers are female with young children, but alongside this picture the tide may be turning. In theory, the medical profession is said to be an employer willing to consider granting part-time status to those who do not fulfil the usual eligibility criteria of childcare responsibilities or illness: in practise financial constraints and tightening budgets in today’s financial climate mean that funding is heavily restricted.

Consider for a moment a male consultant orthopaedic surgeon who has recently gone part-time to further his jazz piano playing. Having learnt as a child he continued to play a little through University but really took it up again in his postgraduate years. Recently, having felt he would love to take his playing to another level he has, with the support of his colleagues and management staff, reduced his clinical sessions by a third and is doing a Postgraduate Diploma in Jazz Piano Performance at the Birmingham Conservatoire. He also plays in a jazz band with fellow theatre staff. At no point does his 100% conviction that he is doing the right thing falter. He is quite clear why he is doing it - quality of life.

The sharp end of beginning LTFT training is the return to work after time off, and it is this that could be done better. At a local level a “Return to Work” course has been designed and will be in place in the New Year. It is aimed at those on or recently
returned from Maternity leave and will cover a range of clinical areas including a session on Neuro-Linguistic Programming to aid confidence building. Currently it is open to all in neighbouring regions, and if it is a success at a local level we hope it will become a model for re-training nationally.

Across all specialities 22% of medical trainees have said they would like to train flexibly sometime in the future, and the Government has expressed a desire to increase the numbers from the current 6.6% to 20% by 2010. If this change occurs, are we about to see noticeable changes around us? Actively managing, understanding, and applying appropriate resources to aid a smooth re-entry into work will ensure a happier workforce and a less bumpy landing.

Tessa Bailey, Yeli Horswill
Specialist Registrars, Bristol School of Anaesthesia, Severn Deanery

References
[8] www.corporatemothers.com

My first night.....

I’m three months into my training now and I think I’m doing alright; my portfolio’s thickening up nicely, my cerebral inbox is overflowing with e-learning and finally, finally I have been given a list of my own. Yet despite this, fearful anticipation consumed me as my first on-call on my own approached.

As luck would have it my first patient was a fit gentleman in his sixties and he was having some sort of a finger operation; should be OK with and LMA, as straightforward as it gets.

I tried to supress the familiar nervousness in my tummy and to remember all the tips & advice I was given during my 3 induction months.

“Propofol is your best friend!”
“Α stands for Airway- it is as simple as that!”

“Don’t worry, it is almost impossible to kill a fit person by giving them an anaesthetic.”

Right?

The induction went fine, the patient was stable and the electronic beep sounded with reassuring regularity. The patient was starting to breathe……but something wasn’t right; I could sense the bag in my hands but at some point it had stopped moving.

Go back to A!

I could still sense the motionless bag in my hands, and the patient in front of me without any visible respiratory effort. I tried airway manoeuvres still holding the bag in my hands hoping to sense any movement at all. Still nothing happened.

Shoot, what do I do now?! Stick to A! Jaw thrust…………bag him…………sweaty palms…………bag not moving…………

stiff………cheest…………not moving at all. What could be causing this?

Everyone and everything around me was moving in slow motion then the most bizarre feeling of déjà vu. I couldn’t focus, the screen was blurred and there was NO friendly beep noise!

Thinking that maybe high ventilation pressures were causing a leak around the LMA I opened the valve slightly, reapplied jaw thrust and squeezed the bag again and … suddenly felt hot liquid all over my scrubs.

The room started spinning, suddenly everything went black… I was sitting in complete darkness in my soaked bed holding an unscrewed hot water bottle in my hands. It was 3am. My first on call the following day went fine!

Patrycja Jonetiko, CT1 Anaesthetics
Royal Devon and Exeter Hospital

References
[8] www.corporatemothers.com
Greetings from America! I want to thank Felicity Plaat for asking me to contribute to your Association in this new forum. I have many friends in the AAGBI, and the ties between American and GBI anesthesiology run deep. I hope to have something to share on a regular basis with my colleagues, and I hope the readers of the AAGBI newsletter will enjoy an occasional note “from America”.

For my inaugural comments, I’d like to share a bit of the history of the intravenous electrolyte solutions we use in our respective practices. My interest in this topic was sparked recently, when during a routine case, my resident asked me how our IV solution got its name. Not the lactate part, but the Ringer’s part. This led to some searching, and the results were quite enlightening. Your solution is most commonly referred to as Hartmann’s, while ours in the USA is most always Ringer’s lactate. While not exactly the same, the content of these respective solutions is remarkably similar. But who are these solutions named for, and how does this represent an ironic link between our two continents?

Sydney Ringer (1834-1910) was an outstanding English physician and researcher (1,2). Born in Norwich, and educated at University College in London, he spent the remainder of his distinguished career at UCH, receiving many awards and being a productive researcher on a variety of topics. Of great interest to anesthesiologists (I am going to use American spelling in these letters, whether you like it or not!) Ringer was the first to apply scientific principles to identify anesthetic gases. While still a medical student, he became interested in the observation that different gases produced different pitches of sound when flowing through a whistle. He recognized that a whistle device attached to the expiratory port of a breathing circuit could, by simple auditory cues, detect the difference between oxygen and nitrous oxide. A clever gas analyzer well ahead of any modern attempts to accomplish the same feat! A more modern description of this auditory phenomenon, published in The Lancet in 1977 (3), indicates that the whistle tone difference between nitrous oxide and oxygen is similar in pitch to the difference between the third and fourth notes of “God Save the Queen”, a familiar tune to all, although known and sung in America as “My Country ’tis of Thee”. Linked we are, through song as well as medicine!

The intravenous solution we now call Ringer’s lactate came to be as a result of Sydney Ringer’s interest on the effect of electrolytes on cardiac and other muscles. Whilst doing experiments one day, his laboratory assistant mistakenly used tap water, supplied by the New River Water Co., instead of
distilled water. Unpredictable muscle contractions occurred, leading Ringer to investigate. Eventually, it was realized that electrolytes, mostly calcium, were in the tap water, having leached from the pipes and other sources, and were causing the muscle contractions. The results of these investigations led to many findings on physiologic electrolyte concentrations and their importance for normal physiologic functioning. For example, Ringer made the insightful observation that fishes did not survive in distilled water, yet river water, even minute amounts, was adequate to sustain fish life.

Alexis Frank Hartmann (1898-1964) was an American pediatrician and biochemist. Descended from a long line of German physicians, and having sons who also became physicians, he was of a strong medical pedigree. Born in St. Louis, Missouri, USA, he was educated and practiced in that city for his entire professional career. His interests included disorders of metabolism, especially renal disease and diabetes in children. Hartmann was one of the first to use insulin in a child with severe diabetes, just after insulin was first used in humans in 1922. His early recognition of the metabolic consequences of acidosis led to his interest in alkalinization therapy, as well as the recognition of the correct ratio of sodium to chloride (i.e., more sodium is needed) when treating conditions of acidosis. Much painstaking work led to his creation, in 1932, of a solution that contains electrolytes and bicarbonate in essentially the same concentrations as is found today. Hartmann enjoyed a distinguished academic career, receiving many awards and accolades.

Ringer’s lactate was given the moniker years after Sydney Ringer’s death. Hartmann, a modest man, did not seek recognition, although it was given to him, by the creation of an internationally utilized intravenous solution that bears his name. How “Ringer's”, despite its entirely British origins, became a uniquely American product, and “Hartmann's”, an American creation, became the fluid of GB & I and elsewhere, is one of the mysteries of modern medicine. I am grateful that my resident asked me about Ringer; it is incredible what a simple question can sometimes reveal.

