Work-life balance: volunteer for the Olympic Games

Letter from America: The Nocebo effect

Letter from Uganda: Anaesthetic Disaster
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.

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

Please Note: These do not count as a cadaver course, only as another course to fulfill the recommendations. An RA-UK specific cadaver course will be held in December 2010 in Oxford.

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

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

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

Fees:
- £350 (£450 (A) (two-day courses) includes VAT, lunch, refreshments and course materials.
- £250 (one-day courses) includes VAT, lunch, refreshments and course materials.

(A) – Anatomy based courses / with cadaveric prostheses.

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

Of butchers and biscuits....

This month in Anaesthesia News we again offer plenty of opportunity to volunteer: at one end of the economic spectrum you may wish to volunteer to work as a medical attendant at the Olympic games in 2012. At the other end of that spectrum, work in Uganda or on the Mercy Ships calls. Alternatively, ensure that your work-life balance is in order by job-sharing; Gill Farnsworth describes setting up a job-share towards retirement rather than the more usual application of this work pattern at the beginning of a career. Jealous? Moi?

Dr Camann’s fascinating commentary on the ‘nocebo effect’ is well worth reading. I suspect there are some cultural differences here; I am not sure that I have ever heard anyone mention bee stings in the course of preparing our patients for an injection; nevertheless needle phobia is a serious problem and I guess the ‘nocebo effect’ may be contributing to this. It would be worth repeating some of this work in the UK.

I attended my first AAGBI Standards Committee meeting today. This committee (and particularly the duty of chairing it) strikes fear into the heart of new Council members; it is by repute the most difficult of all the committees and working parties to engage with, because it consists of discussions about National and International standards for equipment, along the lines of ‘ISO393.456 Part 5 (a) is to be re-formatted into a one part standard, to bring it into line with ES45238766 and BS4834455.....’. Less than riveting, especially if you have no idea what the standard has to do with in the first place.

In the event, it was quite fascinating. I guess it is difficult for an anaesthetist to be truly disinterested in the equipment we use.
David Scott (a veteran standards champion) raised the issue of the angle of curvature of ETT tubes. Apparently there is a standard for the degree of curvature, which is rigorously adhered to by manufacturers. This standard dictates that tubes are much less curved than the red rubber tubes of my youth.

In my own hands, this means that all the (considerable) advances in laryngoscopy have given me a better view of the tube passing behind the larynx. Much to the irritation of our chief anaesthetic nurse, I bought a supply of Parker ‘flex it’ stylets a couple of years ago. This was (it isn’t manufactured at the moment I think).

I had no idea that this was a deliberate matter – I had thought that the plastic just couldn’t be permanently bent into a better curve. Clearly this is a standard which needs urgent revision......

Dr Scott concluded the discussion by mentioning that Dr Magill used to keep his tubes in a biscuit tin, which allegedly has the right degree of curvature. Perhaps this would work today?

I must admit that I had been less attentive to another Standards committee item (about robots) until the speaker mentioned that a robotic halal butcher had been developed to meet the apparent shortage of the human version. A quick-witted Professor replied that he believed he worked with one......

Nick Denny (a former AAGBI council member) has been brave enough to describe his close encounter with a ‘black hole’; we do all need to try and look out for warning signs in ourselves and others and to be supportive. We do a difficult job, often in difficult circumstances, and we are all human (at least until the robotic butchers arrive). Take care to focus on your golf balls, and watch out for the shifting sands!

Val Bythell

**Correction**

A second reference was omitted from Connor H and ZuckD. John Snow’s surviving Ether Vaporisers. *Anaesthesia News* May 2010; 274:29-30. This should have read: Connor, H. and Zuck, D. A very rare ether vaporizer designed by John Snow. *Proceedings, History of Anaesthesia Society* 2009; 41: 105-122. (The whole run of the *Proc. HAS* is now available free on the Society’s web site, at www.histansoc.org.uk )
Much seems to have happened over the last two months. On a particularly sad note Dr J Ed Charlton died over Easter and his very full and well written obituary appears in this edition of 'Anaesthesia News'. A former Assistant Treasurer, Honorary Secretary, Pask Award holder and John Snow Silver medallist he made a massive contribution to the Association of Anaesthetists. He will be best remembered for the development of the management of pain and pain clinics in the UK, but will also be remembered fondly for his inspired editorship of this publication. He was held in such great esteem by all who came into contact with him that when I attended his funeral in Bamburgh a flag flew at half mast over the famous castle in his memory. Our condolences go to Laura and their two children.

Mrs Joanne Silver, General Manager of the AAGBI, has settled back in to her role following maternity leave. Her review of the structure of staffing at the AAGBI is almost complete and is the first formal review for 6 years. Hopefully the new structure will help propel us efficiently into the next decade in all areas of our activity. Education and Events has always been a mainstay at the AAGBI and proposed changes are now under consideration. Essentially these activities will be split into 2 but with an overall lead. Events’ would look after meetings, seminars etc with the Education committee looking after all educational activities including all our publications and the burgeoning development of web-based educational material.

The Patient Safety Net with which we aim to enhance all safety information and streamline its dissemination to hospitals and Trusts, continues its development. Patient monitoring and particularly pulse oximetry have enhanced patient safety over the last few decades. The AAGBI was in at the beginning in providing funding for the Global Oximetry Project, the aim of which is to provide a robust pulse oximeter for use in ‘third world’ countries so that all may benefit from this basic monitoring tool. The project is now at the stage of manufacturing tender and will hopefully move on to quick dissemination to where they are needed. The AAGBI maintains a major influence in this exciting development.

More politically the AAGBI/RCoA commissioned a report into working conditions for SAS doctors. This showed how as a group they were often working beyond that which they were contracted to do with little ability to partake in CME and other educative activities. The BMA have joined with us in trying to address this and we will see how this develops. A joint Clinical Directors day (AAGBI/RCoA) has been held recently, this was clearly popular and well-received with around 120 CDs attending. We intend to continue these meetings possibly making them more frequent. Two ‘glossys’ are on the point of publication. One is on Management and the other on the Anaesthesia Team. These demonstrate the continued focus the AAGBI has, in these increasingly difficult times, on political and management aspects of our specialty.

Finally a few ‘plugs’ for future meetings. The GAT meeting takes place in Cardiff at the end of June. I would encourage all trainees to try and attend. Since my first GAT (then JAG) meeting in the seventies I have always been impressed at the scientific content of these meetings and Cardiff promises to be no exception. Some of the AAGBI Executive and others will be attending the ESA meeting in Helsinki in June. Not only will we be ensuring the UK’s continued influence in this organisation but we are hosting our own ‘Safety’ session at the meeting. At the Annual Congress meeting in Harrogate we are hosting, amongst others, the ASA presidents (USA and Australia) and the Canadian Society’s president. The Common Issues Group meeting will be held immediately after the Congress, but the Presidents will be taking part in a political forum at Congress and we all look forward to that.

As we go to press there has again been a healthy number of candidates standing for election to the AAGBI Council as well as to the two Executive posts of Honorary Treasurer elect and the Honorary Membership Secretary Elect. Watch this space!!

Dr Richard Birks
President
‘Would you like me to give you a hand?’

Positives and negatives

The people we work with largely determine the enjoyment of most working days. It is much more fun to be with people we like, doing the parts of our job we enjoy most. This is one of the reasons that we tend to gravitate to the same list for years, enjoying the easy familiarity of the regular team where we all relate together with mutual respect.

When I worked as a medical director I became much more aware of the complexity of medical life, and the multitude of ways that things can go wrong for people. A regular feature were the difficulties brought about by failing to interact with each other appropriately. In particular, difficulties due to feeling ignored, not appreciated, undervalued or bullied are common.

A career in medicine attracts a rich mixture of personalities: introverts, extroverts, pessimists, optimists, reflectors, geniuses, eccentrics, overconfident, underconfident, leaders, followers, mad and the bad. We meet and work with them all! As individuals we rapidly realize which colleagues we are most comfortable around, and those with whom we do not bond easily. For example people who are less sure of themselves may feel threatened or irritated by those who are brimming with self-confidence.

We deal with all of these different personalities every day among our patients and colleagues. Compare the anaesthetist who rushes to an emergency and immediately takes control with a colleague who is happier to be part of the team quietly taking up their specialist role. Neither is better or worse than the other, it is just that their skills and personalities determine their comfort zones. When departmental decisions are to be taken, some prefer to think things through for a few days, others like to make a snap decision. All these are variations of normal.

In our hospitals decision-making and planning benefit from the mixture of personalities working together which allows different perspectives to be taken into account. Although the potential is always present for making a great team, there is also capacity to create destructive relationships which fester due to a lack of ability to tolerate and understand each other. This can be catastrophic, particularly in small teams with negative results for both patients and staff.

Negativity towards our situation or towards us personally is particularly difficult. When I was a consultant in ICU, I found bed non-availability one of the most difficult things to deal with. The same bed state problem was more (or less) stressful depending on the way the situation was approached by the nurse in charge. Senior nursing colleagues who were able to appreciate and share the clinical problem allowed me to make difficult decisions in a collaborative way; those who could not left me frustrated, as their negativity multiplied the difficulties. Contrast this latter behaviour with one of the best phrases in healthcare: “Would you like me to give you a hand?”.

Our personalities also determine our vulnerabilities. Offence may be taken easily by some, yet others are seemingly invulnerable! Feeling ignored, disempowered or not in control is one of the most negative experiences for a human being, and a common (and unnecessary) experience in hospitals. Check out the recent SAS survey.
I suspect negativity and cynicism has a wider impact on us professionally than just the spoken word. Our young doctors and nurses leave University excitedly anticipating their role in the wider medical world. Already beset with anxieties about careers, these are exacerbated when their senior leaders are negative and cynical about the NHS.

A year or two ago I interviewed a haematologist for a consultant post. When I asked why he had taken up the subject, he attributed it directly to one of his teachers who inspired him whilst a final year medical student.

