The NHS at 60

Art wanted for Torquay!
Paediatric Intensive Care Medicine
ANNUAL CONGRESS
TORQUAY • RIVIERA INTERNATIONAL CONFERENCE CENTRE
17–19 SEPTEMBER 2008

Three parallel streams of didactic lectures
Scientific sessions, current issues and update sessions
Workshops on Difficult Airways, Ultrasound, Thoracic Epidural, Education and more
Eponymous lectures
Keynote speakers
A social programme including partner tours
Annual Dinner
Satellite symposia and Industry Lectures
Extensive trade exhibition

Further information:
www.aagbi.org/events/congress.htm
or contact the events dept 020 7631 8804/03/62

BOOK YOUR PLACE NOW!
The British National Health Service (NHS) came into being on the 5th July 1948. It was introduced by the postwar Labour government which had been elected in 1945, immediately after the end of the Second World War (1).

It is however often forgotten (sometimes conveniently) that the emergence of the NHS was the culmination of a long process of deliberation and legislation concerning possible universal provision for the health of the nation, in which all political parties were involved. The process can be dated back to the Liberal government’s Lloyd George Insurance Act of 1911. A Medical Planning Commission, including politicians of all shades of opinion and representatives of the Royal Medical Colleges and the British Medical Association was set up in 1940. It reported in 1942 during the darkest days of the War, and proposed many of the features that were incorporated subsequently into the NHS. The milestone report of the Liberal academic economist Sir William Beveridge in the same year advocated a health service “free at the point of use”. The spadework of planning for the postwar health service was begun by the wartime health service was begun by the wartime coalition government of all political parties under Winston Churchill, in particular by his
Conservative Health Secretary
Sir Henry Willink.(1)

The concept of the hospital service of the NHS was foreshadowed by the wartime amalgamation of the independent voluntary hospitals and the local government municipal hospitals into a combined Emergency Medical Service (EMS) with a unified “sector” (regional) structure. Patients paid what they could afford in the voluntary hospitals. The members of the senior medical staff of voluntary hospitals were honorary and relied for their income on patients treated from their consulting rooms and in hospital private wings and nursing homes. The local authority municipal hospitals were free to the patient and the senior medical staff were salaried. However, in the EMS, this difference in senior staff remuneration between the two groups of hospitals continued throughout the Second World War until the inauguration of the NHS in 1948. Then senior voluntary hospital medical staff became adequately remunerated as Consultants for their hospital work but, as a concession, retained the right to practice privately in addition.

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) fought hard and ultimately successfully to ensure that qualified anaesthetists were graded as Consultants, and not in the sub-consultant grade of Senior Hospital Medical Officer (SHMO). The promotion by the AAGBI of the establishment of the academic Faculty of Anaesthetists of the Royal College of Surgeons, and the subsequent upgrading of the Diploma in Anaesthetics (DA) to Fellowship standard, was necessary to the successful outcome of that struggle.(1)

The present author did the bulk of his medical training before the inauguration of the NHS in July 1948, passed his final examination at the end of the year and, there not being any requirement for a probationary pre-registration year in those days, became a fully registered medical practitioner early in January 1949.(2)

It must be remembered that medicine was much simpler and much less specialised at that time. For example, there were only three limb leads used for the electrocardiograph, except for a mysterious single chest lead known only to cardiologists. Penicillin had only comparatively recently been released for general civilian use, after successful use in military medicine since 1942 (and then only by painful injection). The only other antibiotics were the sulphonamide group. Streptomycin was under trial as the first available antibiotic for tuberculosis. (1,2)

Medical students also undertook many more tasks than they are permitted to do now. These sometimes included very essential procedures, notably and rather surprisingly, the ABO grouping of patients and the cross matching of donor blood on a white tile (the importance of the Rhesus factor became known in the 1940s, but its assessment was only regarded as necessary in obstetric practice for a number of years thereafter).

In fact I administered my first solo anaesthetic as a senior medical student about the time of the NHS Appointed Day in July 1948. It was the practice for all students to spend a month training with the Anaesthetic Department before proceeding to the obstetric training module. This was intended to allow for the possibility that the medical student might be called upon to act as an anaesthetist in an emergency; specifically in one of the isolated obstetric units.

Undergraduate clinical training was comprehensive and practical. It had to be before the advent of the NHS because many General Practitioners practised domiciliary obstetrics, and others undertook surgery and anaesthesics, particularly in hospitals in smaller towns or rural areas. After the inauguration of the NHS, GPs who actually held specialist diplomas from one of the Royal Colleges generally became Consultants in the new service, and those that did not, however experienced, thereafter confined themselves to general practice. It could be said that the objective of undergraduate clinical training was to turn out a Registered Medical Practitioner capable of practising and acting in any emergency as a ship’s doctor (before the advent of helicopter evacuation), or in a similar isolated situation.(1,2)
that had been developed to provide an alternative to domestic delivery in a wartime London liable to suffer air attack. One evening in such a unit in the old London Fever Hospital in the East End, I was administering intermittent 50% nitrous oxide and oxygen from a Boyle’s machine to a labouring mother as a general analgesic, and talking to her as reassuringly as I was able, while the Senior Resident Obstetrician was guiding the delivery of twins with the patient in the lithotomy position. The first baby presented as a breech. The buttocks and body emerged smoothly but, suddenly the chin of the first baby locked with the oncoming chin of the second twin which was presenting as a vertex. The result was a highly dangerous situation. Almost providentially the Consultant Obstetrician in charge of the unit put his head round the labour room door at this moment. He had no reason to be in the vicinity, but told us later that he had just looked in on his way home “to see what was going on”. “Get the patient deep,” he said, without any attempt to ascertain the status of the potential anaesthetist. With the impetuosity of youth I thrust the lever of the ether Boyle’s bottle over and pushed the plunger down so that the nitrous oxide and oxygen mixture bubbled merrily through the ether. I put the mask firmly on the face of the patient and told her to breathe. She gave one cough and then breathed deeply and then fortunately took this powerful anaesthetic smoothly. The Boyle’s bottle was an uncalibrated vaporiser, but I reckon that possibly in excess of 20% ether must have been delivered initially. The pelvic muscles of the patient were certainly rapidly relaxed! The Consultant obstetrician completed the delivery with great skill. He pushed up the head of the second baby, completed the delivery of the first, and then extracted the second twin with forceps. Both babies were pink and breathed well but were rather drowsy, as was often the case when ether was administered to a mother, but they cried lustily within a few minutes. What a wonderful and safe anaesthetic ether was! If only it had not been flammable. In the aftermath of the case, when everybody was well pleased with themselves, I was congratulated on my anaesthetic. However, I was not yet minded to take up anaesthesia as a specialty.(2)

Tom Boulton

Next month – the 1950s, National Service – and why Tom chose anaesthesia

References


It’s holiday time!

“NHS Boards are required to... set challenging local targets for their inpatient, day case, and outpatient services. They will demonstrate the progress which each Board is expected to make in reaching and then exceeding our national guarantees.”

“Hospitals should monitor and review the cancellation of theatre sessions and operations. Targets should be set to reduce cancellations where these are at an unacceptable level. It is recommended that a theatre session should only be cancelled following consultation with a designated director, and specific protocols should be in place for action following the cancellation of a theatre session by a hospital.”

Extracts from “Managing Waiting Times – a good practice guide” (SEHD publication)

“Parental leave is ... aimed at encouraging a culture of flexible working practices to allow all eligible employees to balance family and work commitments...

...The principle of the legislation is to allow staff with parental responsibilities to spend more time with their children and to enable them to strike a better balance between their work and family commitments.

The legislation entitles parents to access 13 weeks unpaid leave ... Within (name of Health Board) we have agreed to allow parents to receive normal pay for the first four weeks of parental leave.”

Extract from policy document of a Scottish Health Board.