I look forward to writing future “Letters from America” and I hope the readers of this newsletter will look forward to reading them. With appreciation to Felicity Plaat for twisting my arm into this assignment, I remain, sincerely,

William Camann, MD
Director, Obstetric Anesthesia
Brigham & Women’s Hospital
Harvard Medical School
Boston (where anesthesia began), Massachusetts, USA

References:
Annual Scientific Meeting
Nottingham
13/14 May 2010
Albert Hall Conference Centre
Nottingham
For further information please contact Jo Litchfield
(0115) 9249924 Ext: 66241 NAS2010@nuh.nhs.uk
www.nasgbi.org.uk

Difficult Airway Day
A one-day Symposium and Workshops for Anaesthetics Trainees, Career Grade & Consultants
Thursday 17th June 2010
The Walkers Stadium, Leicester

Practical Sessions to Include:
- Oxford Box and Tracheobronchial Tree
- Nasal Fibreoptic Intubation
- Oral Fibreoptic Intubation
- Awake Fibreoptic Intubation
- Simulator (Airman)
- Intubating LMA/C-Trach
- LMA and Aintree Intubating Catheter
- Double Lumen Tube
- Cannula Cricothyroidotomy and Transtracheal Ventilation
- Video Laryngoscope
- Optimising Direct Laryngoscopy
- Human Behaviours/Non-Technical Skills (NOTECHS)

5 CPD points applied for from the Royal College of Anaesthetists
Registration fee: £150 inc. Lunch and Refreshments
Course Directors: Dr M Mushambi and Dr P Ali, Consultant Anaesthetists
Contact: Sam Thurlow, Conference Manager
Tel: 0116 2502305 Email sam.thurlow@uhl-tr.nhs.uk

4th Annual Paediatric Anaesthesia Meeting
Thursday 24 June 2010
9.00am – 4.15pm

NEW VENUE
Imago, Holywell Park, Loughborough University, Loughborough, Leicestershire

GUEST SPEAKER
Adrian Bosenberg, Seattle

Provisional topics for the day:
- Regional anaesthesia in neonates and infants
- Controversies in regional anaesthesia
- Anaesthesia for children with chronic lung disease
- VTE in children and prophylaxis
- Anaesthesia for children with burns
- Ophthalmic anaesthesia
- Communication in children with special needs

5 CPD points applied for from the Royal College of Anaesthetists
Registration fee: £120 inc. Lunch & Refreshments
Course Director: Dr E Dekker, Consultant Anaesthetist
Contact: Sam Thurlow, Conference Manager
Tel: 0116 2502305 Email sam.thurlow@uhl-tr.nhs.uk

Further information: events@rcoa.ac.uk
Whose licence is it anyway?

Does the term “marketing authorisation” hold any particular significance for you? Since 1995 when, in order to harmonise legislation within the European Economic Community, The Medicines for Human Use (Marketing Authorisations Etc) Regulations 1994 came into being, the pharmaceutical industry has included the marketing authorisation (MA) number in the small print at the bottom of any drug advert. The MA number also appears within the summary of product characteristics (SPC) and within product inserts that provide the physician and patient with information about the medicine. Occasionally, however, the MA number is still given in the form of a PL number.

Marketing authorisation (MA) accurately summarises the due process that a pharmaceutical company has to undertake in order to satisfy the licensing authorities. These are the European Agency for the Evaluation of Medicinal Products (EMEA) and the Medicines and Healthcare products Regulatory Agency (MHRA). Official approval in the form of a MA encompasses standards of manufacturing as well as evidence of benefit in the treatment of specified conditions or diseases. On receipt of a MA, the holder can then advertise that particular drug for one or more specified indications.

In an ideal world, the medicines that are given to children would have been subject to the same processes. However, the emotional and financial costs of carrying out widespread trials on children mean that in reality few medicines possess a MA specifically for paediatric use. Similar constraints apply to the pregnant population.

The MRHA has an enforcement arm that exists to prosecute any persons who do not adhere to the law; and in the USA recently, the Department of Justice fined Pfizer a record $2.3 billion (£1.4 billion) for promoting use of four drugs for indications or in dosages beyond those laid down in the relevant MAs. Such use beyond licence, also termed off-licence use, is now most commonly referred to as off-label use. It is important to note that these defined uses for a particular medicine apply only to the holder of the MA. Doctors have never been restricted in their prescribing solely to the indications specified in the MA.

Prior to 1994, very similar processes led to the issuing of a product licence, which lent itself in turn to the concept of a drug being licensed. It is therefore not difficult to see how this situation, in which a medicine is approved for a limited list of indications that are then documented by the manufacturer as part of its product information, could generate the misconception that use for conditions or diseases that were not listed / approved would not be licensed, or would even be unlicensed.

Strictly speaking, an unlicensed medicine is one that has not been approved by the licensing authority so the producer does not possess a marketing authorisation, and in this regard an unlicensed medicine is a very rare entity. However the MHRA does allow certain exceptions, and keeps a register of special order pharmacies that are permitted to compound medicines that are not available elsewhere. Anaesthetists will be familiar with (and thankful for) metaraminol which is prepared in Torbay, and with 4% topical lidocaine, made in Eastbourne.

The Pain Society recognised a need to better inform patients about this matter, and in 2003 published Using medicines beyond licence, updating this document[1] in 2005 and planning a review in 2008. Although briefly mentioning marketing authorisation as equivalent to product licencing, the rest of the document refers to medicines being used outside of licence. The booklet usefully explains why a patient who did not have a diagnosis of depression might have been prescribed antidepressants (to reduce their experience of chronic pain), and of note recommends that a verbal agreement with the patient be obtained by the team prior to any off-label treatment.

When seeking such an agreement, I would contend that there remains a potential to generate confusion amongst patients and their carers by reference to the word licence. Raising the prospect that their doctor has done something which is against the rules is bound to cause concern. Doctors who are unaware that the term marketing authorisation is now used in place of product licence, could possibly encounter greater difficulty in conveying an accurate description of this complicated issue to a worried patient.

Drug Safety Update is published by the MHRA. In the April 2009 issue [2] in the ‘Hot Topics’ section, the responsibilities of the prescriber were highlighted and the following advice when prescribing beyond the MA was provided:

- Before prescribing a medicine off-label, be satisfied that such use would better serve the patient’s needs than an appropriately licensed alternative
- Before prescribing an unlicensed medicine or using a medicine off-label
- Be satisfied that there is a sufficient evidence base and/or experience of using the medicine to show its safety and efficacy

- Take responsibility for prescribing the medicine and for overseeing the patient’s care, including monitoring and follow-up

- Record the medicine prescribed and, where common practice is not being followed, the reasons for prescribing this medicine; you may wish to record that you have discussed the issue with the patient

Note the advice regarding recording the reason for off-label use applies only when this is not common practice, and that a discussion with the patient does not appear to be mandatory.

However, then came clinical guideline 88 from the National Institute for Clinical Excellence (NICE) in May 2009 on early management of persistent non-specific low back pain [3]. This included a footnote highlighting that, in NICE’s view, consent to off-label prescribing should be addressed as a matter of routine when prescribing for this commonplace condition: No opioids, COX-2 inhibitors or tricyclic antidepressants and only some NSAIDs have a UK marketing authorisation for treating low back pain. If a drug without a marketing authorisation for this indication is prescribed, informed consent should be obtained and documented.

This edict would have been easier to comply with had NICE actually listed the drugs that do possess a MA for low back pain (see below*), but at least NICE chose to use the term marketing authorisation. Also note that NICE is now advocating written consent for off-label treatment of low back pain.

The GMC updated its advice on good practice in prescribing medicines in September 2008 [4], and does not stipulate whether written or verbal consent is obtained when prescribing off-label. The following advice seems entirely appropriate:

However, you must explain the reasons for prescribing a medicine that is unlicensed or being used outside the scope of its licence where there is little research or other evidence of current practice to support its use, or the use of the medicine is innovative

With this in mind, we would do well to heed the advice provided by a manufacturer who does not recommend a drug to be given to patients undergoing surgery. Roche (who market ketorolac as ‘Toradol’) state on their product insert that is provided within the box of ampoules under ‘Information for Health Professionals’ in the ‘Contra-indications, Warnings, etc’ section:

- Toradol is contra-indicated as prophylactic analgesic before surgery due to inhibition of platelet aggregation and is contra-indicated intra-operatively because of the risk of bleeding

Patients do not typically have the opportunity to read the information leaflet that is also provided by the manufacturer on the same product insert for their benefit (The Patient Product Information). Here they are informed that Toradol must not be used:

- If you have had operations (sic) with a high risk of bleeding or incomplete stopping of bleeding

Patients receiving Depo-medrone via the extradural route might also be concerned to discover from the information provided within the product insert that administration via the extradural route was not recommended by the manufacturer, Pharmacia. Although wound dehiscence and loss of sphincter control seem unlikely consequences to deserve specific mention, they sound worrying to physician and recipient alike!

In the middle of an anaesthetic when unforeseen circumstances might require the off-label administration of a drug, our patients are usually not in a position to give their consent verbally or otherwise. At the pre-anaesthetic consultation therefore, it would appear prudent to explain to the patient that the possibility will commonly arise for a drug to be given to treat a situation (condition) that is not included in the brief list of uses of any particular drug authorised by the manufacturer. Written information that can be taken away will be appropriate as the nuances of a discussion on the matter of off-label use of medicines will not be assimilated by the majority of patients in a short period of time.

Dr John W Mackenzie MA MRCP FRCAn.
Consultant Anaesthetist
Royal Berkshire NHS Foundation Trust, Reading

References:
2. www.mhra.gov.uk/Publications/Safetyguidance/ DrugSafetyUpdate/CON043809
3. www.nice.org.uk/CG88

*Paracetamol, Diclofenac, Co-Codamol, Ibuprofen, Acemetacin, Flurbiprofen and Tiaprofenic Acid are licensed for the treatment of back pain.
It is almost three years since the hip fracture anaesthesia network was launched, at The Age Anaesthesia meeting at Salford Quays. We realised that to find some answers to some common problems in this group of patients the only way forward was to exchange information using a network. At present there are 115 members, including consultant anaesthetists and SAS doctors, who provide a good deal of the excellent anaesthetic care given to hip fracture patients.