In a team, we don’t have to like each other although it helps! We do however have to be able to work and respect each other. I find trying to focus on the good in people rather than the faults helps a great deal – most people have many good points. Some folk test it to the limit though, including patients! Working with complainants is very instructive!

In medicine I think we could work harder at communicating positively. Some of it is communication skill, but much of it is basic politeness and respect for each other. The personal introductions which are a part of the WHO checklist and theatre briefings are one simple way that can encourage us into recognizing the individual importance of team members.

Knocking the NHS, managers and government is always fashionable but has to be balanced with a sense of reality. The NHS is far from perfect, but nevertheless there are good aspects - we have speedy access to cancer treatment, trauma services and specialist care. However, the regular negativity of the medical press for political ends is depressing. Although we shall never have an excess of money to provide everything, positive debate about where we go is much more productive than wallowing in negativity.

Of course in the NHS, things go wrong and it is always right to put negativity in the right context to ensure improvements are attempted.

Is all of this nonsense? No, I don’t think so. I have had some of the worst clinical outcomes on days with people I respect and like and have walked away intact. Other days have been so unnecessarily negative, usually for no reason!

Iain Wilson
President-elect, AAGBI
Volunteering at the Heritage Museum

The Anaesthesia Heritage Centre was looking for volunteers in July 2007. An article in this very publication was a great success and met with much interest. Here two volunteers write about their experiences over the past three years.

Dr Barbara Thornley writes:

About two years ago, around the time of my retirement, I saw a short article in Anaesthesia News asking for interested volunteers to help with a series of so-called medical walks. I rang the contact number and was invited down to London to meet Trish and Iris to learn about what was involved.

They were looking for anaesthetists with some time to spare who would be happy to go to the museum and talk to groups of visitors, perhaps giving them a short history lesson and talking about the displays in the museum. There was also talk of doing some “research” into unidentified objects in the collection which could be done from home via the internet. It sounded very interesting so I happily signed up!

Unfortunately I was unable to get to any of the first few walks that were booked; not a good start! However I was then asked if I was prepared to help with work on the database/inventory, checking detail and descriptions etc, needed to attain a particular form of museum recognition called Accreditation for Museums.

Never one to turn down an opportunity and a day in London, I agreed to help, and from August 2008 I have been going to the museum approximately every 3 to 4 weeks. I spend about 5 to 6 hours, usually in front of the computer, doing a variety of tasks which may also involve searching through boxes from the storeroom, checking the identity, preservation status and measurements of all sorts of anaesthetic equipment both old and relatively modern. It is strangely fascinating handling items I remember from when I started my anaesthetic training and also seeing the original prototypes of more modern everyday items.

I have also now, at last, had the opportunity to be involved with the medical walks. The groups who book these visits vary but most are of a “certain age”, they come with a guide, often visiting other places with a medical connection, and are always very interested in learning more about anaesthesia, handling some of our equipment, and swapping anecdotes of their personal experiences!

I have also had the chance to go on two courses to date, one on handling delicate and precious objects, and the other on how to take an Oral History. Both were most enjoyable and gave me new skills that I look forward to using on behalf of the Association.

I have recruited a new volunteer, Pamela Laurie, who also seems to be enjoying our work.

The Association kindly reimburses my travelling expenses so I diligently use my Senior Citizen railcard. It is useful that I live within commuting distance from London as it would be either very expensive for the Association, or offer little time for worthwhile work for anyone living too far away to make a day visit worthwhile.

Am I pleased that I volunteered? Most definitely yes. I have learned a great deal (including improving my computer skills), I have made new friends, and I feel that I have kept up a connection with my career and specialty that I might otherwise have lost.

Pamela Laurie agreed and added:

I was pleased to be approached as a potential volunteer, as the idea of retaining a connection with our specialty was also appealing.

It is most gratifying to observe the interest of many lay members of the public in anaesthesia: perhaps all those "Anaesthesia Days" did have an impact! Finally, the Association’s programme of interviewing long-retired senior members of the specialty will be invaluable in eliciting fascinating details of early anaesthetic developments.

Drs Barbara Thornley and Pamela Laurie
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CPD accreditation: 10 points pending
An Update from the GAT Committee

"Time flies when you are having fun", so the saying goes. I can hardly believe that the time has come for my final Update article during my year as GAT Chair. But the deadline looms and time for nostalgia and reminiscence is short, so off with the rose-tinted spectacles and down to business...

The GAT Committee had another full, enjoyable and productive meeting at Portland Place on Friday March 12th. For the first time we sampled the delights of technology which allowed our member from the North East (Dr Beckingsale) to participate by telephone for part of the morning session whilst also working nights. It provided a great opportunity for the airing of views which would otherwise have gone unheard, although it certainly provided an extra challenge in my role as meeting chair. A full meeting report can be found, as usual, on our GAT web-pages.

By the time this issue of *Anaesthesia News* drops onto your doormat, our Annual Scientific Meeting (ASM) will be mere weeks away. However, it is not too late to register for our flagship event and come along to Cardiff from Wednesday 30th June to Friday 2nd July. The full scientific programme can be found on our web-pages; highlights include a session on Peri-operative Optimisation, an Intensive Care Medicine session sponsored by the Royal Society of Medicine, Professor Irene Tracey speaking about her work on Functional MRI, and the annual Pinkerton Lecture by Dr Patricia Oakley entitled “Planning for the future Anaesthetic workforce - a research agenda”. Combine this with the usual ingredients of entries to the Registrars’ and Audit Prizes, the Anaesthesia History Prize, fantastic social events each evening and of course Cardiff’s reputation as a capital city (not to mention the guaranteed summer sunshine) and the lure will be hard to resist. If you have not yet registered I urge you to do so as soon as possible.

The GAT Committee submitted written evidence to the recent ME(E) “Review of the Impact of the European Working Time Directive on the Quality of Training”. A copy of this can be found on our web-pages. We were not invited to present oral evidence to this process. Our recent interim position statement on the EWTR is awaiting an update, but we are reluctant to do this without some more concrete data on which to base our opinions. We will be attempting some data collection of our own, utilising our Annual Survey conducted at the ASM. However, if you are unable to attend the ASM but feel that you have something to add or share with us on this matter then please e-mail me at gat@aagbi.org so we can make our statement as representative of you, our members, as possible.

Our redesigned GAT web-pages will hopefully be launched in the near future, and the Committee members should be congratulated on all their hard work turning their ideas into reality. Do go online and have a look, and again let us know if you have any comments, questions or new ideas for further content. We are particularly keen to develop an on-line Events Calendar into an essential trainee resource and would value your feedback on this.

Watch out for our soon-to-be-published booklet “Who is the anaesthetist?” – our modern take on the previous “Your Career in Anaesthesia” publication aimed at medical students and junior doctors interested in anaesthesia. An accompanying poster board is currently under construction which will be unveiled at the BMJ Careers Fair in October 2010.

The GAT Committee, AAGBI Council and RCoA Council continue to try to find a solution to the issue of GAT losing its position on the RCoA Council last July. The latest proposal involves the formation of a new representative group at the RCoA which will include the GAT Chair in its composition. Keep an eye on the websites of both parties for more information on this. GAT continues to co-opt an RCoA Council trainee representative and we are proud to report that, despite some technical difficulties this year, we have maintained an excellent working relationship with them.
We get a number of requests for help each year with performing audits/surveys, both via our e-mail database and at the ASM. Our policy is to always decline these requests to prevent a deluge of e-mail traffic to members’ inboxes. We will also admit to a certain degree of self-interest in the matter, after all we want our members to reply first and foremost to our own surveys (which we limit to a maximum of two per year) to enable us to function as a representative body. However, if you have an idea for a topic that you think we should be addressing then please do not hesitate to get in touch to discuss the matter with us. We will always reply to any e-mails we receive through our gat@aagbi.org address.

Congratulations must go to Dr Rob Broomhead who has been elected to take over the GAT Chair position at the ASM in July. I am sure he will do an excellent job of leading the Committee and I wish him every success in the future. An election for the position of Honorary Secretary will take place shortly. The Committee will also have two new elected members joining at the ASM. Dr Liz Shewry, our Vice Chair, is taking a six month sabbatical, and elected member Dr Emma Anderson is taking a one year sabbatical, both to Australia. Dr Anderson should be particularly commended for her work on establishing a link between the AAGBI International Relations Committee who have links with trainees in Uganda, and GAT – discover more about this in Cardiff. Our usual practice is to co-opt a replacement for any Committee member who is away for a year.

It just remains for me to keep on encouraging anaesthetic trainees to join up to the AAGBI and therefore to GAT. We have traditionally represented over 90% of anaesthetic trainees and would like to continue to do so. Please go to the website to find out a full list of advantages of membership of the AAGBI and join today.

See you in Cardiff – please come and make yourself known to me!

Felicity Howard
GAT Chair

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**Bacterial Meningitis After Intrapartum Spinal Anesthesia - New York and Ohio, 2008-2009**

_JAMA_. 2010;303(11):1026-1028

This report describes two clusters of meningitis affecting five patients in New York and Ohio. In four patients, the cause was *streptococcus salivarius*, a normal oral commensal.

The first cluster involved 3 patients who developed meningitis within 24 hours of combined spinal-epidural anaesthesia during labour administered by anaesthesiologist A. Standard aseptic precautions included use of a facemask. *S. salivarius* was not isolated from the anesthesiologist.

In the second cluster, 2 patients developed meningitis after intrapartum spinal anaesthesia administered by anaesthesiologist B. A facemask was not worn during spinal anesthesia. *S. salivarius* was identified by PCR in the anaesthesiologist’s oropharynx.

Extensive investigations by the hospitals, state departments of health and the CDC were carried out. In both clusters the anaesthesiologist was found to be the common factor. The accompanying CDC editorial note postulates that *S. salivarius* was transmitted by droplet transmission directly from the anaesthesiologists’ oropharynx or via contaminated sterile equipment.

In 2007, The Healthcare Infection Control Practices Advisory Committee (HICPAC) in America recommended that clinicians performing spinal procedures wear facemasks. This has also been recommended in the UK in the AAGBI safety guideline (Infection Control in Anaesthesia Oct 2008). In 2006, the American Society of Regional Anesthesia and Pain Medicine recommended the use of surgical masks during regional anesthesia procedures.