When you read this, Scottish schools will have just broken up, and we’ll be in a peak demand period for leave. This year, we are all under greater pressure than ever before to meet waiting time targets – in many hospitals at the moment it means “Thou shalt not cancel any list”. The problem we have is that anaesthetic presence is (usually) an all-or-none factor governing whether a theatre is available for any given session. Surgical colleagues can go on leave, but in many hospitals now this does not mean the session is cancelled – pressure on theatre time means another surgeon will generally pick it up. So there is no “spare” anaesthetist to fill in elsewhere. If an anaesthetist goes on leave and there is no flexibility, the session is lost, which upsets the number-crunchers. Enormous pressure is being applied to anaesthetic departments not to cancel sessions. Another solution is for a trainee to do the list, but at peak leave times this can result in consultant supervision being spread very thinly indeed. A few years ago, NHS Scotland was the first to highlight the issue of the “named consultant” anaesthetist for every patient, a subject the AAGBI has grappled with in the past. Most anaesthetic departments fudge together some sort of solution so that peak holiday periods can be managed, but one of the options, session cancellation (even done in a timely manner) appears to be becoming unacceptable.

Add to this the introduction of paid parental leave which is a huge talking point in Scottish hospitals at the moment – with, as you might imagine, a wide spectrum of opinion. I am childless, so am firmly in the “anti” camp – though not as vehemently opposed as those whose children are now too old for them to qualify! For those of you unfamiliar with the background to this, Government legislation introduced in 1999 gave parents
the right to thirteen weeks unpaid leave (in total, not per year) for each child up to their fifth birthday. Implementation seems to vary, but NHS Scotland has recommended this should extend to children aged fourteen and under, and four of these weeks should be paid. This is over and above maternity/paternity leave provision, and is in addition to provision for “emergency” time off if your child is sick or an unforeseen childcare issue arises. Scottish Health Boards are in the process of introducing this, with varying degrees of urgency, and my child-encumbered colleagues are busy filling in application forms.

So – we have people seeking the additional leave to which they are entitled, and when do they want it? During the school holidays, which are already the pinch point in any anaesthetic department. It’s not the first time two separate health service initiatives have had mutually incompatible aims, but it’s one with great impact at the coalface.

Of course, all health service departments will have to reconcile these issues, but anaesthetics has a greater problem than many. The expansion of the specialty over the last ten years means we have a relatively young consultant workforce, so a greater number will have young offspring – I reckon there are over thirty qualifying children in our medium-sized department. That comes to over two years of paid consultant leave – in financial terms, a quarter of a million pounds, give or take. One department, in one hospital. If all my colleagues also opt to take the unpaid leave, we have an additional eight years’ worth of sessions to cover or cancel.

The major impact of this is going to be felt in the next few years as the introduction of the leave is not pro-rata. If your child is thirteen-and-a-half, you are still entitled to the full amount, which you need to use before your child is fourteen, or you lose it. Rota co-ordinators all over Scotland are bracing themselves for a blizzard of parental leave requests over the next few years as the parents of older children get their leave in before their children are disqualified. Presumably after a few years this will settle down and the demand will be more spread out, but it is unfortunate this peak will occur just at the very time there is maximal pressure to drive down waiting times.

There is a degree of angst among those who are not entitled to it. There’s a feeling that leave is already available for both parents when there’s a clear reason for it – maternity/paternity/adoption/emergency childcare – so why do parents need additional leave? In any system where the workload cannot be controlled to match the staff available, somebody has to pick up the slack. The BMA will tell you that parental leave is not covered by existing prospective cover arrangements, and extra payment should be available. As anaesthetic departments work as a team to provide a service, it’s a bit more subtle than that. If a consultant spends a daytime session covering four trainees instead of one, how is that measured? And more importantly, are quality and safety being maintained by a service provided in this manner?

However, parental leave is here, so whether it’s fair or not is not the issue. So read again the two policy document extracts at the start of this editorial, and see if you can reconcile them. This is a huge issue for the whole of the Health Service (think of your theatre nursing staff, and all their offspring) – currently affecting Scotland, but no doubt coming soon throughout the Union, and it isn’t going away. If you have the answer, please let my department rota runner know what it is!

July 1948 marked the foundation of the NHS, and while the organisation we work in now would be unrecognisable to its founding fathers, its sixtieth anniversary is something to mark. Tom Boulton has written a special article about his experiences of the early years of the new NHS which will be published in Anaesthesia News over the next two issues. I wonder what the NHS (if it exists) will look like in another sixty years - will our successors look back on the early 2000s as a halcyon time?
WSM LONDON
14-16 January 2009
QEI1 Conference Centre, Westminster

NOT TO BE MISSED!

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

For further information visit www.aagbi.org/events/wsm
DINGLE “X”

10th current controversies in anaesthesia & peri-operative medicine, dingle, co kerry, Ireland
8-12 October 2008

www.dingleconference.co.uk
REGISTER NOW!

British Society of Orthopaedic Anaesthetists
13th Annual Scientific Congress
Lancashire, Friday 7th November 2008

CALL FOR ABSTRACTS
We invite you to submit work for poster presentation. In addition, selected finalists will be invited to give an oral presentation at the Congress on November 7th 2008. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 5th September 2008. Abstracts should be emailed in the form of one A4 side of printed text in ‘electronic form’. Word or PowerPoint, on or before 10th September marked clearly with your name, address, telephone number and email address. Presenters will be required to register for the Congress.

2008 Congress Chair: Dr Matthew Freyne
Email: bsoaCongress@btinternet.com

PERI-OPErATIVE MEDICINE

FIRST ANNOUNCEMENT & CALL FOR ABSTRACTS

(INCLUDING CASE STUDIES & EXAMPLES OF BEST PRACTICE)


We invite you to submit work for poster presentation. Accepted abstracts for poster presentation are entitled to a 15% discount on registration (1 author only and can not be used in conjunction with any other discount) and selected finalists will be invited to give an oral presentation at the 2009 EBPOM Conference. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 30th April 2008. Abstracts should be emailed in the form of one A4 side of printed text as an attachment in Word or PowerPoint marked clearly with your name, address, telephone number and email to Admin@EBPOM.org

All presenters, both poster & oral, must register for the conference to present their work. MEETING CHAIRMEN Dr. Mark Hamilton and Professor Monty Mythen
My report on the 2007 Art Exhibition started with an eye-catching title that included the word rabbit. I thought that if I used a title that is unusual for *Anaesthesia News*, I might persuade a few more people to read my article. I am uncertain whether this ploy was successful. But, the article did provoke a much better response than usual which is why this article also has a title that includes rabbits! As a result I have three new exhibitors promising work for the 2008 Exhibition. I cannot tell you how delighted I am. The Exhibition needs new exhibitors to ensure its vibrancy and continuing interest.

Before I write about the Exhibition - a few words about the Christmas card competition. Last year, Aleksandra Bojarska’s wonderful watercolour painting was chosen. It was a huge success and shows that you can be imaginative. Robins or snowy landscapes might get chosen, but alternative subjects are even more likely to succeed. I find it hard to say what attracted us to Aleksandra’s painting. It just felt right! So let your imaginations fly and this year, it might be your image on the card.

In previous years I have stressed that absolutely everything is welcomed and accepted for the Exhibition, no-one is ‘not good enough’ because the range of delegate’s tastes means that almost everyone has at least one supporter. Finally, the Exhibition is only as successful as you choose to make it. I was absolutely delighted to read Hilary Aitken’s January 2008 Editorial in which she confessed that the Exhibition is always the first stand that she visits. I suspected that a lot of people make a beeline for the Exhibition but until now, the evidence has been lacking!

Before I list the Exhibition’s minimal rules, I would like to acknowledge a few of the people who have exhibited in the past. There are the regular enthusiasts, many of whom are retired and talented artists who want the Exhibition to continue. Most exhibitors are anaesthetists. But the work of friends and families is always most welcome. In 2006, the Ross clan of Aberdeen, led by Donnie, set the standard. His nieces gave me some superb contributions and their father, Iain, helped to hang the Exhibition. Jenny, his sister-in-law and an anaesthetist herself, has transported Donnie’s Exhibition contributions over many years as have colleagues from the Aberdeen department. They are not alone. Considering that one has to bring a variety of clothes to the Congress (scruffies for relaxing, smart for events and woolly for keeping warm in wind-swept seaside towns), I am constantly amazed at how many generous people devote an entire suitcase to transporting their own or colleague’s exhibits.