There are also some physicians in the network, and perhaps this is going to be the crucial interaction in good clinical care for elderly trauma patients; the relationship between anaesthesia and the relatively new specialty of orthogeriatrics.

The network aims to promote good anaesthetic care and best practice in hospitals across the country. Another good reason to start the network was the obvious ‘postcode lottery’ that exists in the standards of care for hip fractures. The models of care are different in every NHS hospital; some units have very good orthogeriatric care, with consultant surgical and anaesthetic leads for hip fractures. In other institutions the orthogeriatric input may be minimal, tagged on to the end of a busy physician’s normal workload.

The network is run by NHS Networks, which is based in Leicester. They are now able to bulk email for the network and also run a discussion forum, which has been going great guns since it was started in October 2009. There may also be the facility to conduct online surveys, which a couple of members of the network are keen to do.

In 2008 the network conducted a small snapshot audit of current U.K. practice. Twenty-two hospitals reported back and the data was first presented as a poster at the ESA in Milan in June 2009 and the full manuscript will appear in Anaesthesia in 2010. Audit is important but also exchange of other useful ideas. Many trusts now have a hip fracture as first patient on a trauma list. Pre-operative analgesia is another hot topic, and some units are now conducting fascia iliaca blocks in the A & E setting for analgesia. These do not have to be done by anaesthetists; Luton and Dunstable have led the way with this innovation.

The NHS Institute conducted some work on hip fractures in 2009 and as network coordinator I was able to put them in touch with network members in trusts, who were able to help out with educational activities.

Many will be aware that there is a National Hip Fracture Database, which now has 150 hospitals contributing. However, little anaesthetic information is collected and the network may help to lobby for future inclusion of anaesthetic data in this centrally-funded audit.

In the meantime the network continues to thrive. The first network meeting took place at the Age Anaesthesia Association’s annual meeting in Grange over Sands in May 2009. A research officer and membership secretary were appointed at this first meeting: Stu White from Brighton and Rashmi Madan from Kings Lynn respectively.

The annual meeting of the network is fixed for the Age Anaesthesia Association’s annual meeting; the next meeting will be held in Leicester from May 6 to 7 2010. The provisional programme includes excellent presentations on all matters relating to the elderly and peri-operative medicine, from national figures in orthogeriatrics, surgery and anaesthesia. All trainees note: there is always a very good prize to the winner of the free paper session, last year the winner went to the ASA, all expenses paid!!

Early next year the AAGBI will be publishing guidelines for the anaesthesia and peri-operative management of hip fractures. The working party meets in January for the first time and has representatives from Age Anaesthesia, the British Orthopaedic Association and The British Geriatric Society. As well as consultant anaesthetists there will be an SAS representative, who is also an active member of the network - Jonathan Alper from Taunton.

The network has flourished with input from members and the help of the NHS Networks team in Leicester. Anaesthesia may be a small cog in the whole process of hip fracture care but with cooperation we may be able to answer some important questions - regional or GA, the role of nerve blocks, fluid optimization and which “box” to use to monitor cardiac output.

I look forward to your involvement and I thank all the members of the network who have made it such a success. Please visit the site and join. I hope to see you in Leicester in May and do not hesitate to get in touch.

Richard Griffiths
“Get a Head Start!”

Trainees Planning To Sit

The Final FRCA SAQ Paper
Wednesday September 1st 2010
or
The Final FCARSI E&SAQ Paper
Monday September 20th 2010

Weekend Introduction Courses to The Mersey Method & The Writers Club

14.00 Friday 19th – 16.00 Sunday 21st March
Aintree Hospitals, Liverpool.

14.00 Friday 26th – 16.00 Sunday 28th March
Aintree Hospitals, Liverpool

PROGRAMME

Master Class on the Mersey Method
Review & Analysis of Presentation Techniques
+ Three 12 Question Papers
(London or Dublin Format)
Under Examination Conditions
Marking & Review
+ Master Class on The Writers Club
Procedures & Protocols
Early Membership = Generous Practice & Preparation

Inclusive Course Fee
£250
Breakfast – Lunch – Refreshments – Car Parking

For Application & Details
www.msoa.org.uk
The history of medicine interests most doctors in one way or another (though some haven't realised this yet). The 7th ISHA was an opportunity for indulgence in this interest at an idyllic location with glorious weather (in October!) and to be rewarded with CPD points.

Every four years the International Symposia on the History of Anaesthesia give the opportunity for students of the subject to gather together, present their work, and exchange ideas. In October 2009 delegates from 15 Countries assembled at Heraklion in Crete for the seventh such meeting. In total there were three plenary sessions, 6 Guest sessions, and 14 scientific sessions giving a total of 55 oral and 13 poster presentations. The Guest sessions were arranged by organisations from around the World. These included the History of Anaesthesia Society (UK), the Geoffrey Kaye Museum (Australia) and the Special Interest Group of the Australian Society, and from Greece the International Hippocratic Foundation of Cos. The meeting was hosted by Professor Helen Askitopoulou from Crete, supported by her own Department and an International Committee.

The opening ceremony featured the “Hippocrates Lecture” by David Wilkinson, entitled “Losing the Hippocratic Tradition: a Danger to Our Profession?”. His thought-provoking delivery was followed by a Greek choir and then a welcome reception. Anaesthetists from all over the world mingled, meeting old friends and making new ones.

Friday 2nd October began in earnest with four parallel sessions on various aspects of anaesthetic history. A plenary Honorary Lecture was delivered by Professor John Severinghaus on the discovery of oxygen. Was it Mayow, Scheele, Priestley or Lavoisier? A rediscovered letter from Scheele to Lavoisier suggests plagiarism by the latter.

After lunch another plenary lecture on the Minoan Civilisation prepared everyone for the immediate visit to the archaeological site at Knossos. Knossos was one of two highlights of the social programme. Discovered in 1878 by Minos Kalokairinos, a local merchant, it was not extensively excavated until 1906 by the English Archaeologist, Sir Arthur Evans. Dating back to the Bronze Age it was most likely the hub of the Minoan Civilization. Being escorted around the site gave a true perspective to the history of Crete. The second highlight followed shortly. We were treated to an evening at a traditional restaurant in the village of Archanes. The food and wine were excellent and the conversation meandered wonderfully though the dinner.

Saturday 3rd October was a full day of further papers - 4 lecture theatres running in parallel. Keynote lectures (plenary) came from Georgina Kostopanagiotou on the development of COX-2 inhibitors, and Rajinder Mirakhur on the history of neuromuscular blockade. There were guest speakers from Greece, UK, Australia, USA and Germany. Notable was Professor Douglas Bacon’s lecture on using history to teach professionalism. Free scientific papers covered a wide range of topics on anaesthesia and analgesia, including antiquity, equipment, resuscitation and military. The prize for best free scientific paper was won by Dr Meinoflus Stratling (Cardiff) for the history of early respirators.

The Symposium concluded with a gala dinner overlooking the moonlit sea. I’m sure that every delegate departed with newly acquired facts and fired up enthusiasm.

The Eighth Symposium will be held in Sydney, Australia in January 2013. Apply for your study leave now!

Dr Alistair McKenzie  
Dr Neil Adams  
Consultant Anaesthetist, Edinburgh  
Consultant Anaesthetist, Bury St Edmunds
We – that is anaesthetists and medical device manufacturers - have seen changes to the rules and regulations covering the design, development, manufacturing and introduction of medical devices onto the market and into clinical use over recent years.

In the 80’s one of the forerunners of the current MHRA (the Department of Health and Social Security, DHSS) developed and introduced Good Manufacturing Practice schemes covering a variety of different areas including Active Devices, Sterile Devices, Aids for the Disabled and each of these areas had their own coloured guide - Green, Blue and Orange respectively. The premise for these schemes was that the manufacturer should adopt a documented Quality System generally compliant with the then BS 5750, latterly ISO 9000 series.

This approach changed in 1993 with the introduction by the European Parliament of the European Medical Devices Directive (MDD) - 93/42/EEC. Member states were required to adopt this Directive into their national legislation; for the United Kingdom this sits within the provisions of the Consumer Protection Act. There are a number of Directives covering different types of medical devices and all of these have been amended following a major review culminating in a revised Directive which was published in 2007 - 2007/47/EC. This legislation has recently been clarified (Figs 1 and 2) and will come into force fully on 21st March 2010.

Each of the Member States appoints a competent authority to implement the legislation; in the UK this is the MHRA. The MHRA in turn appoints ‘Notified Bodies’ (Fig 3) to conduct audits and inspections of manufacturers in order to ensure compliance with the MDD, and specifically the ‘Essential Requirements’ listed in Annex 1.