The use of surgical facemasks in operating theatres remains a contentious issue. Current guidance would suggest that during the performance of central neuraxial blockade the operator should wear a facemask as part of standard aseptic technique.

Rahul Bajekal
Consultant Anaesthetist
Newcastle upon Tyne
I always thought I would retire at 60 or even earlier. I had done some preparation. I attended a BMA seminar on retirement which was both enjoyable and helpful. I learnt that retirement appeared to offer the opportunity to pursue a number of things that had been hobbies, interests or day dreams. One problem people noticed was the lack of a structure that the regular working week provides. It was possible to drift through days without achieving too much when there was no need to jump out of bed with the alarm clock each morning. The financial aspects of retirement were dealt with very well, explaining the entitlements to winter fuel payments along with travel passes. The NHS pension scheme is particularly good. The pension is based on the full time salary of your current post. If you are not in a full time post the pension is still based on a full time position, the amount you receive depending upon your contributions up to your retirement date. Someone working fulltime for 40 years will receive half their salary as a pension. If you work 35 years full time and 5 years on 5 PAs you would be deemed to have contributed 37.5 years and you would receive 37.5 eightieths of a full time salary.

Armed with all this knowledge, I was talking with one of my colleagues one day. We both enjoyed working. In the past we had both done clinical and administrative work but now were purely clinical practitioners. Clinical work of course is what attracted us to medicine in the first place. Mulling over we both agreed we enjoyed many aspects of our clinical work but had ideas about developing other activities. We discovered our birthdays were very close together. Within two weeks of each other we would reach the magic age of 60 and we came up with what we thought was quite a brilliant idea. As we both enjoyed working but did not want to work quite as much, we thought we would put a proposition to the department that we would share one post. My colleague had spent a number of years in intensive care and I had spent a number of years in cardiac anaesthesia. We did not think we could take over each other’s speciality work and thought it would be much better to think of other areas (particularly orthopaedics) that we both enjoyed. The department was receptive to our idea although possibly a little wary, as we potentially might not offer the same level of involvement in teaching, training, audit and all the other aspects of...
SPA time. The arrangement to reduce to a SPA contract each was approved, with the suggestion that this be reviewed on an annual basis.

On-call was not necessary as the rota was reasonably staffed and the way we arranged the job share was that each of us would work 6 months of the year. We arranged to work alternate months. This meant we would be fully immersed in the department for a month then have a month to do other things.

How did it all work out? I think the answer would be that it worked out better than we and the department originally expected.

What were the advantages? We enjoyed our months of working. It was good to meet up with colleagues, the surgeons seemed happy and doing no on-call was a real bonus. Advantages for the department were that they had experienced senior people giving anaesthetics and we were available during school holidays, half terms etc. A small disadvantage was that the first week back was a little strange. It was like coming back from holiday and re-establishing yourself. By the second week you felt truly embedded and by the third and fourth week you were looking forward to something else. It is also necessary to do all the normal things a consultant does, eg teaching and training, having all the data available for appraisals, continuing to keep up to date by attending some educational activities and partaking in audits.

What did we do in the months we were not working? I was jealous of many of my younger colleagues who experienced GAP years and trips around the globe. South America, Australia and New Zealand were some of the destinations we travelled to and it was possible by mutual agreement to arrange a slightly longer spell than the month on month off if required. I joined a choir and led walking holidays in my spare time. My colleague concentrated on guitar playing, aqua diving and becoming even more fluent in French.

You probably need to be in a fairly large department for this to work. You need to find a soulmate who wishes to downscale. However most departments have grown in size and may continue to grow with amalgamation of hospitals. I can recommend it as a fantastic way to improving your work life balance. I hope I do not sound too smug.

Dr Gillian Farnsworth
Consultant Anaesthetist
St George’s Hospital
London
Introduction

An African Out Of Programme Experience (OOPEs) is a fantastic opportunity to benefit both yourself and others. I have recently returned from serving 6 months aboard the M/V Africa Mercy, the hospital ship of the Mercy Ships charity, which was docked in Benin for 2009. (Benin is the western neighbour of Nigeria; I had to look it up too!) Mercy Ships is a Christian based charity whose mission is to bring hope and healing to the forgotten poor of this world.

The experience, I have no doubt, will be irreplaceably valuable to me in the future and I could not recommend it more strongly for anybody considering working in the developing world. I gained clinical experience that built competence as well as confidence. I gained management experience that will hold me in good stead in the years to come. I made friends for life. I grew spiritually through the good times and the bad. I experienced different cultures both on and off the ship, which has broadened my awareness of others’ needs. And most importantly, I was able to care for some of those who without Mercy Ships would have no other options. For all of these I am most grateful.

Organisation

Organising the trip was relatively simple. I had spent two weeks in Ghana with Mercy Ships in 2006 and a few phone calls and e-mails resulted in my acceptance for a 6 months stint. Once I had completed the formalities with my Regional Adviser and after informing my Deanery, I applied to various organisations for funding as flights to and from Africa are not cheap and while aboard one is expected to pay crew fees, for board and lodging. I am most thankful to the IRC of the AAGBI for granting me £2,000. I also received some funding from the Royal Society of Medicine. My wife, a chartered accountant, was able to join me after being granted a sabbatical to volunteer in the finance department. Her acceptance was relatively simple too as anaesthetists can be in short supply at times and Mercy Ships will do what they can to accommodate longer term anaesthetic volunteers with family.

On Board

We joined the ship in Tenerife where she had been docked for the summer break and maintenance. A nine day sail down the West African coast followed during which we attended orientation programmes about cross cultural experience, community living and what to expect about the running of the onboard hospital.
Once docked safely in Cotonou harbour there was plenty to do. The hospital needed to be set up as everything had been secured for the voyage. All 6 Operating Rooms (OR’s), the stores, pharmacy, 4 wards and the ICU had to be cleaned and set up. During this process I was very impressed with the organisation of the long-term crew. From an anaesthetic point of view, the OR pharmacy/store room was well organised with all a first world anaesthetist could want except for a few items (e.g., remifentanil). There was a neat anaesthetic trolley in each theatre with all the essentials for the management of a critical incident and a fully stocked resuscitation trolley was setup in the corridor and in each ward. The only deficiency was Intralipid™, but one of the UK anaesthetists brought some out.

There was a good range of airway adjuvants, intubating equipment and emergency airway devices including two bronchoscopes, a video laryngoscope and a Saunders jet ventilator. One of the more interesting aids was a light-wand or trach-light which is popular among Canadian anaesthetists. I was pleased to be taught how to use this device effectively. Considering that a fair portion of the ship’s workload involves a difficult airway, I felt it was necessary to assemble a difficult airway ‘grab bag’ with all the essentials, which proved invaluable on several occasions.

There were 6 Ohmeda Modulus 2 anaesthetic machines in each OR. These were maintained by our biotech magician, Tony. We would have been stuck many times over were it not for his efforts. We received some new Sevoflurane vapourisers in May and I understand new anaesthetic machines will be on board by the next outreach in February 2010. Oxygen was supplied via two oxygen concentrators on the upper deck. This was backed up by a cylinder manifold, which unfortunately had to be turned on manually. The concentrators did give problems occasionally and we became accustomed to the oxygen failure alarm. Thankfully there was a highly efficient engineering team who were quick to respond to our needs. Further oxygen backup consisted of H size cylinders in each OR and E cylinders on the back of each machine.

An “open house” evening was held before work was due to commence in the hospital. This was great fun and was an opportunity for the hospital staff to show the non-medical volunteers what we do in the OR’s. This involved various games with role-plays and a tour around the hospital. The hospital is very impressive. There is an admissions area, 4 wards with 15 to 20 beds each, a 5 bed ICU with Siemens 900c ventilators, and an X-ray department with a CT scanner and a laboratory with capability to do most relevant tests including cross matching blood. The “blood bank” is the crew themselves.

The OR setup was as follows: Two were for eye surgery only. Each of them had 2 operating tables with a microscope between them. One table was for general anaesthetics, which made things tight! Up to 30-35 cataract are done daily. General anaesthesia was required for children and those requiring evisceration or enucleation of the eye.

One OR was for maxillofacial surgery. Dr Gary Parker is the resident maxillofacial surgeon who has been on board for 23 years. He is also the Chief Medical Officer. The patients in this OR had various conditions including cleft lips and palates, mandibular and maxillary tumours, encephalocoeles and facial deformity due to noma. I gained invaluable airway experience from these cases. The most challenging of which was a 2.5kg child with a tumour the size of her head on her lateral neck. A very experienced paediatric anaesthetist from Canada managed the case impressively. Another OR was dedicated to general and paediatric surgery. The most challenging cases were large goitres and a few children with Hirschprungs disease. Another challenge in this OR was keeping up with the surgeon as he was incredibly fast and could do an inguinal hernia repair in 8 minutes, including a mesh!

The Surgery

The real work started with an eye-opening event: screening. Approximately 2,000 patients queued along the street to a local sports hall where Mercy Ships had set up a massive preoperative clinic. About 650 were chosen and given a date for surgery. It was gratifying to know that we would be providing free operations for these patients but at the same time it was heart breaking to be aware that there were many we could not help.

Our role as anaesthetists was to conduct a physical examination of patients selected for surgery. This was useful from an acute disease point of view but pre-optimising patients with chronic disease was not really possible. We were able to treat acute infections, including malaria, and all patients received iron and multi-vitamins. However, patients with diseases such as uncontrolled hypertension or diabetes were a problem, as most did not have the resources to obtain appropriate medical treatment. Some of the particularly severe cases and those with overt hyperthyroidism were assessed at a later date by our crew and ward physician.

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The orthopaedic theatre ran for 14 weeks. Sadly, there was a further 4 weeks of operations scheduled that had to be cancelled, as no paediatric orthopaedic consultant was available. We operated on many children with either clubfoot or bowlegs but had a waiting list of a further 80 patients.

