What can anaesthetists learn from pilots?

Council elections are on the horizon

Linkman survey results
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THE ASSOCIATION OF ANAESTHETISTS
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ANNUAL CONGRESS 2008
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Abstracts are invited for oral or poster presentation at the Annual Congress of the Association of Anaesthetists of Great Britain & Ireland. There will be three separate sessions for oral presentation – for original research, audit and for case reports or case series. Please clearly mark which session you are submitting your abstract for. Papers accepted for presentation will be published in abstract form in the journal Anaesthesia*. Prizes will be awarded to the authors of the best free papers in each section, as judged by a panel of experts.

For abstract forms and further information, please contact secretariat@aagbi.org or 020 7631 8807/8812

Closing date for submission: 6th June 2008.

*The abstracts must conform to the journal’s usual ethical, methodological and statistical standards. Authors may be asked to make changes to their abstracts before publication.

The Editor-in-Chief reserves the right to refuse publication.
I must be getting old. It seems like only last week that I published an article in this estimable organ exhorting members to stand for election to the Council of the AAGBI. In fact, it was a whole year ago. I am delighted to report that quite a few members responded to my exhortations and, after a keenly contested election, there came forth three successful candidates: Bernie Liban (London), Ellen O’Sullivan (Dublin) and Steve Yentis (London). These three new Council members are now successfully finding their feet and their roles in Council. However, at the forthcoming Annual Congress in Torquay (17th - 19th September), three other Council members will come to the end of their four-year terms: Les Gemmell (Wrexham), who will become my successor as Honorary Secretary at the meeting, Dave Rowbotham (Leicester) and Sean McDevitt (Dublin). Theirs are indeed hard acts to follow, difficult shoes to fill but quite capacious trousers to wear. However, be that as it may, my duty is to do a little more exhorting and to ask members to consider standing for Council in the 2008 elections so that their places can be filled.

Sitting as the Board of Directors of the Association of Anaesthetists of Great Britain & Ireland, Council makes the important decisions, determines strategy, and manages the finances of the Association. Sitting as the Board of Trustees of the AAGBI Education and Research Trust, Council plays a similar role for the charitable arm of the AAGBI that provides high-quality education while being the largest sponsor of anaesthetic research in the UK. At the heart of the Council are the twelve elected
Council members, who are there not only to express their own views but also to represent the views of the members who elected them to Council. The other voting Council members are the two Vice Presidents, the Chairman and Honorary Secretary of the Group of Anaesthetists in Training (GAT) and the Executive, comprising the President, Honorary Treasurer, Honorary Secretary, Honorary Membership Secretary, the Editor-in-Chief of Anaesthesia, the Immediate Past President and the Immediate Past Honorary Secretary. Non-voting, co-opted members of Council include the conveners of the Irish and Scottish Standing Committees, the Presidents of the UK and Irish Colleges of Anaesthetists, an Armed Forces Representative and the Editor of this aforementioned estimable organ.

Council meets six times a year on the first Friday of every other month, starting with a meeting in October soon after Annual Congress. With regular attendance at other committee meetings, which also take place at the AAGBI’s headquarters at 21 Portland Place on a Friday, an elected Council member may expect to be in London for two Fridays every month. In addition to this, elected Council members are expected to participate in the Annual Congresses and WSM London meetings during their tenure, and in addition, three times a year there is a meeting on the Thursday evening preceding Council, where a less formal, more extended look at some of the issues of the day is undertaken. It is a significant time commitment, and I would advise prospective candidates to negotiate with their colleagues and managers before committing themselves to the ballot. Hard work it may be, but the positive side includes the opportunity to play a leading role in medical and political developments in anaesthesia and its related disciplines, to help guide the patient safety, education and research activities that are at the core of the Association, and to work with a group of motivated and dedicated Council colleagues who are also fun to spend time with.