The over-riding commitment is to ensure that devices placed on the market are safe and effective, such that the device does not expose the user, the patient or any others to an unacceptable risk of harm. Manufacturers commit huge resources to the development of products to ensure that devices are fit for purpose and are what the user (ie you as the anaesthetist) wants and will use. To allow a manufacturer to affix the CE mark to their device, they must meet the Essential Requirements - these basically cover all aspects of the device from its concept all the way through to disposal. Within the MDD there are a number of useful definitions including...
“medical device” and “intended use” this being the use for which the manufacturer has identified and designed the device accordingly.

The essential requirements take the form of a checklist, and manufacturers must complete all the necessary items prior to being able to complete and sign a Declaration of Conformity and affix the CE Mark. The manufacturer has to ensure the relevant processes and procedures exist including: design & development, risk management, clinical evaluation, instructions for use, symbols & labelling, material toxicology, appropriate verifications and validations, packaging, sterilisation, manufacturing etc. applicability of relevant standards eg electrical safety IEC 60601.1 etc.

The product development aspects generally include some form of market research including focus groups where it is common to solicit views from anaesthetists, ODAs etc. It is recognised that not everyone will be satisfied with the resulting features included in any device; some aspects of design are influenced by commercial factors in this ever-changing global environment.

Once a device has overcome the hurdles and reached the market, there is a legal obligation under the provisions of the MDD to have in place an effective, proactive post-market surveillance process. Data from this process can be used to develop and refine the next generation of the device. I believe all manufacturers welcome such feedback and comment in respect of their devices.

Over my 30 years or so experience with the medical device business and your profession I have observed that whilst in the main most manufacturers provide devices which are suitable for the intervention the patient requires there are occasionally times where the anaesthetist feels it appropriate to modify or change the device in some way – other than for use as intended by the manufacturer or even to develop their own, either by creating a brand new device or a variant of a previously designed device. However, you should be aware of your own responsibilities and that of your employers should you modify a medical device and use it clinically. As noted earlier manufacturers place a medical device on the market with an “intended purpose” and all of the subsequent documentation compiled supports that specific use; eg risk management, clinical data, warnings & cautions etc. Should you modify an existing device (for example by modifying a device intended for adult use for paediatric use) and use that modified device clinically, the device is being used “off label”.

Whether we like the thought or not the global world of litigation and liability are with us all in varying degrees. The issue is - should you modify devices? If you do, and an adverse incident occurs in use, what happens? The manufacturer would conduct a detailed investigation, possibly in conjunction with the MHRA. If such an investigation concluded that the device had in some way caused the incident and that the device has been subject to an unauthorised modification, it is my opinion that the person undertaking the modification might be held to account.

For all healthcare professionals involved in the delivery of patient care and for medical device equipment manufacturers compliance with the regulations is crucial in order to ensure that any potential risks are minimised.

Paul Sim
BAREMA – Deputy Chairman
RAQA Director Spacelabs Healthcare

Footnote: Should readers wish to comment, please email: paul.sim@spacelabs.com

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
“Do you have a genuine interest in teaching?”

This was the question asked of me four years ago. My hesitant affirmation was swiftly followed by a request for me to ‘prove it!’ My educational supervisor was very good at suggesting ways to develop my teaching/medical education portfolio. However, when he suggested I join the Society for Education in Anaesthesia or SEA(UK) I have to admit I was uncertain of what he meant.

The Society for Education in Anaesthesia (UK) was founded in 1999 by Dr David Greaves, Consultant Anaesthetist at the Royal Victoria Infirmary, Newcastle upon Tyne. It followed the Calman re-organisation of registrar training and the development of Schools of Anaesthesia. SEA(UK) is a non-profit organisation committed to promoting the art and science of medical education amongst those involved with educating the anaesthetist. Membership currently stands at around 250.

The SEA(UK) council consists of around 15 members with co-opted members representing SEA(UK) on the NIAA and other committees and lay member from the Royal College of Anaesthetists. Our current president is Dr Alison Cooper who is a Consultant Anaesthetist and Director of PGME at Rotherham Foundation Trust Hospital.

Society activities
In the three years that followed, my membership provided me with a platform for furthering my career.

Conferences (Annual Scientific Meeting) and Meetings
The first SEA(UK) meeting was in Newcastle in 2000. I attended my first SEA(UK) Annual Conference in London in 2006. One of my colleagues was presenting an anaesthetic trainee survey she had done. I was impressed by the organisation of the event and the amount of interest it had attracted from around the country. The following year, in Sheffield, I presented a poster of an audit on ‘The decline in anaesthetic trainee publications’. It was the first abstract I had presented at a national meeting and even though I did not win a prize it was valuable experience that I used to help me present at other meetings.

The annual conference returned to the shores of the Tyne on March 16th 2009. It was held at the impressive Sage and the presentations included personal experiences of achieving postgraduate qualifications in medical education, ‘What is an excellent anaesthetist’ and ‘The changing role of the College Tutor’. There was also an enlightening talk by Professor Rowbotham explaining the developments within the National Institute for Academic Anaesthesia. There were a number of high quality posters and presentations by
trainees. Prizes were presented in both categories and 3 abstracts from the meeting have been accepted for publication in Anaesthesia.

SEA (UK) returns to Sheffield on March 15th 2010 for its Annual Scientific Meeting. Revalidation is a very topical issue and the meeting aims to get the GMC and College view and explore the impact on medical education in anaesthesia. There will also be a session by Martin Bromiley of Clinical Human Factors Group.

Association of Anaesthetists Great Britain & Ireland (AAGBI)

SEA (UK) is privileged to have developed an excellent relationship with the AAGBI and has run workshops at previous AAGBI Annual Conferences. SEA(UK) has been invited to run a session at the AAGBI Annual Congress in Harrogate September 2010.

National Institute of Academic Anaesthesia (NIAA)

The NIAA is relatively young establishment which holds much promise for furthering research within anaesthesia. SEA(UK) is proud to be part of the venture and has made a research grant of £15000 available, over 3 years, via the NIAA. The grant will be awarded via the NIAA to a research project relevant to medical education in anaesthesia.

Royal College of Anaesthetists (RCoA)

The society is collaborating with the RCoA to run joint workshops designed to give consultant anaesthetists the confidence to use the workplace based assessment tools. Dr Teresa Dorman (Sheffield) has coordinated a total of 6 workshops around the country, with excellent feedback. Plans to run further workshops in Oldham, Edinburgh and London are already underway. See the RCoA website for further details.

Members of SEA (UK) have also been asked for their opinion on the Royal College’s curriculum review and revalidation project which has been fed back by Dr Cooper, President SEA(UK).

Other Activities

The society is registered with the ACCEA in England and Wales and supports the applications for higher awards of members who have been active in education. We are also recognised by the equivalent bodies in Scotland and Northern Ireland as being able to support members in these regions.

Website

The society’s website (www.seauk.org) provides a method of communication about activities of the society and upcoming meetings. It is also a useful resource with information on things such as the Gold Guide and presentations on supervision and assessment in the workplace and pointers of what to do with the difficult trainee.

Newsletter

The society produces a newsletter once a year in the autumn which is sent to all members and anaesthetic departments. Contributions are always welcome. I wrote my first article for it following my presentation at the Sheffield Annual Scientific Meeting in 2007. I am now the newsletter editor!

Want to join?

We are a growing society and welcome new members. In reality there are education matters within every anaesthetic department – for trainees and consultants.

The Mercure Hotel, Sheffield: Venue of SEA(UK) 2010

The Society wishes to support the educational endeavours of anaesthetists in the UK. I became a consultant last year and was also successful in my application to join SEA(UK) council. My experiences have been good and joining the society is something I can recommend to trainee and consultant anaesthetists who, like myself, ‘have an interest in teaching’.

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Poster Competition Judging
To $O_2$ or not to $O_2$?

I read with interest the latest National Patient Safety Agency Rapid Response Report on Oxygen Safety in Hospitals. The number of serious untoward incidents involving the incorrect administration of oxygen was really rather alarming.

In total, 267 oxygen related incidents were reported from acute hospitals and the majority of these (103 incidents) related to equipment problems, including empty cylinders, faulty equipment, lack of or missing equipment and user errors such as misconnections. Even more worrying were the 75 incidents relating to prescribing and monitoring issues, in which many incidents involved patients on oxygen who were not adequately monitored and in whom abnomral saturation levels were not acted upon. A further 54 incidents described how oxygen was not administered appropriately, some examples included: a patient found blue and unresponsive at a post-take ward round as the oxygen he had been administered on admission had been removed after transfer to a ward, compounded by the fact that his saturations had not been monitored overnight; a patient who had been connected to 10L/min of air rather than oxygen; a patient connected to nitrous oxide instead of oxygen; and a hypoxic patient on high flow oxygen whose flow had been reduced to 28% without medical advice.