The sixth OR was used for a plastic surgery or vesiculo-vaginal fistula (VVF) surgery. Some of these patients were the most memorable. Julian was a young boy, who was severely disfigured by neurofibromatosis. He stayed on board for a few weeks after his surgery but despite his suffering he had such a positive attitude and always appeared cheerful. Other plastic surgery patients, such as Christian, had suffered awful burns as a child and had grown up with severe contractures of his legs, the release of which provided a challenge to the surgeon.

The VVF patients were suffering a condition which at first I did not fully understand. Their stories are heartbreaking. They had experienced obstructed labour for 4-5 days, often resulting in the death of their unborn child and leaving them incontinent for life. This leaves them shunned by their family and friends due to the constant stench of urine. Some could be cured with one simple operation but others were not so fortunate and despite repeated surgery were not healed. From an anaesthetic perspective a spinal or CSE would suffice but the surgery was clearly challenging at times and conversion to GA was occasionally required.

**Critical Incidents**

There were a few critical incidents while I was on board, all of which were reported and acted upon at regular Quality Assurance Meetings. One event stands out. A complete blackout! Dr Parker was halfway through a mandibulectomy, a child had just been induced and we had just intubated one of the biggest goitre patients we had seen. Pitch darkness occurred followed by the whistle of the oxygen failure alarm. No one panicked and torches (flashlights for the Americans) appeared everywhere. Amazingly no patient experienced an adverse event. Unfortunately, the child and the goitre patient cases had to be cancelled, as there was no imminent solution or obvious cause for the power failure. The emergency generator was supposed to kick in and failing that, the battery bank should have at least given us lighting. Power was restored in twenty minutes or so and the mandibulectomy could be completed. As it turns out in most root cause analysis many consecutive events resulted in complete loss of power.

**Experience**

I have found it to be true that giving of oneself often results in receiving many blessings in return. My experience on the Mercy Ship has educated me in many ways. The clinical experience is quite unique. Essentially one treats third world patients in a first world environment. This experience is priceless and to receive training from some world-class consultants is an added bonus. As the longest serving anaesthetist at the time I gained more experience. Besides list allocation, on-call rota organisation and orientation of new anaesthetists, I was challenged having to sort out the occasional interpersonal clash. There were also a few organisational improvements that I was able to make. One patient safety issue that I felt it was important to intervene in was the use of 0.18% saline with dextrose for children.

I was able to teach a Beninese anaesthetic nurse for a week and know he appreciated every moment of his time on board. It would have been rewarding to be able to do more training of local anaesthetists but, due to the high turnover of staff on the ship, this was not feasible.

I was pleased to get involved in the issues raised by perioperative malaria as we had a few patients with this condition requiring surgery. I presented an audit of patients who had malaria at a regional anaesthetic meeting once back in the UK and was pleased to win the registrar’s prize!

**Not all work**

Despite the 8 to 10 hour days there was plenty of time for leisure. I went SCUBA diving (under the ship to clean the air conditioning intakes), surfing, waterfall jumping and camping on safari. Nearby the ship were some upmarket hotels where we went swimming and some great restaurants. On board we enjoyed events such as a South African barbeque, birthday parties on the upper deck and the hilarious 2nd Africa Mercy film festival.

Working with Mercy Ships has been a wholly rewarding, life-changing experience. I have gained much knowledge about anaesthesia and about how a hospital functions. Every person on board, from the surgeons to the finance staff, the engineers to the HR staff, the sterilisers to the translators all had a part to play in supporting the functioning of the hospital. I have learnt first hand about the desperate need of the poor in underdeveloped areas and of the remarkable men and women who have dedicated their lives to serve them. I pray that I can continue to be part of Mercy Ships in the future and I would encourage anyone considering working in the developing world to come on board.

Dr Paul Theron  
Africa Mercy  
www.mercyships.org

I would like to express my most sincere gratitude to the International Relations Committee of the AAGBI for awarding me a £2000 travel grant for my 6 month OOP with Mercy Ships in Benin. Financial support is vital to assist and encourage anaesthetists to participate in volunteer work. I hope my report and the knowledge that funding is available from the AAGBI will inspire others to volunteer in the developing world.
Ed was born on October 9th 1942 and died on Easter Sunday, 4th April 2010.

Born and educated in Newcastle, he graduated M.B., Ch.B. from Durham University in 1965. After an initial period in obstetrics, he began his anaesthetic career in Cumberland Infirmary, Carlisle and after a year returned to the Royal Victoria Infirmary in Newcastle where in due course he passed the examination for the FFA (now FRCA). This exam success was slightly delayed due to his interests in many social and sporting activities – being a very enthusiastic rugby player. As an experienced registrar it was not long before he became a consultant anaesthetist at the RVI, where he developed an interest in the management of pain, the clinical interest for which he is so well remembered.

Pain management at that time was of minimal general interest in hospitals and to gain proper experience he moved in 1973 to Seattle to work with John Bonica – the international doyen of pain management at the time.

He returned to the RVI in 1975 but it was clear to him then that the environment for proper pain management was not yet present and he returned to Seattle where he was appointed Assistant Professor in Anaesthesia and Assistant Director of Pain Management at the University of Washington. He honed his clinical skills, became a founding member of the International Association for the Study of Pain, played a lot more rugby, drank the occasional beer and met his future wife Laura.

His heart remained in Newcastle however, and in 1980 he returned and set about creating a proper Pain Management clinic with Professor John Thomson. It was one of the first of this nature in the UK. Thereafter his progress in this specialist field is common knowledge to all. His was indeed a household name within the specialty of pain management.

In 1987 he was elected to Council of the Association of Anaesthetists of Great Britain and Ireland and another avenue for his talents opened. He became Assistant Treasurer in 1988 and in this post he revitalised the then faltering Linkman Scheme, putting it back in its rightful place. He became Assistant, then Honorary Secretary when his President was his great friend and ally, Peter Baskett. Peter described him as “innovative, hard working, loyal, strong, witty, kind and understanding” - a good description of his term of office.

Finishing his work as Honorary Secretary (itself a very heavy commitment) he could have retired quietly, but not Ed; he became the Editor of Anaesthesia News – which in his hands acquired much additional punch and became mandatory reading in anaesthetic departments throughout the country.

He spoke through a cadre of animals – Deefer Dog, Hoover the Cyber Spaniel and the Beaver. All identified areas their owner had detected needed to be closely inspected – for example, Private Health Insurers, the Monopolies and Mergers Commission, even the Royal College of Anaesthetists and many others. Often readers were unsure of the direction the barbs were pointed in – but the recipients were not! Successive Presidents of the Association, being responsible for the publication, spent anxious nights, usually at short notice as the publication date approached, trying to demonstrate their wish to be both forward looking whilst at the same time fearing the sensitivities of some of the individuals identified whose views they knew were being pilloried! Those were exciting times! He was Editor of the publication from 1992 till 1999 – a fantastic commitment for anyone.

Ed was a generous donor of his time and energies to our profession. A member of 17 learned societies, he was instrumental in founding the principal associations for the study of pain at international, national and local level. He held appointments within the International Association for the Study of Pain for many years, with membership of multiple committees, including the Executive Committee and Council and Honorary Secretary from 1993 – 1998. He was elected Vice-President in 1996.

From 1986 he held office in the Pain Society (UK and Ireland) and was its President in 1997 – 1999. He was awarded Honorary Life Membership in 2001.

In the course of his career he was elected to five overseas visiting professorships, co-authored a highly regarded book...
on intractable pain, wrote 25 chapters in books and wrote or co-authored 39 scientific papers. He sat on several editorial boards and refereed countless manuscripts.

Committees and working parties on a great variety of topics - he did them all. He was in constant demand because everything he tackled he did with enthusiasm, professional skill and above all - style. He was a much sought after lecturer. The invitations came not only for the renowned academic content of his presentations, but also because of his delivery and humour. He never gave a bad lecture as evidenced by close to 300 invitations to speak from all over the world.

As a medical student and at Carlisle as a resident anaesthetist, he had played rugby – not surprisingly in the front row. He maintained his links with the Medicals Rugby Club, serving as Vice-President for many years and then President in 1999. He played social rugby for the Novocastrians well into his forties and then became a referee. He reported that he was ideally suited to be a referee because there wasn’t a dirty move in the game that he hadn’t perfected himself in his playing days.

As a member of the Northumbrian Referees Association he was well known as a man who knew the game and brooked no nonsense. Giants trembled as he explained the rules - his rules. As you might expect, he was in demand as an after dinner speaker with an endless store of anecdotes.

He was a very clubbable man, and belonged to many. Quite apart from rugby and medical organisations he loved exotica - the Blue Funnel Club, the Savage Club, the John Snow Society and the Pen and Palette Club - reflecting his huge range of interests.

In his later years, awards came thick and fast.

In 2000 the Association presented him with a Pask Award for his services to the specialty. Of this he was inordinately proud, with its connections with Professor Pask from Newcastle. At the same time he was elected Honorary Membership of the Association.

In 2003, the Association awarded him the John Snow Silver Medal and the Royal College of Anaesthetists its Gold Medal in recognition of his tireless work in developing the subspecialty of Pain Management.

In retirement he moved completely to Bamburgh where he threw himself with his usual enthusiasm into local village life – developing the Christmas lights and encouraging the Bamburgh Fair. There he lived with his beloved wife Laura and his daughter Danielle and glowed in the success of his son John in Seattle, his second home. He supported the Falcons Rugby Club, drank a little wine, entertained friends and generally enjoyed retirement – but for such a short time.

Intractable pain, wrote 25 chapters in books and wrote or co-authored 39 scientific papers. He sat on several editorial boards and refereed countless manuscripts.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at honsecretary@aagbi.org by 5pm on Friday 24th September 2010.

Dr W R MacRae
Past President AAGBI

The Association of Anaesthetists of Great Britain & Ireland

Evelyn Baker Medal
An award for clinical competence

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Portypridd) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Brian Steer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005, Dr Martin Coates (Plymouth) in 2006, Dr Gareth Charlton (Southampton) in 2007, Dr Neville Robinson (London) in 2008 and Dr Fred Roberts (Exeter) in 2009.