The process for the election is as follows: a formal written call for nominations will be posted to every member in the next couple of weeks. Nomination forms will be downloadable from the AAGBI website (www.aagbi.org) and will also be available from Chloë Smith at the Association (chloesmith@aagbi.org or on 020 7631 8807). Nominees, who should be AAGBI members proposed and seconded by two other members, should send their signed nomination forms and a 250-word personal statement for reproduction in the booklet that accompanies the ballot papers to the AAGBI. The closing date this year is April 18th. Thereafter, the election process is handed over to the Electoral Reform Society (ERS), which mails out the ballot papers and conducts the election under a single transferable vote system. The ERS will inform us of the names of the three successful candidates at the end of May, and the President will then inform all candidates of the results before announcing them formally at June’s Council meeting.

It only remains for me to exhort you to take the plunge and submit a nomination form. If you have any questions about the election process, please email me on honsecretary@aagbi.org.

Will Harrop-Griffiths
Honorary Secretary
AAGBI
You are not alone

Results of the Linkman welfare survey

Anaesthesia may attract a certain type of personality, as described by Gaba1, who might view excitement and fast-paced work with danger lurking just below the surface as attractive attributes of the job. However, with excitement there is the inevitable accompaniment of stress which is part of our working and personal lives. There is a common perception that anaesthetists are exposed to increased stress due to the added responsibility of having the patient’s life in their hands and having to cope with acute critical situations which are sometimes beyond their control. Some stress is beneficial but too much causes problems. Female anaesthetists have reported higher stress levels2 due to the added and demanding responsibilities of combining work and domestic commitments. Trainees seem to be more vulnerable to stress3 and high emotional exhaustion (burnout)4 with the compounding pressures of inexperience, training, examinations and increased competition for jobs. Kain et al5 reported that many anaesthetists exhibit symptoms of chronic stress.

Individuals respond to pressure in various ways – some constructively using coping strategies and others resorting to more destructive means such as increased alcohol or drug intake, aggression or other behavioural changes such as social withdrawal and altered mood. The art of achieving optimal work-life balance can at times be devilishly hard to achieve. Doctors do not behave like other patients when accessing healthcare and it is well known that we are reluctant to seek help or admit that something is amiss. There is evidence that medical personnel, including anaesthetists, are less likely to admit to the effects of uncontrolled stress and fatigue on performance when compared to other professional groups such as those from the aviation industry6. This has implications for patient care and safety.

The AAGBI recognises that a proportion of members will at some point in their career experience difficulties, either personal or professional, of sufficient severity to require external help. The AAGBI Welfare Committee was convened to provide support and help to anaesthetists in difficulties and this replaced the AAGBI Sick Doctors Scheme which was managed latterly by Dr. David Saunders. In order to gauge the extent of the difficulties which anaesthetists may encounter and to guide the Welfare Committee, Council of the Association agreed to a proposal to conduct a survey amongst AAGBI Linkmen. A welfare questionnaire comprising eight questions was sent by post in October 2007 to 257 Linkmen, with anonymity guaranteed to the respondents.

Fifty percent (N=129) of Linkman representatives replied and all but one are consultants working in the NHS. The majority of respondents reported no significant stress or dissatisfaction with their work or domestic life. When asked about the difficulties they encountered in their daily lives, approximately 20% of respondents exhibited symptoms and signs of stress - waking up at night, anxiety, irritability and feeling burnout. 13% reported feeling depressed and 10% have relationship difficulties with their colleagues. 14% of respondents attributed physical problems such as ischemic heart disease, hypertension, constant tiredness and domestic problems to work related stress. What was especially worrying was that a small
percentage of respondents admitted to multiple problems or symptoms at the same time which poses the question of whether such individuals can be functioning at anything like their optimal level. Do you recognise anyone like this in your department? They need help.