Clearly many of these incidents could have been avoided and come down to the fact that human error is to blame: the equipment is faulty or lacking because it hasn’t been adequately checked or replaced by humans; prescription of oxygen and documentation of target saturations have repeatedly been shown to be poor among medical professionals; inadequate monitoring of patients, especially the acutely unwell, can be blamed on many factors including staff and equipment shortages and poor training, but is inexcusable in the current era of safety guidelines, early warning scoring systems, competency-based training, colour-coding, labelling and specific fittings of medical gases, and high-tech monitoring systems.

While I am pleased that the NPSA acknowledges the dangers (and benefits) of oxygen therapy, I am equally horrified to read how badly we are failing our patients because of human error. The NPSA is asking our hospitals to set up a task force to tackle prescription, monitoring, administration and equipment issues. In other words, we are to have systems in place to check on us that we are indeed able to manage everyday basic tasks such as prescribing oxygen, administering the correct gas, monitoring sick patients with a saturations probe, replacing empty cylinders or previously used tubing and masks. I welcome any system that ensures patient safety, but I am sadly left to wonder how we have got to this unsafe level in the first place.

In their document aimed at nurses, midwives and allied health professionals, one of the NPSA’s suggestions is that they “calculate how long the oxygen cylinder will last”. Now, I challenge any of you to ask the consultant/trainee anaesthetist you are working with tomorrow to rattle off all the gas laws, theories and equations required to calculate how long a cylinder in use will last, and see how many of you remember the calculations involved. How on earth are we to expect our midwives, nurses and allied health professional to manage that, when we, as an organisation, need a task force to teach us the difference between oxygen/air/nitrous oxide, the benefits of saturation monitoring and how to spot the acutely unwell patient?

I have, however, come across a couple of easy solutions. The same NPSA document mentioned a study in Manchester which showed that after the introduction of a specific oxygen prescription chart, 91% of patients were administered appropriate oxygen. Perhaps we should consider revising our drug charts with a specific area for oxygen (just as we have for warfarin and some other dangerous or common prescriptions). Furthermore, the MHRA has suggested a poster for the wards in which the calculation of how long a cylinder will last is already calculated for us for different flow rates of cylinders commonly in use, sparing us the hassle of incorrect calculations. I urge you all to suggest these posters be printed and posted on your hospital’s wards.

Barbara Lattuca, ST5, St Helier Hospital

References:

Dear Editor

I would like to thank you for publishing (in your January 2010 issue) my letter outlining concerns about the proposals on an alternative syringe/needle connection system for neuraxial use, and also Hartle and colleagues for their prompt and full response. There is much common ground between us, and time will tell who is right about the differences, but I must follow up their (entirely correct) suggestion that my “comments might better be addressed to the NPSA”. My comments have been so addressed, but I have received not even an acknowledgement, let alone any response. An earlier attempt (Anaesthesia 2002; 57:726) to engage with those whose interests relate primarily to ‘safety’ met a similar fate. Perhaps I am a ‘man alone’, but at least now there is some evidence of there being a debate, and high time too!

Tony Wildsmith
Professor Emeritus, Dundee
Adverse impact of International Accounting Standards (IAS-19) on medical staff annual leave

It may not be bed-time reading for doctors to study how the International Financial Reporting Standards (IFRS) adopted from 1 April 2009 applies to the NHS and other public bodies. Necessary in an increasingly global market, IFRS seeks to standardise accounting practices internationally so that organisations can be directly compared or audited across the world [1].

Readers may be unaware that one small aspect of IFRS may have hugely adverse impact upon the way that they may be asked to manage their annual leave. It has for decades been a provision of all medical staff contracts (including the 2003 New Consultant Contract) that up to 5 days annual leave may be carried over to the next year [2]. This reasonable entitlement promotes flexibility for both employers and employees, as doctors who work somewhat harder in one year to meet Trust needs will nonetheless preserve their right to time off later. The arrangement also recognises that leave granted in lieu days (or leave accrued during sick or maternity leave) may be taken the following year.

However IAS-19, a sub-clause of the IFRS, now requires that all such leave carried over is regarded as an ‘employee benefit in kind’, assigned an estimated (arbitrary) monetary value, and accounted as a liability (ie, something which contributes to Trust deficits). This is the case even if the leave carried over is never utilised. The following is an example of how the accounting applies:

“A Trust has 100 consultants with an annual average salary of £80,000. On average, staff carry over 3 days leave. The working year is accounted as 260 days. Thus the liability for the following year is calculated as: 3/260 X 100 X £80,000 = £92,307.”

Alternatively, by abolishing the right to carry over leave, the Trust instantly ‘saves’ £90K. When translated to other staff groups across the entire organisation, the potential ‘savings’ run into millions. Public bodies and Trusts are undertaking hurried analyses as they realise the huge implications of this small clause [3-5]. Some Trusts (including our own) are issuing desperate pleas for staff to take all leave in this financial year and to abolish the right to carry-over leave completely [6]. Yet this knee-jerk reaction is counter-productive. It translates a potential absence (ie, the leave carried over) into an actual absence, which increases immediate costs. By taking all their leave, staff will do less work for the current year, reducing Trust income and incurring additional expenses for locum cover. In other words, a fictitious saving is achieved at expense of a tangible, greater expenditure.

IFRS compounds the problem by failing to recognise the very real financial gain made when staff actually take less leave than entitled in any given year [7]. Thus in the example above, an average carry-over of 3 days means 3 more days worked in the current year, increasing Trust income and savings (eg, less locum cover in the current financial year), all of which may exceed £90K. A proper accounting method would simply balance the Trust gains from these efforts against the fictional loss assigned to any ‘carry-over’ of leave.

The implications are enormous but the nonsense created by IAS-19 seems here to stay, placing accounting practices in direct conflict with employment law. Employment law will always supervene in the courts, but at the probable cost of deteriorating employer-employee relations and (at least on paper) worsening Trust deficits.

Readers will soon face a choice. Either, they may oblige and choose to give up a few days of accrued leave (year-on-year for the rest of their careers) to help their Trusts out of a major, recurrent - but entirely fictitious - financial problem. Or alternatively, they may exercise their right to retain their hard-earned free time, recognising that the financial problem arises simply due to the vagaries of a novel accounting method and not due to their own errant behaviour.

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References

Superheated on top of Ben Nevis

Scientists are supposed to live for the day when they wake up one morning to find that they are wrong about some fundamental cherished belief that they have long held. I have never made a discovery to rock the scientific establishment. However, I’ve done the next best thing in that I’ve suddenly realised that until one morning, I have not really understood something which until then I had thought I understood very well. I cite the following as an example.

Every year I do a talk at the Mersey School of Anaesthesia about vaporisers and humidifiers. To illustrate how desflurane is so physically different from the other volatile agents I have a PowerPoint slide of Ben Nevis, ambient pressure at the top of which at 1344 metres is 86kPa. Since the saturated vapour pressure of desflurane is 88kPa at room temperature, it should boil up there. This is of course distinct from evaporation, which only occurs at the surface of a liquid. Taking the top off a bottle of desflurane at 20ºC on top of Ben Nevis should cause bubbles to form throughout the liquid - it should boil. You can do the same thing with water, only you have to go up to 63,000 feet and you’d need a space suit to prevent your body water boiling. How compelling would it be though, to have to argue in court to prove that the pressure must be 86KPa? After the kirsch bottle had been emptied all the kirsch. You can decant desflurane without getting lungfuls of the stuff if you refrigerate it first and do it in the open air - I’m not stupid you understand. Determined to be a proper scientist, I had another empty kirsch bottle to fill with water as a control and intended to repeat the whole experiment at sea level. We’d be camping on the ridge the night before, so I had a useful means of raising the temperature of the desflurane in a camping stove. This was an important consideration because there is a lot of snow on Ben Nevis even in June and the average year-round temperature is -1ºC.

So, staggering out of the West Coast Sleeper at eight O’clock in the morning, fortified with Scootrail coffee, we trudged off up into the Grey Corries. I was carrying nearly 1Kg of non-essential gear, which didn’t seem right with the half toothbrush, spoon with holes drilled in the handle and three socks. (Wear two and wash one each night.)

However I hoped to significantly advance the cause of medical education. That night, as we watched the sun go down over the Aonachs, I gravely informed Rob that our expedition had a serious scientific purpose and that his cinematic skills would be required on the morrow. Rob expressed concern that my kirsch bottle might leak and that we might be gassed in our sleep in the confines of the tent. However, Rob is a consultant chest physician; he thinks that oxygen makes you die. Two minutes into a discourse from me about the difficulties of using desflurane as an anaesthetic, including details of the really interesting electric vaporiser and he was asleep without pharmacological assistance. I passed the time rehearsing my “piece to camera” and calculating what the concentration of desflurane would be in our tent if it really did all evaporate: 0.003% - I wasn’t worried.