Nominations are now invited for the award to be presented at WSM London in January 2011 and may be made by any member of the Association to any practising anaesthetist who is also a member of the Association.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at honsecretary@aagbi.org by 5pm on Friday 24th September 2010.
It was quite simply the single most terrifying moment of my life. It was a Wednesday in August almost three years ago. I had finished my morning list and was walking back to the operating theatres after lunch. I stopped - I could neither go forwards or backwards - it was as if I was frozen to the spot. Suddenly, I realised that I could not carry on and do the list. I didn't know at that moment why I could not carry on; all I knew was that I could not. I seemed to stand there for minutes completely immobile. It was as if I were standing at the edge of an infinitely dark and deep abyss that lay right before me - a sort of black hole that would swallow me up if I lost my balance - and my legs were shaking more and more as I imagined the consequences of falling into the black hole. Eventually, I turned and managed to walk to the car park, get in my car and drive home. As I got back to the house, it felt as if my head was going to explode, I felt utterly exhausted and I was terrified that my illness - or whatever it was - would end my career and harm my family. If I could not work, what was the point of carrying on? I felt thoroughly wretched and totally confused. Two days later, I was to go on holiday for three weeks, so I phoned the department and told them that I was sick and would not return until after my holiday. For the next week, I tried to work out what was happening to me - perhaps I really was ill. I thought back to what had happened in the few days before my encounter with the black hole. The week before had been tough - it was August and those of us not on holiday had been working hard to cover all the lists. I had been on call during the week and had a bad night - not only because it was busy but also because we lost a young patient on the operating table. It was no one's fault but we all felt pretty bad about it. Then I was on call for the weekend, which was busy, but not unusually so. Monday was a day of compensatory rest after being on call, so I went to play a round of golf. I recall driving up to the golf club not feeling quite right and thinking rather angrily that I shouldn't have to do on-call at my advanced age! I expected that a day's golf would "blow away the cobwebs", and after a good night's sleep I would be fit for work the next day. I worked on the Tuesday but felt unwell, with a headache, some 'flu-like symptoms and also feeling generally "strange" - I couldn't really explain it. I didn't feel right the next morning, the Wednesday, but I felt okay to do my list - or so I thought. That was the day I arrived at the edge of my own personal black hole. What was happening to me?

It slowly dawned on me that what I was going through was a manifestation of some sort of stress that had been building within me for some months and even years, and had been brought to a head by the emotional challenge of the death of a young patient and by the tiredness of a couple of busy weeks. The previous couple of years had not indeed been easy. My clinical work had been busy, and I was fulfilling a challenging and stressful management role in my hospital. At the same time, I was an elected member of the AAGBI's Council and was travelling to London on a regular basis for meetings. In addition to this, I was the President of ESRA GB & I, and its representative on the main pan-European Board of ESRA, which at the time was going through a political maelstrom. As the person charged with the responsibility of rewriting the society's constitution, I was in the very middle of this storm, and had been the subject of some very typical mainland European wrangling and politicking. I had not had a terribly easy time but I was blithely ignorant of what my lifestyle was doing to me right up to the moment that the black hole opened up in front of me. Stress - isn't that what happens to other people - the weak, disorganised or inadequate? Surely, stress doesn't affect people like me, I thought. How wrong I was.

Stress-related illness is an increasingly common occurrence. It has a significant impact on the individual, on their place of work and on the organisation that employs them. It is estimated that about 1:6 workers is affected. Most doctors are aware of this but few think it could happen to them, me included! This is most certainly not the case. In fact, doctors are more likely to be affected than almost any other group of professionals. There seems to be a spectrum, ranging from a minor event to a full-blown illness requiring significant time off work, but nearly always needing some form of lifestyle change on the part of the individual concerned in order to make progress. Stress is common and does happen to people like me – and you.

Stress is part of everyday life, and low levels of stress are actually good for performance. However, the physical and psychological signs of excessive stress need to be recognised, and if appropriate
steps are taken early in the process, the situation can be remedied without the individual concerned suffering significantly or needing to take time off work. However, the signs of stress should act as a wakeup call for that person and should cause them to make some lifestyle changes, either at home or, more likely, at work. This is where correct management of stress in the workplace is important. If the situation is handled badly or just ignored, the affected individual will be driven towards a crisis and will cease to be a useful employee, requiring considerable time off work. Good employers go to great lengths to help and prevent stress-related illness. This is done not just on humanitarian grounds but also for hard economic reasons.

The key management strategy is for the person affected to recognise what is happening to them, admit it to themselves and seek help. They may approach sympathetic colleagues first, but most hospitals have excellent occupational health services that are also a good starting point for seeking help. Often, some time off work will be required and both psychiatric treatment and psychotherapy may be sought. In the very acute phase, pharmacological treatment may be needed, particularly with acute anxiety states and depression. However, when these symptoms improve, psychotherapy may be very helpful. Its aim is to provide insight into the causes of the stress and how to minimise them. In order to drive a successful recovery from this illness and to prevent future relapses, some form of change to the person’s lifestyle is required, whether this is at work, at home or both.

So what happened to me? With the support of my wife, I spent the holiday thinking through the things that were causing me stress and working out how I might be able to decrease the pressures on me. Although I was concerned that continuing to do on call would be a source of significant stress, I eventually realised that my worry about the pressures of being on call was more a symptom of my overall stress than a cause of it. Perhaps the turning point in my case was a series of long chats with a colleague who had been through something very similar a few years before. He had admitted to himself that he was stressed, had sought and received professional help, had made some changes to his life and had returned to full health. This gave me a real boost. As it happens, my terms of office at my hospital, the AAGBI and ESRA were all coming to an end, so I promised myself that I would not replace them with equally demanding positions and I was able to build more relaxation into my life.

So, there you have it. Stress is common. It happens to people like you and me. It is not the end of the world and it doesn’t mean the end of your career. People will not think any less of you if you admit to being stressed and seek help for it. You could almost say that the sort of people who are good anaesthetists are the sort of people who are particularly vulnerable to stress – hard-working people who try their best to treat patients well and who sometimes take life just a little too seriously.

I will finish with a well-known story that I think sets life into its proper context:

When things in your life seem almost too much to handle, when there seem to be not enough hours in the day, remember the mayonnaise jar, the golf balls and the two beers:

A professor stood before his philosophy class with some items in front of him.

When the class began, he wordlessly picked up a very large and empty mayonnaise jar and proceeded to fill it with golf balls.

He then asked the students if the jar was full. They agreed it was.

The professor then picked up a box of pebbles and poured them in the jar. He shook the jar lightly. The pebbles rolled into the open areas between the golf balls. He then asked the students again if the jar was full. They agreed it was.

The professor then picked up a box of pebbles and poured them in the jar. He shook the jar lightly. The pebbles rolled into the open areas between the golf balls. He then asked the students again if the jar was full. They agreed it was.

The professor next picked up a box of sand and poured it into the jar. Of course, the sand filled up everything else.

He asked once more if the jar was full. The students responded with a unanimous “yes”.

The professor then produced two beers from under the table and poured the entire contents into the jar, effectively filling the empty space between the sand. The students laughed. “Now”, said the professor as the laughter subsided, “I want you to recognise that this jar represents your life.

The golf balls are the important things: your family, your children, your health, your friends and your favourite passions… and if everything else was lost and only they remained, your life would still be full.

The pebbles are the other things that matter like your job, your house, your car.

The sand is everything else… the small stuff”.

“If you put the sand in the jar first,” he continued, “there is no room for the pebbles and the golf balls. The same goes for life. If you spend all your time and energy on the small stuff you will never have room for the things that are important to you.

Pay attention to the things that are critical to your happiness.
Spend time with your children.
Spend time with your parents.
Visit your grandparents.
Take time to get medical checkups.
Take your spouse out to dinner.
Play another 18 holes.
Take care of the golf balls first - the things that really matter.
Set your priorities.
The rest is just sand”.

One of the students raised her hand and asked what the beer represented.

The professor smiled and said: “I am glad you asked.

The beer just shows you that no matter how full your life may seem, there’s always room for a couple of beers with a friend.”

Dr Nick Denny,
Consultant Anaesthetist, Kings Lynn

The author would like to thank Julia Herrick and Will Harrop-Griffiths for their assistance and support in producing this article.

Anaesthesia News June 2010 Issue 275
When I was in high school, college, and medical school, I worked (at least whenever anyone would hire me) as a professional magician - no kidding! I learned many things, including why magicians almost never reveal the secret workings of their tricks and illusions. The reason is that most of these are so darn simple, revelation would take away the mystery of the performance, and detract from the alleged skill of the performer. This is especially true for so-called “close-up” magic, such as card, coin, rope, hand kerchief, and similar effects. The simplicity inherent in the secret of many illusions, in reality, relies on a concept that is basic to the practice of magic, namely “misdirection”. Misdirection involves having your subject, or audience, look away at just the proper time, or somehow not notice what you are doing, even when doing it literally right under their nose, and thus, the trick, or sleight-of-hand, is accomplished. Misdirection involves many very simple techniques of psychological manipulation, including tone of voice, body language, eye movements, and even the very specific nature of the words used (magicians call this the “pat ter”) during the performance of the illusion. When proper misdirection is done perfectly, the audience will have no idea how or when or even whether they have been manipulated.

What does all this have to do with anesthesia? Enter the “nocebo”. We are all familiar with the placebo (Latin for “I shall please”) concept, or that of an inert substance or verbal suggestion causing a real, but beneficial effect. The “nocebo” (Latin for “I shall harm”) effect is just the opposite, wherein a negative suggestion can result in harm or adverse occurrence or worsening of a symptom.