Many trainees attend the Congress but it is rare for them to exhibit.
Last year was special because Imelda Galvin and her husband TC Choo not only contributed some wonderful paintings but also, Imelda was our first trainee winner of the coveted AAGBI medal. Last year, for the first time, I showed the work of two medical students, Matthew Gwinutt and Jennifer Thorburn. Both did attachments at my hospital and I have high hopes that they are future recruits to our specialty. In the meantime, it was wonderful to discover that they have artistic talents and are keen to support the Exhibition.

Friends come in many forms but in 2004, we exhibited a painting from a friend who turned out to be a surgeon! I have high hopes that this article will produce work from more friends. I am completely unbiased and contributions from surgeons would be welcomed. I am hoping that in 2008, an ODP from Torquay will let us show his paintings.

Do you have a talented friend (even if they are a surgeon)? Please encourage them to support our Exhibition!

The rules are simple – there are none!

- I accept everything I am offered
- There is no restriction on what is art. Paintings, photographs, drawings, cartoons, jewellery, stained glass, sculpture, wooden bowls, greetings cards, painted plates, CD slide shows, a beaded door curtain and a coffee table have featured previously but I am always open to alternatives. Poetry has been promised but has so far not materialised!

- All that is necessary is that I can find a means of showing an exhibit to its full potential
- No-one is too amateur, too new to their art form or ‘not good enough’
- There is no size limit provided you can deliver your exhibit to me at home, Portland Place or the Exhibition itself.

In summary, I am immensely grateful for anything you would like to give me. I am willing to provide help with mounting images, transport or anything you want. Realistically, September 12th is the last date for exhibits to arrive at my house if you want me to mount them. If you need any advice or help please contact me (anne.sutcliffe2@btinternet.com) or Julie Gallagher at the AAAGBI. This is my last year as curator of the Art Exhibition and I would like to retire with the knowledge that I have created another Exhibition that has given pleasure to hundreds of delegates.

Anne Sutcliffe

Editor’s note: sales of the AAGBI Christmas card raised over £1000 for the Overseas Anaesthesia Fund.
The Anaesthetists Agency

4TH NATIONAL ANAESTHESIA RESEARCH MEETING (NARM)
organised by
THE ANAESTHESIA RESEARCH TRUST
16 - 17 October 2008
Stratford Manor Hotel, nr Stratford upon Avon, Warwickshire
International Keynote Speakers
Workshops
Abstracts invited: Research, Case Reports and Audit
Poster and Oral Presentations
4th Annual Networking Dinner
Informal, friendly, informative and fun
Contact the conference organiser, breathingspace at:
NARM@breathingspace.uk.com
tel: 08453 880037
FULL DETAILS OF THE CONFERENCE AND ABSTRACT SUBMISSION CAN BE FOUND ON THE ANAESTHESIA RESEARCH TRUST WEBSITE AT:
www.anaesthesiaresearch.org.uk

safe locum anaesthesia, throughout the UK

Freephone: 0800 830 930
Tel: 01590 675 111
Fax: 01590 675 114

Freepost (SO3417), Lymington, Hampshire SO41 9ZY
e-mail: info@TheAnaesthetistsAgency.com
www.TheAnaesthetistsAgency.com
Managing your Management Competencies

Now that competency based training has become firmly established, Anaesthetic Specialist Registrars (SpRs) are required by the Royal College of Anaesthetists (RCoA) to obtain competencies in the “Development of Professional Knowledge, Skills and Attitudes” as part of their training.

As the consultant job market becomes increasingly competitive, it is now an essential requirement for senior anaesthetic trainees to complete all our competencies prior to job application. The majority of the required clinical competencies are quite straightforward to achieve during routine clinical practice and accompanied lists. What are more difficult to achieve are the non-clinical competencies laid down in the RCoA competencies handbook. Within this category are the Professional Knowledge competencies which the RCoA have suggested as a minimum requirement. I include the management competencies in this category and clearly it is not enough just to have taken part in rota-writing activities. Achieving such competencies can be problematic, time consuming and costly, especially with the ever increasing burden of service provision within our rotas.

The required competencies are provided in Appendix H of the RCoA CCT in Anaesthesia guidance, Book I, which is downloadable from the RCoA website. It is recommended that most of these objectives are achieved at senior trainee level, and there is further guidance in Book IV of this series, which deals with higher and advanced level training.

One can divide the requirements into two distinct types. The first includes those competencies that should easily be met at a local level. However, one can just imagine the look on the Medical Director’s face as ten anaesthetic trainees ask to spend two weeks shadowing. Such management competencies extend from the knowledge of terms and conditions of employment of medical staff, fitness to practice and equal opportunities, through to knowledge of roles such as the college tutor. In an ideal world, our own anaesthetic department and college tutor should be supportive in our attempts to acquire the appropriate management experience, even if it takes away availability for service commitment for a limited period of time. Some of the competencies are clearly more easily achievable than others. If difficulties are encountered in gaining time to achieve these requirements, then such problems should be raised at the annual Record of In-training Assessment (RITA), thus hopefully easing the path for future trainees.

The competencies clearly state that a trainee should attend a formal NHS Management course. Many deaneries offer locally based management courses but these are mainly generic and open to SpRs of all specialities. A number of commercial courses are run, both by independent companies and by departments of universities such as Keele and Manchester. The Group of Anaesthetists in Training (GAT) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI) have
previously run one day seminar courses covering some but not all of the aspects required. Anaesthetists in Management (AIM) also run day seminars at the AAGBI and hold an annual conference in November. These are specifically geared to addressing management issues faced by anaesthetists in day-to-day practice and, although aimed at consultants, are of interest to senior trainees. AIM also runs an annual trainees essay prize to encourage and promote the practice of anaesthetists in management.

To facilitate anaesthetic trainees, GAT and the AAGBI are launching a two-day management seminar course to be run at the end of this year with the aim that it will become the first choice for anaesthetic trainees looking to obtain their competencies and learn more about the national and local structure of the environment they work in. The seminar will be run over consecutive days and will be based on competencies from the RCoA list, particularly those more difficult to experience in the workplace.

This will be a unique seminar with the content aimed and directed at senior anaesthetic trainees in preparation for their consultant career. Costs will be kept to a minimum and the course will represent excellent value. Support in running the seminar is provided by AIM and will incorporate nationally recognised speakers. The seminar facilities and catering at Portland Place are excellent and with good transport links the central location should maximise the number of trainees able to attend.

I think it is important to emphasise that obtaining such competencies is not just a box-ticking exercise. New consultants are expected to participate fully in the running, management and development of today’s National Health Service. Indeed, time dedicated to this is recognised within job planning activities. Such commitments can range from a departmental level, for example taking responsibility for rota writing, to a role at hospital level such as a clinical director of the department, representing one’s colleagues within the hospital. Anaesthetic consultants have gone on to become hospital Medical Directors and a full range of opportunities exist at national level through organisations such as the RCoA, the Association of Anaesthetists (AAGBI) and the British Medical Association.

We look forward to welcoming you to Portland Place in November of this year.

Dr Michael Parris
Gat committee member and SpR, Oxford Deanery

References:
CCT in Anaesthesia I, RCoA (January 2007)
(http://www.rcoa.ac.uk/docs/CCTpti.pdf)
CCT in Anaesthesia IV, RCoA (January 2007)
(http://www.rcoa.ac.uk/docs/CCTptiv.pdf)
(http://www.aagbi.org/gat/publications/docs/gathandbook2007new.pdf)

Useful Websites
www.rcoa.uk
www.cmu-keele.org.uk
www.aagbi.org
www.aimgbi.org

ANAESTHESIA APHORISMS

Submitted this month by John Asbury, Glasgow, Andrew Williams, NE Thames and Yoav Tzabar, Carlisle.