The next morning dawned with clear views, but we immediately ascended into dense cloud. The summit of Ben Nevis is only clear of cloud on one day in every ten, so we were prepared for this. We were fortunate to avoid any of the 261 gales that blow up there every year, although we got our share of the 4350mm of rainfall and yes, there was snow.

After groping our way in the murk around three of the UK’s biggest hills, we finally arrived on Ben Nevis, the top of which is a monument to scientific curiosity and eccentricity. I don’t know whether any one had taken an anaesthetic volatile agent up there before but it is recorded that a hospital bed was wheeled up there in 1981. A Model T Ford, horse and cart and a barrel of beer have also reached the top and a piano was found buried on the summit in 2006. We sheltered in the remains of a meteorological observatory built by a mentalist from Birkenhead called Clement Wragge, who climbed the mountain every day for over a year in the 1880s to take weather readings. “Inclement Wragge”, as he was known to his mates, is also notable for being the first person to give cyclones names, and for attempting to make rain in Queensland using huge vertically mounted blunderbusses.

My altimeter read 1344 metres; the exact true height of Ben Nevis, proving that the pressure must be 86KPa. After the kirsch bottle had been immersed in a carefully temperature controlled cooking pot at 20ºC for twenty minutes, with a ludicrous sense of anticipation, I unscrewed the lid from the bottle. Nothing happened. The camera was rolling. Rob was looking bored and cold. I peeled closer. The stuff was certainly evaporating. You could see vigorous convection currents as the liquid on the surface was cooled by evaporation and sank to the bottom. But of bubbles, the hallmark of boiling, there were none.

I was aghast. A number of competing hypotheses for the failure of my experiment fought for validity in my head. Was my physics all wrong? Had I poisoned the mind of every junior I had taught with my erroneous contentions? Was my desflurane contaminated? Had there been a tragic mix up back at my garage? No, I was at sea level and the concentration of desflurane should have been 0.003%.

The next day I had an obstetric list. The spinal was in, the baby was out, I’d written up the post-op analgesia and was sitting there with painful legs brooding on the capriciousness of the laws of nature when a tube of ethyl chloride caught my eye. ‘Ha’ I thought, “ethyl chloride has an SVP at 20ºC of 132kPa!” I squirted some into an upturned plastic cap from a new ventilator circuit. It evaporated, but it didn’t boil. Now I was really annoyed and decided to do some serious research into the problem.
We read with interest the article by Picard et al [1] in the February issue of Anaesthesia on the adoption of the AAGBI guideline for Intralipid use in local anaesthetic toxicity by London NHS hospitals. Like many hospitals we have also adopted the AAGBI guidelines and made Intralipid available in clinical areas where regional techniques are frequently performed. We were interested to find out what knowledge our colleagues had of these guidelines.

As part of an audit on knowledge and training in resuscitation we conducted an anonymous survey of 47 anaesthetists (33 consultants/SAS, 14 trainees) on their familiarity with the Intralipid guidelines. Our survey gathered information on whether individual anaesthetists were aware of the guideline, knew which drug and its initial dose should be given in local anaesthetic toxicity, and finally where to locate both the drug and the protocol for its use. We present the findings of our survey in Table 1.

We discovered that whilst awareness of the guidelines was good, familiarity with the content of the guideline was poor. Few anaesthetists knew the correct initial dose of this potentially life saving drug and a significant number of anaesthetists were unaware of where to locate the drug.

Clearly, adoption of a guideline by a hospital does not necessarily translate into well informed clinical staff. Part of the solution in our hospital has been to change the location of Intralipid; for consistency it is now always located in the resuscitation trolleys in the relevant clinical areas. Additionally as part of planned changes to the delivery of mandatory resuscitation training, we are going to tailor resuscitation updates for anaesthetists to include important speciality specific information such as the AAGBI guideline on Intralipid use in local anaesthetic toxicity [2].

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The Annual Linkman Meeting preceded Annual Congress at the Liverpool Arena. As it was my first time running the Linkman meeting as AAGBI Hon Membership Secretary and our first time in the venue I approached the event with some trepidation. The conference centre overlooks the Mersey River in the beautiful dockland area of the city. All seemed eerily empty when I entered the large foyer but the buzz of anticipation started as a large number of linkmen arrived to register. Over the next four days the Conference centre was our home and their staff served us well—always friendly, helpful and efficient.

Topics for last year’s linkman meeting were developed with input from some of the active linkman. We repeat key issues from year to year whilst trying to include topical and emerging concerns.

To start the meeting I presented the latest AAGBI membership figures which continue to rise. We are maintaining our position as the largest specialist medical association in UK and Ireland and the size of our membership lends authority to our opinions. To continue to give good service to our members accurate data is essential. All members are encouraged to update their profile in the Secure Access Module, SAM section of the website www.aagbi.org. Over 6,200 members have already used SAM and registered their specialist interests. This helps us enormously when organising educational activities and other benefits for our members.

I launched the new AAGBI Membership handbook which was distributed to all linkmen. The booklet outlines the benefits of the AAGBI and describes its recent activities. There are ‘themed’ sections, one of which gives an overview of the two organisations of the Association (i.e. AAGBI and the AAGBI Foundation) and their objectives, education, publications etc; The booklet also gives a brief description of each committee and includes a section on ‘how members/non members can become involved’ and the benefits of membership. New membership includes free attendance at a Seminar at 21PP (valid for 12months) Copies of this Membership Booklet will be sent to all departments so the linkmen can circulate them to all new and potential AAGBI members.

The first Linkman session dealt with a wide range of “contract issues” including SPA time, job planning, EWTD and manpower issues. Dr. Andrew Hartle’s talk was entitled “SPA time and how to protect it”. Everyone is aware that SPA time is coming under the microscope and its erosion may be seen as a way to recoup finances by management in the future. Andrew’s mantra that “all should be paid for the work that

Linkmen:
A New Charter

Report of Linkman conference 2009

Linkman Charter 2010
This sets out the basis for the relationship between the AAGBI Linkman and the AAGBI.

AAGBI will:
1. Keep linkmen regularly informed on policy and membership developments
2. Provide linkmen with suitable promotional materials for educational events, potential members and for other purposes as may from time to time occur
3. Be responsive in a timely manner to requests from linkmen for information and advice
4. Invite linkmen annually to the Linkman Conference and Dinner

Linkmen will:
1. Provide AAGBI with an up-to-date email address which is checked regularly and whose mailbox is routinely emptied so that communications do not ‘bounce’
2. Aim to attend two Linkman conferences in each three year cycle (one day preceding Annual congress)
3. Respond to reasonable queries from AAGBI
4. When requested, distribute information and promotional material from AAGBI to colleagues and trainees in electronic or paper format
5. Respond to local members queries and concerns and where appropriate pass them centrally to AAGBI
6. Make a sustained effort to routinely approach each new trainee joining the department and encourage them to join AAGBI. This to include both new-starters in the specialty and non-members rotating inwards

From 1st March 2010 the Term of Office of each Linkman will be three years in the first instance and renewable thereafter for further three terms by mutual agreement.

Ellen O’Sullivan
Hon Membership Secretary, AAGBI.
they do but you should do the work that you are paid for..." was stressed. He also encouraged all to use Dr Bayly’s matrix/grid (previously published in Anaesthesia News—September 09) to aid in describing the non-clinical activities they are engaged in within their trusts.

This theme was continued by Dr David Whitaker who spoke about “Job planning—pitfalls and successes”. Job planning is about objectives and the SPAs that are required to deliver them. It is essential to agree these objectives each year and the work programme to deliver them. Dr Les Gemmell, the Hon Secretary, updated the meeting on the EWTD under the heading “how was it for you?” He set out the history of the EWTD in detail and where we are today including the opt-out issue. This was followed by a talk from President-elect Dr Iain Wilson on manpower issues. He started by staying he would pose more questions than answers. He reviewed the manpower calculations made over the past 10 years and their reliability. In 2002 a shortage was predicted i.e. insufficient output to achieve the 8,500 consultants needed for a consultant-delivered service. Two projects arose from these calculations, the first to increase the numbers of trainees and the second the Physician Assistant Project. He then discussed the pros and cons of a sub-consultant grade—and gave us lots to think about and discuss.

The next item was the Clinical Excellence Awards (CEA) scheme. The President, Dr Dick Birks, gave an update and reported on the meeting he had with Professor Jonathon Montgomery who is the Medical director of the CEA Scheme. Discussions concentrated on the relative position of anaesthetists in comparison to other specialties at gaining CEA’s. There is already awareness that anaesthetists fare badly but this situation is now being reviewed. The good news from the 2008/9 round was that anaesthetists got 38 bronze awards compared with 26 the previous year. All anaesthetists should apply every year and must ensure that there is appropriate anaesthetist representation on the local awards committee. ACCEA are going to publish some of the ‘personal statements’ which have been successful. Dr Birks offered useful tips e.g. fill in the forms carefully having read the latest ACCEA guidance and complete all five domains. There followed an excellent presentation from Dr Henry Robb on the Scottish CEA scheme highlighting the similarities and differences.