For many years, I have observed residents, my colleagues, and nurses, talk to patients during relatively minor procedures, such as local anesthetic skin injection prior to a regional block, using words (often with dramatic tone) such as “BIG BEE STING!” or “WORST PART OF THE PROCEDURE”. or “OUCH OUCH OUCH BURNING BURNING!!!!!!” Observing this, I have always wondered why they use such harsh words. Typically, patients would jump or otherwise express unpleasantness when the needle hits the skin. Does anyone really think they are making this procedure any better for the patients by warning them that will feel a BIG BURNING OUCH OUCH BEE STING? Apparantly so, given the widespread use of such words. In contrast, in my own practice, I have generally used words such as “small pinch, comfortable local anesthetic, make you numb, etc…..”. And apace, most of my patients tolerate the skin injection quite well, without distress or significant discomfort. Placebo vs. nocebo, in action.

The nocebo effect has been formally studied. Investigations into the effect of words used during intravenous cannulation, central line placement, postoperative pain assessments, and other settings too, have clearly shown that the choice of words can have a meaningful and substantive effect on the patients’ perception of the pleasantness, or lack thereof, of the procedure. Studies using functional MRI have even shown that there are neurological and anatomical correlates of nocebo suggestions, corresponding to anti-nociceptive anatomical and neurotransmitter cerebral activity. After many years of observing this phenomenon in my own practice, I, along with several colleagues, just recently completed an investigation, in a study published in the March 2010 issue of Anaesthesia & Analgesia (Nocebo-induced Hyperalgesia During Local Anesthetic Injection, A&A, 2010; 110:868-70). In this randomized controlled trial, patients were randomized to “harsh” (nocebo) words or “nice” (placebo) words, comparable to that noted above, before local anesthetic skin injection during labor epidural, or spinal anesthetic for cesarean delivery. A blinded observer obtained a visual-analogue pain score immediately after the skin injection. The pain scores were significantly lower when the placebo words were used, vs. nocebo.

This was a very simple study, but one that I believe has wide implications for our practice. The words we use, among other forms of non-verbal communication, are critical for eliciting certain responses among our “audience”, or in the case of medicine, our patients. These are the basic principles I learned when practicing magic. Communication skills are critical in the practice of medicine, and in many respects, when we interact with our patients, it is like we are “on stage”. I am working with my colleagues and our nurses to no longer tell patients that a simple skin injection is “the worst part of the procedure” or a “BIG BEE STING”, or other such harsh words. It is an uphill battle, as these types of words are so very ingrained in our culture of practice. It is also, to some, counterintuitive, as many of us believe that such harsh words will best prepare the patient for what may be a painful procedure. The evidence is clear, from my study and others, that this is not the correct approach. Anesthesiologists have many ways of easing pain. Medications are just one of these ways. As a wise mentor told me many years ago, we can also “inject words of kindness”.

Cheers,

Bill Camann
Department of Anesthesiology
Brigham & Women’s Hospital, Boston
USA
Final Viva Weekend  
14.00 Friday 11th – 16.00 Sunday 13th June

Final Single Best Answer Weekend  
14.00 Saturday 24th – 16.00 Sunday 25th July

Final MCQ Course*  
14.00 Sunday 8th - 16.00 Friday 13th August

Final Short Answer Question (SAQ) Weekend*  
14.00 Friday 13th – 16.00 Sunday 15th August

Final Revision (Booker) Course*  
14.00 Sunday 15th – 16.00 Friday 20th August

SAQ Writers Club Private Weekend*  
14.00 Friday 20th - 16.00 Sunday 22nd August

Primary MCQ Course*  
14.00 Sunday 22nd – 16.00 Friday 27th August

Final FCARCSI E & SAQ Weekend*  
14.00 Friday 27th – 16.00 Sunday 29th August

Primary OSCE Weekend  
14.00 Friday 3rd – 16.00 Sunday 5th September

Primary Viva Weekend  
14.00 Friday 17th – 16.00 Sunday 19th September

The FRCA Primary OSCE/Orals Course  
14.00 Friday 24th September – 16.00 Friday 1st October

* Scheduled to allow candidates to attend successive courses
Practice management guidelines on red blood cell (RBC) transfusion in adult trauma and critical care were developed in 2009 by a joint taskforce of the Eastern Association for Surgery of Trauma (EAST) and the American College of Critical Care Medicine (ACCM) of the Society of Critical Care Medicine (SCCM).

The goal of these guidelines was to review the evidence regarding efficacy, indications and risks of RBC transfusion in adult trauma and critical care, and to review the practices associated with decreased need for RBC transfusion and possible alternatives to transfusion.

Recommendations were graded from Level 1 to 3 based on scientific information and expert opinion. They can be summarized as follows:

1. Recommendations regarding RBC transfusion in the general critically ill patient
   - RBC transfusion is indicated for patients with evidence of hemorrhagic shock. (Level 1)
   - RBC transfusion may be indicated for patients with evidence of acute hemorrhage and hemodynamic instability or inadequate oxygen delivery. (Level 1)

2. Recommendations regarding RBC transfusion in sepsis
   - The transfusion needs for each septic patient should be assessed individually since optimal transfusion triggers are not known. (Level 2)

3. Recommendations regarding RBC transfusion in patients at risk for or with Acute Lung Injury (ALI) and Acute Respiratory Distress Syndrome (ARDS)
   - All efforts should be made to avoid transfusion in patients at risk for ALI and ARDS after completion of resuscitation because transfusion related acute lung injury (TRALI) is the leading cause of transfusion-related morbidity and mortality. (Level 2)

4. Recommendations regarding RBC transfusion in patients with neurological injury and disease
   - There is no benefit of a “liberal” transfusion strategy (transfusion when Hb< 7 g/dL) in patients with moderate-to-severe traumatic brain injury. (Level 2)
   - The transfusion needs for patients with subarachnoid hemorrhage should be assessed individually since optimal transfusion triggers are not known and there is no clear evidence that blood transfusion is associated with improved outcome. (Level 3)

5. Recommendations regarding RBC transfusion risks
   - RBC transfusion is associated with increased nosocomial infection rates independent of other factors and is an independent risk factor for multiple organ failure (MOF) and systemic inflammatory response syndrome (SIRS). (Level 2)
   - RBC transfusions are independently associated with longer ICU and hospital stays, increased complications, and increased mortality. (Level 2)

6. Recommendations regarding alternatives to RBC transfusion

- Recombinant human erythropoietin (rHuEpo) administration increases reticulocytosis and hematocrit, and may decrease overall transfusion requirements. (Level 2)

- Hemoglobin-based oxygen carriers are currently under investigation for use in critically ill and injured patients but are not yet approved for use in the United States. (Level 2)

7. Recommendations regarding strategies to reduce RBC transfusion

- The use of low-volume adult or pediatric blood sampling tubes is associated with a reduction in phlebotomy volumes and a reduction in blood transfusion. (Level 2)

- Intraoperative and postoperative blood salvage and other methods for decreasing transfusion may lead to a significant reduction in allogeneic blood usage. (Level 2)

- Reduction in diagnostic laboratory testing is associated with a reduction in phlebotomy volumes and a reduction in blood transfusion. (Level 2).

Commentary

Whilst there are no guidelines in the UK and Ireland specifically aimed at the trauma and critical care patient, it would seem reasonable to generalize the American guidelines to the UK situation. Indeed the 2008 AAGBI guideline "Blood transfusion and the Anaesthetist", which addresses blood transfusion in the perioperative period, recommends similar transfusion triggers (<7g/dl or <8g/dl in the presence of significant cardiorespiratory disease) and equally emphasizes the risks of blood transfusion, with the added risk of transmission of variant CJD in the UK.

Dr. Nageswaran Narayanan
Consultant Anaesthetist,
St. Vincent’s University Hospital,
Dublin – 4,
Ireland.
Email: ninbha@yahoo.com

New guidelines

Two AAGBI working parties have produced guidelines this month:

The Anaesthesia Team

Anaesthetists have always worked as a team rather than individually but over the years that team has extended and personnel from many disciplines combine to improve efficiency and safety for the patient.

This latest version of the ‘Anaesthesia Team’ gives a broad outline as to where all those involved fit in, including their training and limitations of practice. Pre-operative assessment and post-operative care including PACU (recovery) and post-operative analgesia are described as well as team work within the operating suite. Some standards are achievable now and some, as with all our ‘glossies’ are standards which we believe could and should be achieved in the short to medium term. All the disciplines described have contributed to this document and we are most grateful to them all for this.

Dr RJS Birks
Chair - Anaesthesia Team
President AAGBI

Clinical Management in Anaesthesia

Good clinical management is key to effective clinical care in the NHS and other healthcare systems. A recent working party including AAGBI Council members and AIM (Anaesthetists in Management) members has produced a new ‘glossy’ describing the role of clinical management in our specialty.

The publication describes the national structures of healthcare in different countries and also details how hospitals are managed locally. Different management posts within each trust are described, along with some of the challenges and opportunities clinical management provides. The publication also includes a description of the legal responsibilities of clinical managers and also the military medical services structure.

The glossy will be of interest to all anaesthetists. Those awaiting their consultant interview will find the description of healthcare structures useful; those considering a management position will find helpful information throughout. We hope that all colleagues will reflect on the important contribution made by clinical management in keeping our clinical care safe and effective.

Dr Iain H Wilson
Chair – Clinical Management Working Party
President-elect AAGBI
The 17th December 2009 was a very grim day for anaesthesia in Uganda.

It was the day of the burial for Mr Ibanda Edison, a senior anaesthetic officer from Mulago Hospital, Kampala. He had worked for many years at Mulago and as a sign of respect for someone and as a way of celebrating their life it is very important in Uganda to attend the burial service which takes place in the home village. The department of anaesthesia had organised a 24 seater bus and a 14 seater minibus for staff from the hospital to attend the burial in his village. The SHOs hired a car. They left Kampala at 10am and headed east and the bigger bus and car arrived at the burial as they were lowering the coffin. Meanwhile the minibus, close to the village but unsure of the way, stopped on the side of the road to ask for directions. Suddenly a large Isuzu bus careered into the back of the minibus and it somersaulted off the road. The bus continued on its way without stopping! The impact was massive and one senior anaesthetic officer, Nsereko Florence died instantly. An obstetrician survived relatively unscathed and called the colleagues at the burial to come and help. They immediately returned to the site of the accident only to find Florence’s body which they picked up as all the other passengers had been transferred to the nearest hospital.