Any pharmacological problem is easier to get into than out of.

Patients can be infected with a form of verbal diarrhoea which usually breaks out when you have lots of patients to see and little time.

‘A noisy airway is a bad airway’

Always thank the recovery staff member for patient information given while you are looking after the next patient, even if it seems useless; not doing so might inhibit them from providing life-saving information next time.

No one has ever died as a result NOT having an arterial line or an epidural inserted.

When ‘maintaining’ a patient, position yourself so that you can easily look up from your anaesthetic chart, and see in one glance the monitors, your IVI and the surgeons.

The longer the birth plan, the longer the labour.

14
The Mersey Weeks

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

FRCA Primary Course (MCQ)
Six Long Days of Intensive of MCQ Study & Analysis
Designed for Primary FRCA Candidates
Sunday 17th – Friday 22nd August

FRCA Primary Course (OSCE/Orals)
Seven Full Days
The Definitive OSCE/Viva Experience
Friday 26th September – Friday 3rd October

Mersey Selective Course
Lectures, Tutorials & MCQ Tests on the Basic Sciences
Suitable for Primary & Final (Revision)Candidates
Sunday 2nd – Friday 7th November

FRCA Final MCQ Course
Six Long Days of Intensive MCQ Study & Analysis
Designed for Final FRCA Candidates
Saturday 23rd – Thursday 28th August*

FRCA Final (Booker) Course
The Mersey ‘Flagship’ Revision Course for the Final FRCA
SAQ Practice – MCQ Papers – Lectures - Tutorials
Sunday 21st – Friday 26th September

For
Details
Assessments
Application Forms

WWW.MSOA.ORG.UK

* This Course starts on the Saturday and ends on the Thursday for the convenience of those wishing to attend
The FCARSI Final E&SAQ Weekend Course
Friday 29th – Sunday 31st August.
The Society was formed in 1996 at a meeting of collectors and museum curators and a steering committee set up under the chairmanship of John Kirkup FRCS. The Society’s first Honorary Secretary was David Warren MRCP who was the prime mover in conceiving and establishing the Society. He very sadly died at the age of 55 during the first year of the Society’s existence. It was a fitting tribute to his drive and enthusiasm that the Society survived this difficult start.

In the early days professional medical antique dealers were strongly represented, including several from the United States. Nowadays we have one or two members who deal in antiques but generally membership is spread widely amongst practitioners from various medical disciplines, nurses, veterinarians, collectors and museum curators. The only requirement for membership is an interest in historical medical equipment. Currently there are some 70 members, six of whom are anaesthetists.

The first meeting of the Society was held at the Royal College of Surgeons in London in April 1997. One-day meetings have been held twice a year since that time. The meetings have evolved to the following format: the presentation of some four papers during the morning session, lunch, then a museum visit with possibly another paper in the afternoon and finally an equipment identification session over tea. Recent venues have included the Jenner Museum in Gloucestershire; the Royal Devon and Exeter Hospital, Exeter; the Association of Anaesthetists in London; the Army Medical Services Museum at Aldershot; the Royal College of Surgeons in London; Manchester Medical School Museum; Glenside Psychiatric Museum, Bristol; the Charnley Research Institute, Wigan; Emmanuel College, Cambridge; Worcester Royal Hospital; and the Thackray Museum, Leeds.

A great strength of the Society is the expertise of individual members in their own specific fields. We all have some knowledge in our own specialties but it is particularly interesting to acquire a more general understanding of equipment and instrumentation. We maintain a list of members’ interests which is circulated to individual members from time to time. Annual subscription is £15. We come under the umbrella of the British Society for the History of Medicine.

The Society publishes its Bulletin twice a year. This contains an editorial, abridged versions of the papers presented at the previous meeting, additional papers, reports on various museums (particularly in Europe), book reviews and recently a correspondence column. The Bulletin consists of 16 pages in full colour.

Some medical historians favour the study of personalities rather than equipment but in fact behind each piece of equipment there is a human story and the development of equipment is intimately connected with the evolution of medicine and surgery. This is particularly so in anaesthesia where behind every great name there are often several eponymous pieces of equipment. It is pleasing to hold in one’s hand these tangible links with the past and to try to understand how they worked and to marvel at the thought that went into their design.

Dr Tim Smith
Hon Secretary
Historical Medical Equipment Society

[for details of membership please contact drtgcsmith@aol.com]
Dear Editor...

SEND YOUR LETTERS TO:
The Editor, Anaesthesia News,
AAGBI, 21 Portland Place, London W1B 1PY
or email: anaenews@aagbi.org

Gorillas, "Special K" and electro-ejaculation

I read the article titled "A tale of unrequited love or an anaesthetic nearly given" in the April 2008 issue of Anaesthesia News with concern. Admittedly it was written 15 years ago but there have been huge advances in the practice of anaesthesia for great apes. The anaesthetic technique described in the article is comparable to that of human anaesthesia in the early days of William Thomas Morton. It worked but things have certainly moved on.

Poly-pharmacy is commonplace in gorilla anaesthesia and with the use of alpha-2-agonists such as medetomidine (0.025mg/kg) in combination with ketamine (2.5mg/kg) and premedication with oral diazepam (1mg/kg) (concealed in a small amount of yoghurt - organic and sugar free: nothing but the best) we can now use volumes as low as 3.5mls as opposed to the 45mls mentioned. Intubation is also commonplace and isoflurane or sevoflurane are agents of choice to prevent the need for hasty retreats described in the article. Inductions are smooth, maintenance often unchallenging, and recoveries without incident. Basic monitoring includes heart rate, respiratory rate, temperature, capnography, pulse oximetry and blood pressure (NIBP or invasive as needed) with blood gases if required and BIS becoming more popular. For the few obstetric medics reading this, we also can predict pregnancy much more accurately with faecal or urinary hormones, or training that allows trans-abdominal ultrasound in the conscious animal. In addition male fertility assessment across the species is simple with electro-ejaculation techniques being relatively commonplace, and for trivia lovers gorillas have one of the smallest ejaculates relative to size for any primate, including man. When anaesthetic procedures are required they are fully planned events with most eventualities being taken into consideration. I enclose an image of our gorilla undergoing a health check, and these wouldn't be possible without the kind assistance of interested human medical consultants who assist in obtaining data to allow the best care possible for these magnificent creatures.

Veterinary anaesthesia is not that different from human anaesthesia, except when it comes to fish.

Jonathan Cracknell
RCVS Trust Resident in Zoo and Wildlife Medicine
Veterinary Anaesthetist, Zoological Society of London

Persistence doesn’t pay off

I couldn't agree more with the editorial published in “Anaesthesia News” of April 08. The breed of people who would say “this is my job” does not exist any more.

In one of my previous hospitals, I used the side door of the day surgery unit to go to work. The door, in normal circumstances, should be electronically locked and needed a hospital staff card to enter. It had a complex arrangement of locks, and was very easy to accidentally leave open. This was the case on few occasions when I arrived for my night duties. Thinking it could be a security risk, I informed switchboard. The situation persisted and next time I called the night security staff to inform them about this. Guess what happened next? Nothing.

Being a stubborn person, I did not quit and my next contact was to security staff during working hours who, once again, promised to sort it out. It required minor modifications to ensure it would close properly on every occasion. That, however, never happened and I decided I had tried my best and forgot about it.

However, a couple of weeks later there was an “open day” event conducted at the hospital and I saw a man and a woman who were all smiles standing behind a table near the cafe. They were “the managers” and I was offered help in the most pleasant way that I can remember (they thought I was “public” as I was not in my usual scrubs and also without ID batch). It was suggested that I email a particular person, which I did and in reply, received a name and a bleep number to contact. So it was back to me once again to sort it out. I bleeped this person twice but received no reply (If someone other than an anaesthetist answers a bleep, you are lucky. If someone other than a doctor answers a bleep, you must be joking). So that was the end of it. I am sure I (or for that matter anyone) can still wander into that hospital without a staff ID badge as the situation is highly unlikely to be any different now.