Following lunch came the session on Independent Practice. Dr William Harrop-Griffiths gave an excellent update on the thorny issue of AXA-PPP and the various measures taken by the AAGBI on behalf of its members on this issue. William re-iterated his message to all i.e. they should read the 2007 AAGBI publication on the Voluntary Code of Practice on billing private patients. He encouraged us all to deal directly with patients in a manner which is open, honest and legal. Dr Whitaker continued with the parity theme giving excellent practical advice to all Linkmen.

The next session was on challenges facing us all in the near future. The first was REVALIDATION and Prof Rob Sneyd who sits on both the AAGBI and RCoA councils, is in a good position to discuss this topic. He started by saying that both organisations are taking this extremely seriously but that it should not be threatening to individuals. He went on to describe a personal account of his voluntary trip to the General Medical Council’s Assessment Centre. This is a process only intended for 0.1% of doctors and costs ~£1,000 per person. He claims to have found the experience very fair but a little daunting. I believe he passed! He then introduced the concept of “Enhanced Appraisal” as a key element of revalidation. This is an evolving process but he speculates it will involve all the elements of the present appraisal system plus new questions and perhaps some specialty specific ones. Again it appears that ‘core’ CPD will be expanded and Multi-Source Feedback (MSF) will be introduced. Revalidation will occur through the RCoA and Prof Chris Dodds has been leading on Revalidation at the college. A CPD draft ‘Matrix’ with three levels has been introduced. At CME meetings in the future the programme will be coded according to the Matrix to help you prepare for enhanced appraisal. The revalidation process will be ROBUST and must be completed over a five-year cycle to retain a Licence to practice medicine.

He then spoke about MSF and again our brave Prof Sneyd gave his personal experience as he had volunteered for MSF in his trust and found it a very fair system. On the question of which MSF to use it may be OK to use a generic MSF tool from a particular company PROVIDED that anaesthetists are compared with a clinically relevant group of comparators i.e. other anaesthetists. Finally he discussed the concept of the “Responsible Officer”. A person, either a Medical Director or not, definitely someone who is clinically active, who will act as an outpost of the GMC in your trust and will engage with this process. This is still being debated in the Department of Health so watch this space. It is important that we engage in the shaping of this process and insist that it is carefully piloted and sympathetically introduced. It must start slowly and not be threatening.

The next speaker got the prize for most dramatic entry. It was of course our Honorary Secretary, Dr Andrew Hartle wearing a surgical gown, gloves and a fit-tested FPP-2 Mask!! Yes, he was giving us an update on Influenza A (H1N1). He claimed the regalia to be most uncomfortable but persisted for dramatic effect. His excellent talk discussed the evolution of a pandemic and the effect on the Intensive Care bed capacity. The problem is that these patients present with profound refractory hypoxaemia and need very intensive one-to-one nursing and LEVEL 3 facilities. He stressed, as if talking to managers, that ventilators DO NOT equate with ITU beds! The implications for anaesthesia are decreased elective work, and re-rostering. What are the risks to us the anaesthetists? The H1N1 virus poses less of a risk than SARS and there is yet little information about health care workers contracting H1N1. We must remember though that there were no reports of healthcare workers who wore gloves, gowns and had high efficiency masks
contracting SARS. Intubation is the single highest risk activity in terms of contracting the virus.

Dr Isabeau Walker from Great Ormond Street Hospital discussed ‘How to introduce the checklist sensibly’. She gave an update on the Safe Surgery Save Lives (SSSL) project and then the MPSA version. The latter addresses critical points in the patient journey through theatre where patients can come to harm. The MPSA has taken up the introduction of the Checklist with great enthusiasm with all trusts expected to have a Clinical Lead to introduce it by February 2010. The aim is that the Checklist is completed for every patient and the use of the Checklist recorded in the notes. Isabeau highlighted the unanticipated problems and challenges which arose in the Great Ormond Street whilst introducing it and how they managed them. A change in culture around how we work in the operating theatre must be achieved. It helps to identify enthusiasts, and although the nurses can have ownership of it, the process will only happen if the clinicians lead it. In summary the Checklist is an evidence-based intervention which will make a major contribution to team work and non-technical skills in our operating theatres and will ultimately improve patient safety.

There followed a very lively Question and Answer session where questions submitted by the Linkmen were discussed in detail. We learned a lot about what is happening across the country and identified shared anxieties and issues for further work.

Although a little fatigued we all headed to the Pan Am Restaurant in the Albert Dock in Liverpool to continue our deliberations in an informal setting. It was my first meeting as the Honorary Membership Secretary and Linkman coordinator and I felt it was a privilege to meet the linkmen who are so active in the AAGBI. I encourage all Linkmen to get involved and to contribute to AAGBI on behalf of your colleagues.

AAGBI strategy is set by Council but informed by the opinions and needs of our members. The Linkman system is our most important channel for communication and consultation and one that we greatly value. We are keen to strengthen the system and make it more inclusive, especially at a time when external activities are under scrutiny by trusts.

To this end we have developed, in consultation with our Linkmen, a draft ‘Charter’ that defines what the Linkman can expect from the AAGBI and what the AAGBI might reasonably expect from them. We hope that this will clarify the Linkman role and assist engagement with line managers when discussing job plans, appraisal etc.

We are writing to all Linkmen to ask if they are willing to continue as Linkman on the basis defined in the Charter. If a Linkman indicates that they do not wish to continue in the role or does not respond we will approach the Department and ask them to nominate a replacement.

At the AAGBI we value our Linkmen and their contribution. We are striving to improve the scheme and hope that, by implementing this Linkman Charter, we will strengthen and improve our relationship with our members in the future.

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As a few of you may be aware, Scotland (that’s the bit at the top of the weather map) is a bit of a hidden gem. There are many benefits to living and working in Scotland. As well as Westminster and tears (sic) of local government we have our very own parliament. In fact in some parts of the country you can’t spit your gum onto the pavement without hitting a politician of some sort (and they say they don’t get feedback!). All this in true Scottish style is paid for by people in England – specifically Col. Angry of Tunbridge Wells. [D. Teleg. 12, (Jun 5, 2008)].

Lifestyle verges on the idyllic. We have electricity now and TV and running water – so plentiful that we have it running down the backs of our necks. No one knows what a hosepipe is let alone why they should be banned, though I gather there are other parts of the country where the water shortage has recently been somewhat alleviated. Clean air? There’s virtually no pollution since the last dregs of industry were removed in the 1980s. Yet despite this our economy is thriving. While most countries’ economies are in the red we apparently retain a black economy. Health is improving too: young people’s obesity levels are set to fall as the planned Gaelic language TV comes to dominate output, children will, albeit out of frustration, heed the advice of their parents to “Go play in the traffic!” (Yes, people do have cars, though not necessarily their own). All the big cultural activities are here too: Ikea, Gap, Waitrose, even Harvey Nick’s. So life in Scotland is indeed a bed of roses.

What of work? The NHS in Scotland has avoided many of the radical changes seen South of the Border. Instead it retains the charm of a grand Edwardian country house hotel - like Gleneagles without the golf. Gleneagles is run by Diageo, the NHS by the Scot Nats. Each has an equal regard for their responsibilities to communities and the welfare of their people: neither would consider setting aside such values in cynical pursuit of their own narrow benefit. Such old fashioned values continue in relations between NHS management and staff in Scotland. Decisions are taken in Partnership. Nicola Sturgeon, our Health Minister, likens that partnership to the relationship between a lorry cab and its trailer. I’ll leave you to work out who’s in the cab and who follows slavishly in its wake. Take the consultant contract: they just have. As an example of partnership in action this takes some beating. Unilaterally reinterpreting the contract so that now all new consultant jobs have nine direct care sessions to one SPA. Yet with an excess of CCTs there’s no shortage of applicants. This single SPA session is to cover appraisal, revalidation, personal audit, professional development, teaching and educational supervising, research, emails and letters, advising on or reading policy documents (ver. 7) and study as well as crosswords etc. With such incontrovertible proof that time does indeed appear to expand to an observer close to a body of extreme density, the Scottish Government has surely shown that Einstein was right. It will be interesting to see how many hip replacements can similarly be squeezed into such a Sturgeonian DCC session.

Well even Einstein must have stopped for lunch, sorry probably nearer afternoon tea by now. The take home message is clear – if the chaos of privatised healthcare is getting you down, if you’re one of Sally Traffic’s regular informants – move to Scotland and join our quest to unravel the mysteries of time and space. Is all the Dark Matter hiding in Edinburgh? Was it not this Athens of the North that gave us Voldemort? What are the schools like in your area?