Respondents reported contributing factors to their problems which included a stressful environment (42%), lack of support (19%), bullying (8%), discrimination (6%) and alcohol abuse (2%). Other problems undermining their work and wellbeing are the lack of control/autonomy, constant pressure from managers, difficult colleagues, not feeling valued, constant changes in the NHS, MTAS, lack of inclusion in decision making and sleep deprivation. Useful sources of support and help cited by respondents were colleagues (12%), General Practitioner (11%), Occupational Health and counselling services (8%). Other useful external sources of help mentioned included the BMA Doctors’ Support Group, AAGBI, Hospital Consultants and Specialists’ Association and supportive family members. What was worrying was that 86% of the respondents were aware of other colleagues suffering from similar problems or exhibiting symptoms of acute stress.

We have to interpret these findings within the limitations of the survey. All but one of the respondents are consultants and only 50% of the Linkman representatives responded. The majority seemed to be content with their work-life balance based on the specific questions of the survey and if you are one of them, congratulations. However, if you are one of those in difficulties, you are not alone. At least one in five respondents exhibited signs and symptoms of stress and help from empathic colleagues, friends and family played an important role to get them over their difficulties. If you are one of the contented majority, you have an important role in helping a colleague in difficulties - you yourself may require help one day.

Nobody in my department realised that one of our consultant colleagues who was a beacon of strength and support to many in the department was in critical difficulties himself until it was too late. He could take no more and took his own life in a secluded beauty spot. His widow has bravely given permission for me to publish these details. It is worthwhile remembering that it is common for doctors with difficulties not to recognise or admit that there is a problem until a crisis occurs. If your department has a mentoring system, participate in it but above all have a watchful concern for your colleagues, young and old. Evidence from previous research and more recent pressures put upon trainees make them a vulnerable group that will require all the help and support they can get from colleagues.

What can the AAGBI do for those in difficulties? The Welfare Committee has three senior council members who are part of the BMA “Doctors for Doctors” support group of advisers. Contact details for doctors in difficulties are published monthly in Anaesthesia News (see P15 in this issue). The committee has compiled a Welfare Resource Handbook full of useful information and advice on coping strategies. It will also provide an appendix of useful contact numbers with the aim of providing help before you reach breaking point. This will be published within the next couple of months on the AAGBI website and subsequently as a glossy.

Life skills which can help you and your colleagues to cope include communication skills, assertiveness, conflict management, time management and constant reflection of your work-life balance. Get a life outside work. Have a ‘buddy’ or better, ‘buddies’ whom you can talk to regularly - they do not have to be someone from your own Trust. They can give you a frank reality check.

It is important to judge success in your career by your own standards and not those of others. If you are enjoying your work, you keep up to date, give safe anaesthetics and enjoy domestic life, you are having a successful career and life. But there will be times in our busy and sometimes stressful lives when we ALL need a sympathetic ear and good counsel; so seek help to get you over a rough patch. You are not alone.

Michael Wee
Assistant Editor
AAGBI Welfare Committee member

References
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It seems a long time ago that I took a group of twelve post-fellowship anaesthetists to British Airways’ (BA) flight training at Cranebank near Heathrow while an anaesthetic registrar. Cranebank has fourteen full flight simulators and four fixed base simulators for both Boeing and Airbus, and is the biggest Boeing training centre outside the US.

The aims of the study day were two-fold. I wanted us to gain some valuable ideas from the pilots and trainers at British Airways about how simulation training and Crew Resource Management (CRM) training (including human factors) has improved their safety record, and see if we could extend this into the theatre environment. However, it was also an opportunity to get anaesthetic friends and colleagues together from all over the Bristol area to have a day out to Heathrow and “fly a plane”!

I became interested in simulation and CRM when I attended a course on Anaesthesia Crisis Resource Management at the Barts and The London Simulation Centre\(^1\). I was fascinated by inter-personal behaviours and how interactions can have a major influence on the outcome of critical incidents. This course was based on the airline programme and it was this that prompted me to organise the study day.