Zahid Waheed
SpR in Anaesthesia, Norfolk and Norwich University Hospitals
When you tell people that you are training for a career in Paediatric Intensive Care Medicine (PICM) the nearly universal responses are either “is it not really depressing?” or “rather you than me”. It would appear that many people believe PICM to involve an endless cycle of dealing with dying children coupled with huge amounts of stress. So why does a reasonably sane person choose such a future?

After graduation there were two main areas that interested me: anaesthesia and paediatrics. I applied to both training schemes in Aberdeen and was given interviews for both. I was interviewed for the paediatric rotation the day before the anaesthetic interview and only two days before my wedding in Northern Ireland. Given the circumstances I was happy to be offered the paediatric job later the same day and accepted the post before heading off to get married with my stress levels only slightly reduced. During the next three years I enjoyed working in a variety of paediatric jobs but the parts that particularly interested me were an optional paediatric anaesthetic attachment and time working in PICU. During both these attachments I enjoyed the real time application of all the basic sciences coupled with the practical aspects. No more waiting six months for the next clinic appointment to see if the child was better! I was also particularly impressed by the enthusiasm, knowledge and approachability of the consultant staff. So having decided this was the path that I wished to go down I successfully applied to the anaesthetic training rotation in Northern Ireland. Having completed two years as an anaesthetic SHO and three years as a specialist registrar I am currently seconded to Yorkhill Hospital in Glasgow to undertake a year of higher training in PICM.

Entry to higher training in PICM is available to trainees from paediatrics, anaesthesia and surgery under the regulation of the Intercollegiate Committee for Training in Paediatric Intensive Care Medicine (ICTPICM). ICTPICM contains representatives from the Royal College of Anaesthetists, Royal College of Paediatrics and Child Health and Senate of Surgery. Those wishing to have a sessional commitment to PICM should complete a year of higher training in a recognised centre (level one training) with anyone wishing to have a major sessional commitment in PICM required to complete two years (level two training). With PICM now counted as a sub-speciality of Paediatrics, trainees from paediatrics can apply for a two year National Grid training post. Anaesthetic trainees can complete some of the required training in programme with up to 18 months being spent training in one area. This
time will include the required three months in paediatric anaesthesia and for those wishing to complete level 2 training they will have to take some time as an OOPS or post CCT to ensure completion of all parts of general training for a CCT in anaesthesia. It is also recommended that in addition anaesthetists complete six months in Neonatal intensive care with paediatricians in training spending six months in anaesthesia.

So is a career in PICM for you? There are three possible answers to this question: definitely “yes”, definitely “no” and “maybe?” To those who are undecided I would encourage trying to spend some time working within a unit to test the water. There will be many similarities to the adult Intensive Care Units that you will have worked in which can help you to “find your feet”. However there are a multitude of differences, aside from the obvious patient group, which will challenge your skills and require some reading to gain understanding. When faced with a small collapsed patient with complex congenital heart disease knowing the diagnosis and deciphering the obligatory TLA (Three Letter Acronym) is only a start to understanding how blood is being pumped around. If you decide that it’s not for you then you will still have gained valuable experience managing acutely unwell children which may prove invaluable regardless of your future career pathway. In future when you are called to A&E to deal with the collapsed infant you may be glad of having spent some time working in PICU.

What do I say to those people who ask if it’s a depressing job? When 95% (www.picanet.org.uk, 2007) of your patients are discharged alive after a usually short length of stay it tends to be more rewarding than depressing. With adult ICUs reporting a unit mortality of between 17.9 and 23.7% (Harrison, 2004) it has always seemed ironic that most of the people asking this question are adult intensivists. That said children do die and learning to cope with this aspect of the job is vital in order to continue working in PICM. I think that it’s for this reason that formal, and more informal caffeine-rich, debriefing sessions are more a part of the culture than other jobs I have worked in. What also helps is reviewing the more frequent success stories. Watching a smiling child playing that within the last week was requiring multiple inotropes and oscillation for overwhelming sepsis will certainly make it easier to come back to work the next day.

So who should you speak to if PICM seems like a possible path for you? The website of the ICTPICM contains all the documentation relating to training requirements. It also has contact details for the administrator who seems to have answered most questions before and is very approachable. The UK Paediatric Intensive Care Society is available to give guidance relating to any general queries. At a local level speaking to your nearest PICU can not only allow you a chance to have a face to face chat but might also open the door to a trial attachment and some hands on experience.

If you decide that PICM is for you, then I am sure that you will encounter the “depressing” question. You too can then attempt to dispel some of the myths attached to this rewarding and interesting career.

Mark Terris
Glasgow

Reference

Useful websites
Intercollegiate Training Committee in Paediatric Intensive Care Medicine - www.rcoa.ac.uk/index.asp?PageID=37
UK Paediatric Intensive Care Society www.ukpics.org
www.picanet.org.uk.
The Mersey Weekends
“If you feed the children with a spoon, they will never learn to use the chopsticks”

FCARCSI Final E&SAQ Weekend
Learn & Practice the Mersey Method for Success with the FCARCSI Examination
Friday 29th – Sunday 31st August

FCARCSI Final Viva Weekend
Presentation Tricks & Treats - Viva Practice & Revision
Friday 26th – Sunday 28th September
Limited

FCARCSI Primary Viva Weekend
Presentation Tricks & Treats - Viva Practice & Revision
Friday 17th – Sunday 19th October
Limited

FRCA Primary Viva Weekend
Presentation Tricks & Treats - Viva Practice & Revision
Friday 12th – Sunday 14th September
Limited

FRCA Primary OSCE Weekend
Intense OSCE Intelligence & Exposure
Friday 19th – Sunday 21st September
Limited

FRCA Final SAQ Weekend
Learn & Practice the Mersey Method for Success with the RCA Examination
Friday 10th – Sunday 12th October

FRCA Final Viva Weekend
Presentation Tricks & Treats - Viva Practice & Revision
Friday 21st – Sunday 23rd November
Limited

Details – Assessments - Application Forms
WWW.MSOA.ORG.UK
CLASSES & COURSES
Punctuality has been described as the politeness of kings. While I have never worked with a king, I did hear of surgeons who thought they were God; rather worrying as all I can remember from my psychiatry lectures is that people who thought they were God are always dangerous.

Evelyn Waugh described punctuality as the virtue of the bored. I was rarely bored, even during my regular Saturday morning endoscopy lists. I divided these procedures into “cystoscopy”, “cystob*gg*rabout a bit” and “cystob*gg*rabout a lot”. Before the introduction of fibreoptic technology this classification depended more on the bulbs, leads and battery boxes than on the skill of the surgeon. When a consultant was using the longest colonoscope while his registrar was using the longest gastroduodenoscope I warned them to look out for each others headlights as the hospital could not afford the cost of repairs should there be a mid gut collision. While a registrar I worked in a department that had introduced a complicated anaesthetic record system with a four page long form: it took longer to fill in the form then to give a short anaesthetic.

The results were put onto punch cards, which were sorted by a Hollerith, a sort of mechanical computer. This produced the “fact” that retention of urine was a postoperative complication of trilene anaesthesia; not surprising, as “pentothal, gas, oxygen and trilene” was the usual anaesthetic for urethral procedures.

A small child had been anaesthetised for the Ophthalmic Theatre Sister to remove some sutures; the anaesthetic record was correctly filled in accordingly. I was told by the anaesthetic records clerk that this was impossible, as although there was a code for all grades of “surgeon” from medical student to consultant, there was none in the system for a Sister, so she could not have done it!

On an autumn Monday morning list the Surgeon repeatedly apologised for being so slow. This surprised me, as things were proceeding at the usual steady pace. On turning and looking at the clock above my head I realised that it was an hour fast, as it had not been altered when Summer Time had ended the previous Saturday night.

Thomas Gainsborough said that painting and punctuality mix like oil and vinegar, and that genius and regularity are utter enemies, and must be to the end of time. Many of my surgical colleagues could be regarded as geniuses. The most unpunctual of all was a gifted amateur artist.