Now all of us who live in LEDCs (Less Economically Developed Countries) know that the travelling on the roads is probably the most dangerous thing we do but the way this story unfolds is what saddens me the most.

At the nearest district hospital, the SHOs, who arrived first, found one nurse administering X-pen injections to the injured (it was undoubtedly the only thing that she felt she could do) but there was no doctor on site and no equipment. Rachel Kasumba, the principal anaesthetic officer at Mulago, was lying on her back in the female ward with an open head injury but conscious. They tried to start a systematic review of the injured and commence resuscitation but there were no IV cannulae, no intravenous fluids, no drugs, no oxygen and no suction! Where to start? Resourceful as ever one went into town to buy whatever he could lay his hands on in the local drug store. Rose Mukyala (a midwife) the other severely injured passenger had a tension pneumothorax and bilateral fractured femurs. Meanwhile the other bus had arrived which was fortunate because they were the only medical staff available to attend to the injured. The tension pneumothorax was needled and IV fluids started but of course there was no means of monitoring any vital signs except for the pulse and the conscious level. Drugs and intravenous fluids, as there were a number of injured passengers, were running out and a second visit to the drug store in town was required. To their horror they found that the prices had doubled as the shop owners were aware that there was an urgent need for their supplies due to the accident!

Unfortunately the hospital ambulance was not available so the nearest Regional Referral hospital (at a distance of 40km) sent their ambulance to transfer the most severely injured. Regrettably Rachel had by now spent 3 hours at the district hospital, and just before transfer to the ambulance she lost consciousness. The
team intubated her with difficulty (one laryngoscope with a very poor light, an old endotracheal tube and no suction) and ventilated her with an Ambu bag but no oxygen. She died as she was being transferred into the ambulance.

The ambulance set off with Rose and a few others and arrived at the Regional Referral hospital, only to find it plunged in darkness as the emergency generator was not working. Rose had a cardiac arrest on arrival and died. Mulago Hospital in Kampala had also been contacted and sent 2 ambulances to the Regional Referral hospital (about 170km away), they transported the other injured passengers back to Kampala and the buses took the dead bodies.

This was Thursday evening. Later that night mobile phones of anaesthetic officers around the country were buzzing as the news trickled through. In a country with less than 20 physician anaesthetists and 350 anaesthetic officers the community is small and everyone knows each other.

Mulago responded swiftly and on Saturday morning a bereavement service was held in the grounds of the nursing school. Three tents had been erected, benches and chairs from the school spread out but still people had to sit on the grass or stand on the grassy bank in the blazing sunshine. Wreaths were laid, speeches and eulogies given followed by a short service. All staff, including the hospital director, made time to attend and the Commissioner for Health services from the Ministry came.

In a country that has only 0.6 anaesthetic providers per 100 000 population (unlike the UK which has 20) this is a huge blow. Sitting next to a senior anaesthetic officer I work with we both felt the pain and agony in the Head of the Anaesthetic Department’s voice has he described watching his colleagues die due to circumstances totally out of his control.

The lack of personnel, equipment and drugs in the district hospital is inexcusable but it is also the reality and is an important reason for the low morale amongst anaesthetic providers; why enter a specialty where you will never be able to deliver a good quality service?

Life goes on, useless visits to the ministry will continue, broken equipment will not be replaced and drugs will be in short supply but somehow anaesthesia is still given and the trainees still want to be taught. If anyone wants the challenge of working and teaching in such an environment then you would be welcomed with open arms especially if you felt able to give a longer period of time like 6-12 months.

Dr Sarah Hodges
Consultant Anaesthetist, Head of Department of Anaesthesia, CoRSU Rehabilitation Hospital, Kisubi, Uganda
sarahhodges1911@gmail.com
Dear Dr Bythell,

Dr McHardy raises an important issue ‘Variable pre-transfusion patient identification practices exist in the perioperative setting’ (Anaesthesia News, April 2010). There are many differences between surgical and non-surgical blood transfusion situations – the most obvious being that transfusion during surgery is likely to involve giving blood to an anaesthetised patient, who is covered by drapes and surrounded by surgeons. In the NPSA Safer practice notice 14 ‘Right patient, right blood’, the recommendations include a final identity check ‘next to the patient by matching the blood pack with the patient’s wristband’ and ‘competency-based training and assessment for all staff involved in blood transfusions’. Unfortunately, the document does not appear to consider blood transfusion during surgery.

As Dr McHardy points out, there may be difficulties in checking the patient’s wristband during surgery including inaccessibility (especially during major surgery) and previous removal during line insertion.

I think that it would be very helpful if the AAGBI issued some guidance about how the NPSA recommendations on identity check and competency-based assessment should be met in our perioperative transfusion practice. Perhaps an update in the ‘Blood Transfusion’ glossy?

Dr Robert Self
Consultant Anaesthetist, Royal Marsden Hospital

In reply:

There are some potential solutions to this problem; for example:

1. Wristbands - if applied on two limbs, one on the dominant arm - often the last area for arterial line insertion, can remain in place even after line placement.
2. If applied with enough room to insert two fingers underneath the arm band can be moved up or down the arm to allow IV and arterial line placement.
3. There is a lot of interest in the use of radiofrequency wristbands which can be scanned and may be read even through operating drapes.

I would agree that this needs addressing and could be done via an AAGBI working party.

It may be that a working party on Patient ID in all situations would be in order as there are generic safety issues. We need to consider new technologies such as scanning and wireless technology to aid correct drug therapy or correct intervention for the correct patient not just correct blood.

Dafydd Thomas, Chair AAGBI working party

Dear Editor

I read with interest the letter of Carle and Humphreys [1] having been a fan, for number of years, of the “folded Inco Pad” (one fold to form a triangle, place behind the head and join the points over the forehead) as a cheap disposable heat retention device.

May I just add a note of caution. I recommend that the Inco Pad should be removed before entering recovery. I had a formal complaint made about me by a member of staff (whom I have never met) who assumed I was placing “nappies” on patients’ heads purely for comical effect.


Tim McCormick, Oxford (ST5 Oxford Rotation)

Exubation: are we cleared to land?

The role of an anaesthetist can be, and often is, compared with that of a pilot. For a pilot, the crucial phases are those of take off and landing. For us as anaesthetists, this metaphor applies to the intubation/extubation sequence.

Pilots undergo intensive training during their apprenticeship to learn the skills of preparing a plane correctly, including checking the equipment and aircraft adequately before take-off. They then learn the necessary skills for safe take-off as well as navigation and flight-maintenance skills. Finally they will learn the skills necessary for a safe landing as well as what to do in an aborted landing and landing in difficult circumstances. If anaesthetic training is compared with that of a pilots, is that where the similarity ends?

Traditionally, during the first three months of the anaesthetics ‘novice’ life, there are numerous supportive training opportunities to create a competent trainee who is then capable of delivering a safe anaesthetic and of course to enter the joys of the on call rota.

The syllabus and requirements of The Royal College of Anaesthetists set out an initial test of competence for anaesthetics novices which are ideally completed within 3 months. The principles of this initial test of competencies are divided into 5 main points:

- Preoperative assessment
- General anaesthesia for ASA I or II patients (including competencies in general anaesthesia with spontaneous respiration and general anaesthesia with endotracheal intubation)
- Rapid sequence induction and failed intubation drills
- CPR skills
- Adequate clinical judgement, attitudes and behaviour.

There are roughly 63 sub-points to be assessed. Of those, approximately half of them are dedicated to the importance of intubation, both standard endotracheal intubation and rapid sequence induction, skills which are obviously vital for a safe and competent anaesthetist. However, interestingly there are only 2 sub-points where a trainee is assessed whether they are competent to extubate a patient appropriately and safely.

In general departments training the novice anaesthetist are keen to allow their novices to gain as much intubation experience as possible, seeking out any opportunities within the theatre environment. Trainees are frequently called out temporarily from their own list and duties to perform a quick RSI or a standard intubation.

In general departments training the novice anaesthetist are keen to allow their novices to gain as much intubation experience as possible, seeking out any opportunities within the theatre environment. Trainees are frequently called out temporarily from their own list and duties to perform a quick RSI or a standard intubation.

Returning to our comparison with pilots, we feel that generally pilots will practice as many ‘take-offs’ as ‘landings’ and so complete the whole ‘journey’ within their learning experience. As second year trainees in anaesthesia and from our personal experiences, we believe that the syllabus does not give the same focus of clinical experience for safe and appropriate extubation as intubation. Perhaps a dedicated section for extubations or an enhanced assessment of intubation as a whole to focus more on safe extubation as part of the completion of the ‘journey’ of anaesthesia should be included in the Royal College of Anaesthetists syllabus and initial test of competencies. Otherwise, the trainee may be left flying high.

Dr Emma Sans-Solachi and Dr James Hadlow
CT2 Anaesthetics, QEQM Hospital, Margate

Letters

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

Dear Editor

I read with interest the letter of Carle and Humphreys [1] having been a fan, for number of years, of the “folded Inco Pad” (one fold to form a triangle, place behind the head and join the points over the forehead) as a cheap disposable heat retention device.

May I just add a note of caution. I recommend that the Inco Pad should be removed before entering recovery. I had a formal complaint made about me by a member of staff (whom I have never met) who assumed I was placing “nappies” on patients’ heads purely for comical effect.


Tim McCormick, Oxford (ST5 Oxford Rotation)
Risk in the medical setting may be defined as exposure in the hospital to a potential injury or financial loss; thus, a risk management programme involves identifying that risk and preventing harm where possible. Several tools including Severe untoward incident reporting are used as part of risk management programmes, but these tools are not without their limitations. In their paper, Cook et al present a subset of data of all claims filed under ‘Anaesthesia’ in the Clinical Negligence Scheme for Trusts between 1995-2007. In this paper, the authors examined the claims specifically relating to airway, respiratory and dental damage; their analysis presents results showing the percentage of claims made for each clinical category and the consequent costs incurred. Apart from the factual knowledge gained from this paper the message is much more far-reaching. The authors suggest that the analysis of litigation data has been a missed opportunity in previous years in helping to improve clinical practice and thus patient safety; and although they acknowledge the limitations of using such a dataset, the use of litigation data may be a helpful tool in providing a more robust system for monitoring adverse anaesthetic outcomes in the future.