The programme started with an introductory talk by Captain Phil Dales, Chief Training Pilot, who explained how BA trains its pilots; in particular their compulsory attendance at Flight Training for two days every six months. This is a legal requirement to maintain their registration and licence. For most pilots, this is an opportunity to hone their skills and practice emergency procedures which they do not encounter when they are flying; however it is also an opportunity to pick up any problems a pilot may be having. As Captain Dales pointed out, the simulator sessions are taken very seriously and pilots who fail to show the required levels of competence can be failed.

He also produced the quarterly BA incident report, a document containing information on recent incidents and other statistics. A tense few moments for the nervous flyer! However, it was reassuring to know that the majority of incidents were not serious and were mainly due to human factors, not equipment or aircraft failure. These are freely reported within a blame-free culture to enable system errors and personal issues to be picked up early and addressed. Some are used as training opportunities in the simulator.

BA stated in the 1990’s: “All staff are expected to report any incident which may affect safety...It is not normally British Airways policy to institute disciplinary proceedings in response to the reporting of any incident affecting air safety...”.

Before dividing into two groups for the rest of the day, First Officer (FO) Mathew Page briefed us all on the Boeing 777 simulator we would be “flying”. How to fly a plane in 30 minutes - keep the box on the cross or let the autopilot to do it. They made it look so easy! Due to the size of the groups we had to fly the plane on a “fixed-base” simulator for safety reasons. However, the visual display really made
you feel like you were flying - although I was glad to not feel the bumps as I careened off the runway prior to take-off, or the thud when some of us landed!

Our pilots Mathew Page and Pete Nateraj showed us the pre-flight checklist and the emergency checklists for events like engine failure, which are displayed on the computer between the pilots. They discussed their views on simulator training and assessment, the procedures for briefing and debriefing with their captain, and how the crew work as a team under stress. They were also fascinated to hear how our training and experience of teamwork and emergencies compared.

Captain Martyn Townsend-Smith, a pilot and CRM instructor, explained the history and background to CRM. In the early days of aviation, accidents were often due to aircraft technical problems. However, as technology rapidly improved during the 1960-80s and the aircraft became more reliable, accidents occurring were then attributed to “pilot error”. With information from Flight Data and Voice Recorders, it became apparent that many accidents were not caused by aircraft malfunction or failure in aircraft handling skills, but by the “inability of crews to respond appropriately to the situation in which they find themselves”2. After a NASA workshop in 1979 on improving air safety, Crew or Cockpit Resource Management was born.

Crew Resource Management is “…a management system which makes optimum use of all available resources - equipment, procedures and people - to promote safety and enhance the efficiency of flight operations”3. However, it was not formalised into UK flight crew training until 1992.

Incidents were found to be caused by errors in professional judgement. For example, loss of situational awareness, poor decision making, ineffective communication and personal style issues (particularly involving the Captain). It is these four categories which now form the basis for Human Factor (HF) training programmes. This training aims to provide crew members with the appropriate knowledge, skills and attitudes to help manage and contain inadvertent errors by pooling resources and working together as a team.

However, in order to progress with CRM, there are a few assumptions that need to be challenged - the assumption of perfection, the assumption that experience avoids errors, the assumption that interpersonal skills occur naturally and the assumption that technology makes things easier. Sounds familiar? I
think the days of medics feeling they are God have long gone. However, medicine still has a strict hierarchy where juniors are not expected to question the decisions made by a senior colleague - but errors aren't only made by junior staff. Just because we may have the technical skills to do our job doesn't imply we are good communicators or team players; technology is only as good as the person using it.

Captain Townsend-Smith gave an example of how he uses his CRM training in the cockpit. Once all the formal pre-flight checks have taken place, he briefs and empowers his colleague by encouraging him or her to speak up if there is anything that he/she is not happy with, emphasising that they work together as a team. It is the core of CRM to have open communication between all team members and shared decision making processes. There may be many years of flying experience between them in the cockpit which should be pooled to help solve problems.