David Rowlands
Retired anaesthetist
When Dr. Ruxton was alive and anaesthesia was an adventure, for the anaesthetist at least, other doctors thought of anaesthetists somewhat as archaeologists consider Indiana Jones. They dressed weirdly and they weren’t real doctors. They were beyond the pale and to put it at its kindest, not an asset to medicine. So much has changed since then, though in the eyes of our colleagues we still addle our brains with noxious gases. But are we still the object of fear from our patients? If so, and recent surveys still indicate that we are barely recognised by the public as doctors, let alone our colleagues, why has pre-medication changed so much?

Dr. Ruxton asks why don’t we premed patients any more? He recalls well how necessary was premedication when ether was (almost) the only anaesthetic available. An opiate to control coughing and an antisialogogue to control secretions were essential, and that hung over far, far into the halogenated era. There was a furore among other ancient anaesthetists when “Om & Scop” was deleted from the pharmacopoeia, but they soon learnt from younger colleagues to push benzodiazepines for that pre-op wait. And in fairness, in those days, many patients readily expressed their fear at the prospect of anaesthesia, far more than the hazardous surgery that made it necessary.

He asked the question, because he materialised one day when his humble amanuensis was revising the department anaesthesia record sheet. This recent (to Dr. Ruxton) innovation bemused him; that three pre-printed pages are now used when a blank sheet and a fountain pen were all that he required, but in general he approves. He was pleased to see that much was still familiar but was dumbfounded to learn that the section labelled “Premedication”, would henceforth contain no anxiolytics. For who gives anxiolytic premedication today? It has fallen completely out of fashion, so that prescription is by far the exception, and there is no need for a routine tick box on the record sheet.

Ever concerned for his patients, Dr. Ruxton asks; are we cruelly ignoring their distress, or have we achieved a silent victory, so that they are now quietly confident of our care and expertise? He feels that it is the latter, as more and more patients come before him, without concern, racked by extreme cardiac or pulmonary disease wanting to have risky surgery. Are they so confident that they feel no need for sedation? It would be nice to think so, but when he reminds them of the risks and that they are multiplied many times by their other ailments this comes as surprise to them, so it may be that they just aren’t thinking of any of the risks, let alone the anaesthetic!

Dr. Ruxton is all for Continuing Medical Education. He has a lot to catch up on, what with being eighty years dead and with audit days in the hereafter being rather parochial. (Suggestions for audit; “Inappropriate prescribing of burns dressings”, “Mad, bad, or just dangerous to know – a demon auditing tool”). So he was interested in a recent conference.

What caught his insubstantial ear was the frequent use of the word “emergent”. Dr. Ruxton does recognise that new technologies – new to his humble scribe, let alone to our long-deceased physician – may be described as ‘emergent’ when they are new flown from the research laboratory and still finding a place in clinical medicine. Or ‘emergent’ may be applied to recently developing nations that have embraced 21st Century industries like information technology and will soon lead the world in new versions of killer games. All these are emergent to Dr. Ruxton, to whom a typewriter is high-tec.

So what was “emergent” surgery, or “emergent” anaesthesia? Were the robots taking over, their titanium hands freshly sterilised in flame, like a pathologist’s inoculating loop? Were helium or electrical anaesthesia, or MRI-directed epidurals about to be the new ether? No, it was our American cousins. With their genius for neologism, they have truncated “emergency” to only two syllables.

Dr. Ruxton agrees with Humpty Dumpty, that words mean what you choose them to mean, and believes that his creator, Dr. Dodgson was the finest neologist there has ever been, but “chortle” and “Jabberwock” were wholly new. What is more, they fulfilled a need for new words, despite English already having the largest vocabulary of any language. But “emergent” is not a new word; it is an old one, with its own meaning and usage. And we already have a perfectly good one, with three syllables that do the job perfectly.

An ironic question to the lecturer, asking when this “emergent anaesthesia” would find a place in anaesthesia might have shown our transatlantic cousin the error of his ways. But Dr. Ruxton’s voice is difficult to hear, even through the hi-tech radio microphone system that our lecture hall was provided. So the question went unasked, as his amanuensis had to refuse the urgent request to voice the question himself. Anaesthetists who hear voices may find themselves on ‘gardening leave’.
### British Association Of Indian Anaesthetists

**7th Annual Meeting, Saturday 11th October 2008**

**Wellcome Trust Conference Centre**

**Genome Campus**

**Hinxton**

**Cambridge CB10 1RQ**

The scientific programme will include lectures and discussions from Professors Chris Dodd, David Menon, Sandip Pal, Mervyn Singer and Drs. William Haropp-Griffiths, Dominic Bell, Suresh Reddy, Dan Wheeler, Anand Sardesai and other eminent speakers.

The meeting is open to all anaesthetists.

Anaesthetists in training presenting papers are eligible for prizes.

The deadline for abstract submission is 15th September, 2008.

**CME 5 Points**

For further details, contact the Organising Secretary

Dr Rama K R Rebbapragada, Consultant Anaesthetist

Addenbrooke’s Hospital, Hills Road, Cambridge CB2 0QQ

Tel: 07929998187 (Mob.)

E-mail: rkraso.rebbapragada@addenbrookes.nhs.uk

Website: www.baoia.org

---

### 18th National Acute Pain Symposium

**Thurs 4th & Fri 5th September, 2008**

**Crowne Plaza Hotel, Chester**

#### Ketamine in Acute Pain

#### Acute Pain in the Military Operational Field

#### A Painfully Big Problem (Pain in the Bariatric Patient)

#### Entonox into the Community

#### Gabapentin in Acute Pain

#### Acute Pain in the Opioid Addict

#### Case Reports and Panel Discussion

#### Ultrasound in Acute Pain Practice

#### Paracetamol - new data, dosing, mechanisms

#### Chronic Pain after Surgery: Ten Years On

#### National Audit on Neuraxial Blockade

---

**For details & bookings contact:**

Georgina Hall

Tel: (0151) 522 0259

E-mail: medsymp@blintnemet.com

Registration:

- Doctors £ 345
- Trainees £ 270
- Nurses £ 195

---

### DERBY ANAESTHETIC ACADEMY

**FIFTH DERBY UPPER LIMB REGIONAL ANAESTHESIA MEETING**

**Thursday 27th November 2008**

**Derbyshire Royal Infirmary**

The program is dedicated to upper limb regional anaesthesia with an emphasis on practical, hands-on Ultrasound training and experience for those looking to increase confidence in performing regional blockade. DVD included.

**Course Organisers:** Dr Adrian Searle, Dr Zahid Sheikh

**CME approved 5 points**

Application forms and more information from:

Course secretary Mrs. Shirley Goddard

Shirley.Goddard@derbyhospitals.nhs.uk

Tel. 01332 347141 Ext 2174

Derbyshire Royal Infirmary, London Road, Derby, DE1 2QY

---

### Final F.R.C.A. Examination

**Intensive Preparation Course**

**The Bristol Crammer**

**Monday 15th – 19th September 2008**

This five day course includes sessions on examination technique, intensive therapy, new drugs, current topics, and practical subjects (ECGs, X-rays), as well as mock examinations and performance analysis.

Conducted by national and local experts at Burwalls Conference Centre, Bristol.

**For further details, please contact:**

Jane McLean

Department of Anaesthesia

Bristol Royal Infirmary

Marlborough Street, Bristol BS2 8HW

Telephone: 0117 928 3801 (Direct Line)

E-mail: jane.mclean@ubht.nhs.uk

Course Director: Dr S Underwood FRCA

---

### Some Accommodation Available

Course Fee £450

Includes course dinner, coffee, lunch and teas

---

### DERBY ANAESTHETIC ACADEMY

**FIFTH DERBY UPPER LIMB REGIONAL ANAESTHESIA MEETING**

**Thursday 27th November 2008**

**Derbyshire Royal Infirmary**

The program is dedicated to upper limb regional anaesthesia with an emphasis on practical, hands-on Ultrasound training and experience for those looking to increase confidence in performing regional blockade. DVD included.