Steve Lawrie
The NHS buzzword for 2010 is going to be “efficiency”. The Government has poured many billions of pounds into the NHS in the last 13 years. Much of this money has been spent wisely in treating more patients. Sadly, a large amount of it has also been squandered on management consultancy fees, the multiplication of middle managers and lining the pockets of investors in private companies that have earned millions from operations done badly – or indeed not at all – in ISTCs. This increased NHS spending sadly coincides with the huge increase in national debt occasioned by the Government’s response to the Credit Crunch. Whatever the cause of the financial crisis (I am assured it was the bankers’ stupidity and base, venal greed), the result is rapidly becoming evident: UK public sector workers (that’s you and me) will be helping to repay the national debt by foregoing pay rises while also giving the exchequer more money in the form of taxes. Meanwhile, the NHS will be asking for greater “efficiency” from its employees. Already, managers are putting pressure on anaesthetists to increase the number of Direct Clinical Care (DCC) PAs in their contract at the expense of SPAs. I was discussing this my chum Nobby while we sat in the theatre coffee room one Monday morning at about 10.15 am. We had a bit of time on our hands because we were still waiting for our first patients to arrive in theatre. There we were, two of the best-paid consultants in the hospital, once again suffering a protracted period of frustrating and inefficient idleness because the Admissions Lounge had descended into its usual Monday morning cauldron of cacophonous chaos that makes the Tower of Babel seem like an example of excellent communication. What can be done about such an abject waste of time and money? Have no fear - help is at hand! The NHS Institute for Innovation and Improvement has produced a programme called “The Productive Operating Theatre”. Arguably the best bit about it is its acronym: T-POT. The website is well worth a visit if you have an idle aeon between cases: (http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_operating_theatre.html). Excited by how a box of six lavishly illustrated, ring-bound pop-up books (this is what you get sent if you sign up for T-POT) could drive such far-reaching changes, I pored through the documentation. Within seconds, I felt the usual wave of nausea that sweeps over me whenever I encounter management-speak that subverts the English language: the T-POT process starts with a “Visioning Workshop”. My enthusiasm crumbled to dust. Later in the book, you are told of the importance of cleaning the sluice room as a key way of making the theatre productive. This cleaning is the “Shine” component of the “five S’s”, the others being Sort, Set, Standardise and Sustain, although I could suggest another word beginning with S that would be readily found in a sluice room and would have just as much of an impact on theatre efficiency.

Although I am sure that T-POT will serve to make some dysfunctional operating theatre suites a little more functional, and will at least give senior nurse managers something to fill their day, I have considerable reservations about whether it will make any real difference to theatre efficiency. It certainly would not have stopped Nobby and me having to stare at the coffee room ceiling for two hours while patients were dragged from the Admissions Lounge. As a result of our discussions, we have come up with our version of T-POT – we call it B-FORE: the B****es-Free Operating and Recovery Efficiency toolkit. It is completely devoid of Visioning Workshops and no shelf-shining is required. Key points include:

- Put a senior anaesthetist and theatre nurse in charge of the whole shebang. Give them complete authority and their own office with comfy chairs and a secretary with an IQ in treble figures.
- Tell the surgeons they have to get their lists in before 16.00 h on the day before surgery or they lose the list. Enforce this diktat with absolute ruthlessness in spite of all the whingeing that it will generate.
- Always schedule a long procedure first on the list and admit the patient the night before, thereby guaranteeing a prompt start.
- Tell the surgeons that 8.30 am is the knife-to-skin time, not the saunter-up-in-a-pinstripe-suit-clutching-a-skinny-latte-and-chatting-to-colleagues-time.

There are many more pearls of wisdom in B-FORE, but space does not permit me to detail all of them. They are simply a distillation of experience and common sense devoid of any management speak.

We would welcome contributions from...
What initiatives like T-POT fail to recognise is that most of the barriers to efficient working in the operating theatre are either external to the operating theatre or are controlled from outside theatre. If you don’t believe this, next time you are forced to stare at the ceiling while waiting for patients, write down the reasons and see how many can be solved by cleaning the sluice. However, greater efficiency could be achieved if clinicians with a broad understanding of how operating theatres and hospitals work, i.e. anaesthetists, were given managerial control over all the processes that directly affect the running of the theatres. Until this happens, there is no point whatsoever increasing DCC PAs at the expense of SPAs. This will simply decrease the quality and safety of patient care while creating a group of rightly resentful consultants. The barrier to greater efficiency in NHS hospitals is not the number of consultant anaesthetist working hours. If you are asked by your managers to increase your DCC PAs in the interest of “efficiency”, politely refuse and offer to show them how greater efficiency can be achieved without paying management consultants, playing with pop-up books or compromising patient safety. Tell them that if they want to know about how to achieve efficiency, they should ask an anaesthetist.

Best wishes,
Victor
The site of action (peripheral and/or central) is still debatable and there are several potential mechanisms. Paracetamol is a substituted phenol (para-acyl-amino-phenol) and acts as a reducing agent converting both the COX enzymes (1 and 2) from active oxidized form (Fe³⁺) to an inactive resting form (Fe⁴⁺). Inhibition of prostaglandin synthesis remains the main putative mode of action. This action, in turn, is inhibited by peroxides which explain why paracetamol is not active at peripheral sites of inflammation where concentrations of peroxides are high. Paracetamol selectively inhibits COX in the CNS, explaining its anti-pyretic effect.

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The authors describe recent findings supporting the ‘self-synergistic’ interaction between spinal and supraplalinal sites by activation of descending opioid pathways. Other proposed mechanisms for the analgesic actions include activation of serotonicinergic bulbospinal pathways, involvement of nitric oxide pathways and an increase in cannabinoid tone.

Paracetamol-related hepatotoxicity is well known to all of us. This article stresses that within the recommended dose (1g 6 hourly), there is no evidence of hepatotoxicity even in patients with chronic liver disease.

Recent investigations have revealed that the combination of paracetamol and warfarin is not as safe as is generally thought. A significant increase in the international normalized ratio (INR) with reduction in vitamin K-dependent clotting factors has been observed. Also, since paracetamol is metabolised by glucuronyl-transferase enzymes, the possibility of drug-drug interactions cannot be ignored. However the anti-aggregatory effect of paracetamol alone is not clinically relevant with regards to postoperative surgical bleeding.

This article supports the use of intravenous paracetamol, due to its bioavailability and faster onset. A loading dose of 2 g i.v has been found to be superior in magnitude and duration of action compared to 1 g i.v without any increased side effects. In the postoperative period, combination of paracetamol with PCA (patient controlled analgesia) morphine induced an opioid-sparing effect of 20% but there is no change in the incidence of opioid related adverse events. However, oral combination of paracetamol with codeine, tramadol and oxycodone seems to optimize efficacy and tolerability.

There are still considerable gaps in our understanding of the actions of this ubiquitous drug. Work is continuing. Watch this space....

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2009 European Guidelines on Perioperative Beta Blockade

Cardiac events are the primary cause of perioperative morbidity and mortality in non-cardiac surgery, and risk reduction is of utmost importance. The specific issue of whether perioperative beta-blockers reduce cardiac risk in non-cardiac surgery has been very controversial in the past few years with apparently conflicting data derived from two large clinical trials, POISE [1] and DECREASE-IV [2].

In 2009 the European Society of Cardiology issued their first ever guidelines on the management of cardiac risk in non-cardiac surgery [3] and likewise the American College of Cardiology and the American Heart Association have released an update (published online on 2/11/2009) on their 2007 guidelines on the perioperative use of beta-blockers for non-cardiac surgery [4]. The main focus of these updated guidelines is when and how to use beta blockers perioperatively.

The recommendations can be summarized as follows:

1. For patients who are already on beta blockers for the treatment of conditions with ACCF/AHA Class 1 guideline indications, beta blockers should be continued.

2. For patients who are undergoing vascular surgery and intermediate risk surgery, who are identified as having high cardiac risk owing to coronary artery disease, cardiac ischaemia or as defined by the presence of more than 1 clinical risk factor (history of ischaemic heart disease, history of compensated or prior heart failure, history of cerebrovascular disease, diabetes mellitus and renal insufficiency [creatinine > 2mg/dl]), beta blockers titrated to heart rate and blood pressure are reasonable and probably recommended.

3. For patients with a single clinical risk factor in the absence of coronary artery disease who are undergoing either intermediate risk procedures or vascular surgery and patients undergoing vascular surgery with no clinical risk factors who are not previously on beta blockers the usefulness of beta blockers is uncertain.

4. Beta blockers should not be given perioperatively to patients who have absolute contraindications to beta blockade.

5. Patients who are beta blocker-naive undergoing non cardiac surgery should not be given high dose beta blockers in the absence of dose titration as this may be harmful.

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References