Dr Jan Shaw (a consultant anaesthetist from Manchester) talked about the Human Factor Training Course she runs and how we can use simulators in anaesthetic training. The group had a lively discussion about how CRM could be introduced into anaesthesics and theatres and how to get the surgeons on board! Like Captain Townsend-Smith, Dr Shaw uses her knowledge of human factors to encourage team working in her theatre so the staff feel able to speak up if they are not happy. We are there to give the patient a safe anaesthetic and to look out for each other at the same time.

I had a great day at BA Flight Training and the feedback from my anaesthetic colleagues was very enthusiastic. I am trying to act upon what I learned that day by encouraging my anaesthetic team to speak up if there are problems and to look out for each other. I don’t think this necessarily needs to be said openly all the time - having a friendly environment and making yourself approachable should do the trick. However, I think there is an art in speaking up if there is a problem, and care should be taken not to be rude or cause offence.

In my new consultant job I am now involved in setting up simulator training and I would like to get more experience in human factor training with a view to introducing it into the theatre environment. There will be resistance, but I hope that it will improve the safety of patients and help form a more cohesive team.

Kay Spooner
Consultant Anaesthetist
Royal Glamorgan Hospital

I would like to thank Andy Clubb, Capt Townsend-Smith, Capt Dale, FO Nateraj and FO Page of BA, and Dr Shaw from Manchester. The day was sponsored in part by Laerdal who sent along representative Neil Bradbury to demonstrate the features of SimMan, and Abbott. It was also subsidised by BA.

References:
2. Civil Aviation Authority, Safety Regulation Group, CAP 737. Crew Resource Management (CRM) Training. Guidance for flight crew, CRM instructors (CRMs) and CRM instructor examiners (CRMIEs). Issue 2, 28 February 2006. Chapter 1, paragraph 1.1

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Final FRCA Core Knowledge Days
One day FRCA syllabus based lecture series

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Although tailored towards the exam syllabus these days are suitable for anaesthetists looking for a focused refresher course. Speakers are mainly Consultants within the UCLH group of hospitals and allied units in London.

£25 per day
Numbers are limited
Venue: Royal College of Anaesthetists, London (Churchill House, 35 Red Lion Square, WC1R 4SG)

BOOKING: Email: (clare.prudden@uclh.nhs.uk)
ENQUIRIES: Clare Prudden, Course Co-ordinator - 0207 691 5827
WEBSITE: www.schoolofanaesthesia.co.uk (see latest News and Meetings - front page)
The Royal College of Anaesthetists recommends that a trainer should normally be a consultant who has responsibilities for the clinical teaching and educational supervision of trainees, including responsibility for appraisal and assessment. The AAGBI describes the primary relationship between a consultant and trainee as that of teacher and pupil – the consultant being responsible for teaching not only the science and practice of anaesthesia but “all the other attributes which make a good anaesthetist” and the GMC also defines and details the personal and professional attributes required for this role.

In the last six years I have rotated to a dozen hospitals and have worked under direct and indirect supervision with numerous consultant anaesthetists who differed from each other in their personal and professional attributes and skills. All of them were excellent as clinicians but were they all good trainers too? I have asked myself this question throughout my training career, and more importantly, what constitutes a good trainer?

Although some may consider it inappropriate to stereotype anaesthetic consultants, I find that many trainers can easily be grouped.

The Laid-back Lions
It has always been a pleasure to work with the senior, near retirement consultants in an anaesthetic department. Trainees should resist the temptation to emulate them too closely in clinical practice because they have been doing anaesthetics for a lifetime, hence they know how to get it right even if it doesn’t appear right, and illustrate the proverb that everything is safe in safe hands. They have a lot to offer to trainees but their enthusiasm and passion for teaching has dissipated over the years. Moreover, they belong to a generation of anaesthetists trained through the apprenticeship model, when trainees used to observe and adopt practice informally, and these senior consultants have serious reservations about current competence-based training and related paperwork. However, if a trainee shows keenness and eagerness, they love to share their pearls of wisdom and are among the best people to get your paperwork for competence-based training signed off.