Course Organisers: Dr Adrian Searle, Dr Zahid Sheikh

CME approved 5 points

Application forms and more information from:

Course secretary Mrs. Shirley Goddard

Shirley.Goddard@derbyhospitals.nhs.uk

Tel. 01332 347141 Ext 2174

Derbyshire Royal Infirmary, London Road, Derby, DE1 2QY

---

### British Association Of Indian Anaesthetists

**7th Annual Meeting, Saturday 11th October 2008**

**Wellcome Trust Conference Centre**

**Genome Campus**

**Hinxton**

**Cambridge CB10 1RQ**

The scientific programme will include lectures and discussions from Professors Chris Dodd, David Menon, Sandip Pal, Mervyn Singer and Drs. William Haropp-Griffiths, Dominic Bell, Suresh Reddy, Dan Wheeler, Anand Sardesai and other eminent speakers.

The meeting is open to all anaesthetists.

Anaesthetists in training presenting papers are eligible for prizes.

The deadline for abstract submission is 15th September, 2008.

**CME 5 Points**

Chief Guest: Prof. D. Dasgupta,

Mumbai, India

For further details, contact the Organising Secretary

Dr Rama K R Rebbapragada, Consultant Anaesthetist

Addenbrooke’s Hospital, Hills Road, Cambridge CB2 0QQ

Tel: 07929998187 (Mob.)

E-mail: rkraso.rebbapragada@addenbrookes.nhs.uk

Website: www.baoia.org
Nothing like the death of a young person to make one evaluate one's life. As an AAGBI Council member one receives regular reminders of one's obligation to produce articles for Anaesthesia News (actually they're threats – but very nicely worded. Ed.) – reports of working parties and committees in particular. As one of the new boys on the Council I don’t really have anything to report, but instead have collated various thoughts I’ve had for some time now but that have come up in conversations increasingly frequently over recent months.

Life

So, nothing like the death of a young person to make one evaluate one’s life. In the past few months a number of people in their forties – family friends, colleagues, and friends of colleagues – have died suddenly. All men, all hard working, all successful, all apparently happy, all tragic. Just a coincidence, or is this the inevitable price for hard work and high achievement? Surely not inevitable, though perhaps 'high flying' is merely another risk factor, alongside family history, smoking, high cholesterol, etc. Does adjusting one’s activities (i.e. taking on less and saying ‘no’ more often) reduce this risk, in the same way as reducing cholesterol levels, or is merely having the drive and motivation to be such a person harmful enough, irrespective of whether one ‘lives the life’? Or is it that strange phenomenon one sees in public life, politicians being a good example, whereby successful people assume an unwarranted invincibility and start taking risks, or stop avoiding them, that most others – themselves perhaps in their previous lives – wouldn’t ever consider? A fixation error (i.e. I’m alright) of monumental, and sometimes fatal, proportion? Now we come back to the AAGBI. How many people, I wonder, are aware that there’s an AAGBI Welfare Committee? The advert in May’s Anaesthesia lists helping members, offering support and training in life skills amongst its activities. All good and worthy aims, but perhaps its main benefit is its very existence – if our own professional body has such a committee it reinforces the importance of welfare in our professional lives. We must look out for each other, in our departments, in our specialist societies. Have you ever realised with a start that one of your colleagues has been off sick for several weeks, but you’d not noticed? I know I have, and I felt awful about it. As departments get bigger and busier, we risk finding ourselves increasingly at the coalface, chipping away in the dark and on our own. Twenty years ago, the collective spirit and mutual support that seemed to go with anaesthesia were the main attractions of the specialty to me (along with the prospect of not having to do PR examinations), but I didn’t realise then just how important they were or how much effort was required to keep them going. Some departments seem to be able to achieve this so much better than others; why is this and how do they do it? For me, the main benefit of annual appraisal is that it forces us to discuss aspects of professional and even personal life with a colleague, one-to-one, with adequate time, when there might otherwise be little opportunity. Perhaps just a tiny window but at least it’s open.

Pooh

I used to read the BMJ from cover to cover, in the days when it was a journal and not a magazine. One of the occasional ‘fillers’ was ‘A book/film/patient that changed my practice’. Only once did I ever buy a book as a result. It didn’t really change my practice or even my life, but it described a transition I’d already made over the previous few years but had never
thought about; indeed it was my surprise at recognising myself in the description (BMJ 2004; 329: 151) that prompted me to buy it in the first place. *The Tao of Pooh* by Benjamin Hoff was first published in 1982 and by today’s standards, can only be described as rather cheesy and twee (or, as one Amazon reviewer put it, "Preachy, judgemental, anti-intellectual, semi-facist crap aimed at stupid gullible middle-class yuppies"). It has led to an awful lot of self-indulgent navel-gazing, it is true, and a large number of spin-offs including *The Te of Piglet*. The premise, though, is that the author is trying to write a book about Chinese philosophy but has to break off continuously to explain each passage to Pooh Bear, who keeps interrupting. (Though one might wonder whether someone who is interrupted by a talking bear might be better off seeking a psychiatrist rather than a publisher).

The Confucian way of life, in which one deals with the chaos of life by imposing order through rules and regulations, is doomed to cause anguish and frustration, whilst the Taoist approach, to take life as it comes, is the true path to peace and harmony. The latter attitude is epitomised by Winnie the Pooh, as opposed to know-all Owl, busybody Rabbit, overconfident Tigger and pessimistic Eeyore. All this has relevance to life, death and stress, both within and outside the NHS, and I’m sure that I deal with such things better as a bear than as a rabbit or an owl, though I need to remind myself sometimes. Look around and you’ll see such animals all about you (and perhaps in the mirror too, even occasionally). Perhaps discovering one’s inner Pooh ought to be included in the Welfare Committee’s training events.

**Everything**

A downside of course of being a bear all the time is that one risks losing the motivation to change anything. One problem of a huge, lumbering organisation like the NHS, especially one so heavily regulated, is the feeling engendered at ground level that there’s no point trying because nothing can be achieved. This is a mistake; I’m convinced that change can be effected but one has to learn how to use the tools available. In management terms, if something isn’t recorded it didn’t happen (the same is true in legal proceedings). So if something isn’t right, the first step is to gather information via audits, critical incident reports, etc (especially the latter). Why do doctors have such aversion to filling the forms in?; the second step is to present the information to the right person (finding who that is can be a challenge but there always is such a person). Finally, one must never give up until the outcome is achieved, for I’ve learnt that the most important part of the process is a champion, someone who will argue the case, fill in the forms, empty the bins, or whatever it is. On a wider scale, this is where a body like the AAGBI comes in again. I thought I had a pretty good idea of what the AAGBI did before I took my place at the table, but I have been impressed by just how much it assumes that champion role, arguing for change, supporting standards, and all the usual stuff we read on these pages each month but don’t really take in. And should we ever forget what this is all about, consider those poor families left without fathers, brothers, husbands. Nothing like the death of a young person to make one evaluate one’s life.

Steve Yentis
AAGBI Council member

### 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
Statement from the Association of Anaesthetists of Great Britain & Ireland (AAGBI) on Advanced Critical Care Practitioners (ACCPs)

The AAGBI was both surprised and dismayed to read that a recent Department of Health publication outlining the role of ACCPs equated this new role with that of established medical staff [1]. The role of the doctor in the key areas of diagnosis and clinical decision-making is clearly misunderstood by the authors of this document. This fundamental misunderstanding throws significant doubts on the credibility of what may otherwise have been a potentially useful document. The AAGBI, in common with other organisations that hold patient safety to be paramount, does not accept any direct comparison between those assisting doctors in caring for patients, e.g. ACCPs or Physician’s Assistants (Anaesthesia), and the doctors themselves who have the ultimate responsibility for the medical management of the patient.