The theme of patient safety is continued in the case report by Hanke et al. It is well recognised that the increased use of regional anaesthesia in obstetric practice has significantly reduced maternal morbidity and mortality since the early 1980s. The ROTEM device has been well established in other areas of clinical practice such as cardiac surgery and general surgery for point of care coagulation testing, but its usefulness in obstetric practice still requires further evaluation. In this case report, the authors used the ROTEM device to monitor coagulation in a patient with an inherited coagulopathy, who presented for an elective caesarean section. The ROTEM device was used to guide correction of the coagulopathy before the caesarean section, thus allowing neuraxial anaesthesia to be performed safely and also reducing the risk of peripartum bleeding. This case report highlights a novel use of the ROTEM in obstetric patients but also emphasises that further research is needed to evaluate its use in improving safety in patients undergoing neuraxial anaesthesia.

Dr S Malhotra, Editor, Anaesthesia
In just over two years time the London 2012 Olympic and Paralympic Games will begin. Our vision within the London Organising Committee of the Olympic and Paralympic Games (LOCOG) is to use the Games to inspire change. The Olympic and Paralympic Games is the largest sporting event in the World and will generate enormous excitement and enthusiasm which many people want to be part of and if they are not actually competing, volunteering is the best way to do this.

The recruitment of up to 70,000 volunteers will start in July 2010 but the recruitment of healthcare professional volunteers will start this spring. Healthcare professionals can apply directly (provide a one page CV and a 100 word expression of interest statement to ems@london2012.com) to be added to the list of medical specialists expressing an interest in volunteering for the Olympic and Paralympic Games.

**Emergency Medical Services**

Emergency Medical Services is one of five workstreams that comprise LOCOG Medical. Our goal is to provide comprehensive emergency medical care for all who attend the Olympic and Paralympic Games in London in 2012 whether they come as a competing athlete, official, VIP, Olympic family, workforce or spectator. The Olympics last 17 days and the Paralympics 11 days with a two-week build up when medical services will have to be provided totalling a period of over two months.

We are planning our service to cover 26 Olympic sports with 10,500 athletes from 205 countries competing in 38 venues, followed by 20 Paralympic sports with 4200 athletes from 147 countries competing in 21 venues, and an estimated 9.2 million spectators. Our medical response teams must be proficient and experienced in crowd medicine or field of play retrieval, providing levels of service that are bespoke and will leave a legacy for sport in this country in the future.

We aim to provide a unique experience for all our medical volunteers in a wide variety of sports and venues. Our main venue is the Olympic Park, currently under construction in the East of London, which will provide competition venues for 11 sports. The Excel Centre will house five arenas and across the river the North Greenwich Arena a further 4 sports. Nearby, Greenwich Park will host the Equestrian Events and the Woolwich Royal Artillery Barracks the shooting. Further afield Weymouth will host Sailing and Eton Dorney rowing. The variety of sports and the range of requirements for medical skills are challenging. Planning is proceeding and we are developing our detailed operating procedures and medical team skill mix around the specific individual field of play and the requirements of the each venue. For the injured athlete we will work closely with the Team Doctors our own Sports Medicine colleagues in delivering emergency care on the field of play or with our specialised medical teams in the Olympic Polyclinic. We aim to deliver the majority of spectator care in the venue and only to transport injured casualties to hospital where advanced emergency care is required. Finally, no major event in the United Kingdom would be allowed to proceed without a detailed Major Incident Plan and we have prepared our command and control structures to sit alongside those of our own Olympic security services and the statutory ambulance authority.

**Volunteers at the Games**

Volunteers are at the core of the Games and essential to all the functional areas that make up this global festival of sport. The
Games have the power to change lives and volunteering is one of the major ways in which this happens.

All volunteers will need to commit to at least ten days. Although volunteer days will be scheduled for eight-hour shifts, their time will need to be flexible to cover the busiest periods and the variable competition schedule. All selected healthcare professionals will be expected to attend test events in 2011 and training days in the run up to the Games. There is no remuneration or honorarium for volunteers but they will receive a volunteer uniform, a meal when on duty and free local transport.

All shortlisted applicants will be interviewed and their skills and experience will determine success and help ascertain which venues, whether as crowd medical or field of play responders, they are most appropriately allocated. By identifying and selecting doctors, nurses and ambulance staff who wish to volunteer for the emergency medical services early, LOCOG will identify any potential gaps in emergency cover or experience. Healthcare professionals who know they have been selected as volunteers have the chance to gain further relevant experience and arrange leave and cover.

The Olympic and Paralympic Games are truly motivational and this is really a unique opportunity for all who volunteer to be part of this special event. Doctors, nurses and ambulance staff are essential to the successful running of the Games in 2012 so we want to make sure we use these valuable resources to help London host a safe, successful and inspirational Olympic and Paralympic Games. We need your help to do that.

Conclusion
If you would like to be part of this once in a lifetime event then send a brief expression of interest to ems@london2012.com.

Dr David Zideman
LVO, QHP(C), BSc, MBBS, FRCA, FIMC
Clinical Lead, Emergency Medical Care,
Medical Services.
The London Organising Committee of the Olympic and Paralympic Games.

The Association of Anaesthetists of Great Britain and Ireland invites applications for the SAS Travel Grant for 2010. This is a grant (up to a maximum of £2000) exclusively given for SAS doctors to visit a place of excellence of their choice for two weeks. This is not meant for attending a meeting or a conference. All SAS doctors who are members of the AAGBI are eligible to apply for the grant.

Applicants should complete an application form and return it to the AAGBI. The successful applicant will be expected to submit a report of the visit which may be published in Anaesthesia News.

If alternative funding becomes available for a project already supported by the AAGBI, the AAGBI should be notified immediately.

Please contact Chloë Hoy (020 7631 8807 or chloehoy@aagbi.org) for an application form, or visit www.aagbi.org/sas.htm. The closing date for applications is Friday 22nd October 2010.
Dearest all,

You will be aware of the recent controversy over consumption of tea and coffee in the Anaesthetic Room. We, the Society of Coffee Room Anaesthetists – better known as SOCRATIS have patiently watched and listened and wish to make our position clear. We have the backing of our sister society, the Society of Coffee Room Surgeons (SOCRON). First let us describe our history for those who are unfamiliar with it.

SOCRATIS is amongst the oldest of anaesthetic societies and it is unusual for an anaesthetist not to have been a member at some stage. It is a humane society of Anaesthetists formed by free association and abiding by the tenets of the society. Membership is open to any doctor that has been appointed to a position in anaesthesia by competitive interview and who demonstrates respect for the tenets of the society as listed below. There are no annual fees or dress codes. There is no central office or HQ for reasons that will become clear. Our core value is that the Coffee Room is a place of upmost importance to the anaesthetist and thereby to the workplace and hence the wider patient population.

The Coffee Room is more than just a room to drink coffee and it's congeners. For the weary anaesthetist, it is a place of rest. For the anaesthetist in turmoil or ‘at sea’ managing the unexpected it his terra firma.

For those in need of companionship and collegial support it is here in the Coffee Room that they will find it. To those with strong views it is a pulpit. Those troubled by a near miss or serious incident may unburden themselves. It is a place where the pace of the day will slow, the pulse rate decrease, anxieties wane, reflexes attenuate and the pupils constrict. It is there that one can peacefully navigate the day’s obstacles undisturbed and unperturbed. Furthermore, it is the only true such place. Is there one among us who has not felt this way?

The Tenets of the society are:

- Caffeine is the most important drug in anaesthesia
- The ideal coffee is unachievable but can be approached
- The ideal coffee is described by ideal temperature, volume and caffeine concentration, viscosity and presence of the core constituents
- The core constituents are water, coffee extract, sugar and mammalian lipoprotein extract – ideally bovine.
- The spirit of the ideal coffee is captured in the Turkish saying ‘strong as hell, black as death and sweet as love’
- The ideal coffee is only approached when the temporal relationship to the days rigours and coffee consumption is optimal
- A positive coffee room experience is comprised of good coffee, good company and the absence of the obligation to be somewhere else – this is the Holy Trinity.
- The only reason to leave the Coffee Room in a hurry is a threat to Life or Limb.
- No SOCRATIS member shall ever question the presence of another member's presence in the Coffee Room
- No SOCRATIS member shall interfere with another member’s coffee

We hold the above tenets to be true and unchangeable and have variably described them as the Coffee Room Laws and the Ten Commandments.

In the recent past the sign of a respectable Department of Anaesthesia was that there would be a continuous anaesthetic presence in the Coffee Room. Indeed, some of the more senior members spent more time in the Coffee Room than the operating room (OR) (and a handful were rarely seen outside the Coffee Room) and with the passing of years this ratio would increase in favour of the Coffee Room. The Coffee Room - OR balance is crucial to the wellbeing of the SOCRATIS member.

The continuous presence of SOCRATIS in the Coffee Room is under threat. The advent of the roster and the middle manager and other influences that will collectively be termed ‘the dark force’ have threatened this balance and we must act. We perceive that the above elements are a barrier to our members entering the Coffee Room at all. This is without precedent. Our heritage, our values and our welfare are threatened. SOCRATIS has decreed that this will not stand.

SOCRATIS cannot understand the furore over drinking coffee outside the Coffee Room and points out that the real issue the inability of its members to reach the Coffee Room in the first place. At the SOCRATIS AGM it was concluded that anaesthesia, hospital medicine and society at large is best served by the continuous presence of an anaesthetist in the coffee room. Furthermore we propose a restoration of the CR - OR time ratio of no more than 1-3 when averaged out over a working week. That is our position.

Per Caffeine ad Utopia Maxima!

‘Mick D’