Surveys have clearly shown that patients readily confuse the roles of healthcare workers with titles that include the word “practitioner”. The AAGBI calls on those involved in the ACCP programme to change the title to Physician’s Assistant (Critical Care), in line with an approach successfully adopted by NHS Scotland that has been supported by both the AAGBI and the Royal College of Anaesthetists in replacing the working title ‘Anaesthetic Practitioner’ to the now universally accepted title Physician’s Assistant (Anaesthesia). Using the title Physician’s Assistant (Critical Care) will help to avoid potentially dangerous confusion in the minds of doctors, nurses, patients and the public.

REFERENCE

“What you really need to know about airway problems but have never been taught”
Learn how to objectively assess a potentially difficult airway.
Learn how to formulate and execute the correct management plan.
Learn about postoperative management planning.
Get hands on experience with a wide range of airway devices.

Feedback from previous courses:
“An excellent course” “A very good framework to guide assessment” “Well organized and practical”
“Loved the patient orientated approach - it really made me think beyond the immediate problems” “Excellent course: most of which I am not taught in normal lists at work”
“Excellent remifentanil sedation technique for awake intubation” “Well defined content and lectures”

BOOK NOW TO AVOID DISAPPOINTMENT
Resuscitation Training Department University Hospital Aintree Liverpool L9 7AL £200 (includes manual and lunch)

Friday 5th September 2008
Cheques payable to Aintree University Hospitals NHS Foundation Trust. Closing date for entry is August 27th Full prospectus on receipt of application.

Approved for 5 CPD points.
For further information and booking please contact; Mrs. Denise Morgan-O’Neill, Office and Information Manager Email: adam.aintree@nhs.net Phone: 0151-529 5153
Ultrasound where you need it, when you need it.

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

The new M-Turbo: ultrasound with the power to transform the way you practice. Incredible image quality for increased accuracy and efficiency across a range of applications in a versatile system that you carry right to the point of care. The S-Nerve ultrasound tool was designed by anaesthetists for anaesthetists. Focus in on your target area in seconds, using just two controls: for speed and accuracy. Mount it on its stand or on a wall or ceiling for zero footprint. See for yourself.

SonoSite.

www.sonosite.com | +44 1462 444800
europe@sonosite.com

© 2008 SonoSite, Inc. All rights reserved. M4705E3 05-08

Ultrasound Training Courses 2008

2008 course dates:
US Guided Regional Anaesthesia – Introduction
27-28 October – Hitchin
US Guided Regional Anaesthesia – Advanced
2-3 October – Liverpool
5-6 December – Nottingham
Critical Care
19 November – Hitchin
Chronic Pain
15 September – Hitchin

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

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

US Guided Regional Anaesthesia – Advanced
The two-day advanced practical course is aimed at anaesthetists already proficient in regional anaesthesia and comprises of didactic lectures on ultrasound anatomy and regional anaesthetic techniques. It includes practical workshops on brachial plexus and abdominal blocks. Topics covered will include regional techniques for upper and lower limb surgery and neuraxial blocks.

Critical Care
This one-day course is aimed at all critical care physicians and surgeons. The programme is suitable for those who already have some basic ultrasound experience as well as those who are new to the clinical applications of focused ultrasound at the patient bedside.

The course is suitable for consultant and middle grade clinicians across the spectrum of specialties (emergency medicine, acute medicine, surgery, paediatrics and intensive care medicine for children or adults).

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

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

To register or for more information contact:
Sarah Wood
01462 444800
or email:
education@sonosite.com
www.sonosite.co.uk
Is it me?
I think it is time for me retire. I’m clearly past my sell-by date. I find myself increasingly out on the edge of safe practice. I can, for instance, put in CVP lines and nerve blocks without the use of an ultrasound device and a safety net. I use vapours to keep patients asleep, and I am pretty sure they are (asleep) without having to attach a sensor to their foreheads. I find myself becoming more and more irritated with Trust policies. The words ‘teach’, ‘granny’, suck’ and ‘eggs’ pop regularly into my head. I frequently wonder if I am developing Tourette’s syndrome in meetings as the urge to shout ‘Bo**ocks!’ becomes irresistible.

Is it just me or have the lunatics finally taken over the asylum?
Our latest Trust offering is a ‘tool’ for spotting and treating sepsis. ‘Tools’ are prescriptive policies that, when followed religiously, liberate the health care worker from any form of diagnostic skill, analytic thought or decision making. They are written by nurses, aided and abetted by naïve consultants. I say naïve advisedly because I’m pretty sure that the intention is to replace us when the entirety of medical knowledge has been distilled into ‘tools’. There will be no need for consultants. Specialists will not be consulted. Now I’m all for policies that assist foundation doctors to recognise serious sepsis on the ward (although old curmudgeons like me would concur that more thorough undergraduate training might achieve as much). It seems to me, however, that even today’s graduates might be able to work out from whence the sepsis is arising without the aid of a handy anatomical diagram indicating just exactly where organs are such as the lungs and bladder.

Dumb and dumber!
I went to a one-day seminar this week on good practice for educational supervisors. I have been an educational supervisor for 24 years and I pretty much thought I knew what I was doing. I actually thought I was quite good at it. However, the burgeoning paperwork, Byzantine complexities of e-portfolios, mini CEX, CbDs, ARCPs (if you don’t know what these acronyms stand for you probably, like me, need to retire) and the College’s and Deanery’s insistence that educational supervisors are all ‘trained’, caused me to seek enlightenment. I learnt some fascinating stuff. I learned, for instance, that educational supervisors are different to clinical supervisors. You see this is where I have been going wrong – in my innocence I thought we were supposed to supervise the acquisition of clinical knowledge and skills, when it turns out the trainees also need supervision of education and career progression. Frankly if they haven’t worked out in the first six months that they need to work for and pass their exams as quickly as humanly possible, they probably ain’t going to make it in anaesthesia. “There’s the curriculum – get on with it. You are an intelligent adult with several A levels, a degree, a mortgage and children”, clearly is insufficient. Moreover, I’m not convinced all this paperwork is really about ensuring good training as much as it is about ticking boxes. No matter, I know how to tick them now and that is all that is required of me.

Dumb and dumberer!
I am also increasingly getting into trouble, particularly from the germ Gestapo. I have grudgingly conceded that all hospital acquired infection is the fault of doctors, particularly filthy consultants. I wander the hospital wards and corridors, arms ‘naked from the elbows down’, sans watch, sans jewellery, bloody freezing. I am constantly late for everything as none of the clocks are right and I have no idea what time it is. I have suggested a hooter goes off at 12.30 and 17.00 so we know that the lists are running late. And yet I still get into trouble. Last week for not wearing a pinny on the HDU. I did point out to our consultant microbiologist (who bears an uncanny resemblance to Margaret Thatcher crossed with a Rottweiler) that I had just taken it off to write in the patient’s notes before donning a fresh one and examining the next patient, but it was to no avail. Apparently, prevention of cross-infection is not as important as following the rules which state I must wear a pinny all the time even if it is the same one. Must tick the box dummy!

Anyway, I had the last word. I had been saving this up for an emergency and I commend it to you as small spanner to throw in the infection control works. As she was leaving the unit, I casually asked my colleague if the levers on the gel dispensers at the doors of the wards were ever swabbed. Depressed regularly by the heel of dirty hands and never cleaned, they present a point of contact by the heel of dirty hands and never swabbed. I thought I was quite good at it. However, I knew what I was doing. I actually thought I was quite good at it. However, apparently, prevention of cross-infection is not as important as following the rules which state I must wear a pinny all the time even if it is the same one. Must tick the box dummy!

Anyways, I had the last word. I had been saving this up for an emergency and I commend it to you as small spanner to throw in the infection control works. As she was leaving the unit, I casually asked my colleague if the levers on the gel dispensers at the doors of the wards were ever swabbed. Depressed regularly by the heel of dirty hands and never cleaned, they present a point of contact by the heel of dirty hands and never swabbed. I thought I was quite good at it. However, I knew what I was doing. I actually thought I was quite good at it. However, apparently, prevention of cross-infection is not as important as following the rules which state I must wear a pinny all the time even if it is the same one. Must tick the box dummy!

Perhaps I can have some fun throwing more small spanners into works in my few remaining working years.

Seems like a plan.