The Cheeky Foxes
There are plenty of them around but be careful while working with them. They strongly believe in the “Let’s share the work” principle but the application of the principle is slightly odd and discretionary: the trainee does all the work and the trainer takes the break. They make you feel that you are in control by saying “It’s your list, see your patients, make your plan and crack on with it,” and to avoid interfering with your anaesthetic plan, will proceed themselves for a quick coffee.
break, which surprisingly may extend beyond an hour, with a promise to let you have an early lunch at 1 pm. Being alien to the country I have not been able to figure out what constitutes late lunch. The bargain for trainees is that they would get all their competence-based paper work signed off at the end of the list: not a bad deal!

The Singing Cuckoos

These are intelligent people with excellent clinical skills, knowledge and acumen but unfortunately suffer from “Self-admiration syndrome”. It would be very difficult, almost impossible to impress them with your knowledge, skills, and efforts. On most occasions, you will find them singing:

“No one does it the way I do, I am the smartest person around you
Can I ask who has taught you
A technique that’s so seriously flawed
Let me tell you, what’s wrong with it
Just not the way I would like to do it”

Getting your competencies signed off by them can be very difficult if not impossible. They take competence-based training very seriously and genuinely believe that signing off competence is similar to passing a driving test - it doesn’t matter how good a driver you may be but if on the day of test you make mistakes you fail the test.

The Wise Owls

These are the consultants whom you see, yet failed to take notice of, walking down the hospital and theatre corridors, deep in their thoughts, apparently unaware of their surroundings, but highly respected and regarded in the department for their knowledge, wisdom and stature. If you enquire, a list of achievements and contributions to the specialty of anaesthesia attributed to them can be easily identified. Familiar with their names but not faces, when you first accompany them during a teaching theatre list, you realise that there’s an ocean of knowledge and wisdom but how to fish? They can be inspiration for many to acquire knowledge and skills or role model for others to develop attitude & behavior, emulating them in one aspect or other.

Herr Trainer!!!!!

They have the knowledge, skill, enthusiasm and passion for teaching and training; in a nutshell they are “the born teachers”. There is no way out, whether trainees like it or not they will get hold of and instill into trainees the knowledge and skills acquired by them over the years and soon the trainee will feel they are being indoctrinated by them. They will support trainees all the way through their training, whether it’s MCQs or SAQ practice sessions, and will sacrifice personal time for mock viva practices, always willing to go an extra mile to help and support trainees – but you better make sure your paperwork’s up to date.

Attributes of a Good Trainer: A Trainee’s perspective

Knowledge sharing

A good trainer develops a relationship with trainees based on mutual respect for and understanding of each other’s knowledge and views. When sharing his knowledge and expertise with a trainee a good trainer should encourage discussion and stimulate debate. A dialogue will be more productive and will create a healthier environment for learning than a monologue.
Clinical and practical skills

While teaching clinical or practical skills, a trainer has to adopt a role of a coach, irrespective of whether the trainee is a novice or has some experience in anaesthetics. He should provide a non-threatening, welcoming environment that nurtures learning. A trainer should feel comfortable about allowing trainees to perform procedures under his supervision without putting undue stress and pressure on them about the risks and complications, or fear of consequences if things do go wrong. A supportive attitude following an error earns trainers a lot of respect from trainees.

Attitude and behaviour

Patience is a virtue for a good trainer. It takes time to know your trainee, and to appreciate their requirements, strengths and weaknesses and then to adjust your teaching to match the trainee’s goals. All trainees are different: some are enthusiastic and self motivated but are slow learners, while others may be fast learners with sharp minds but may lack application. A good trainer should not only be able to teach what they know but also be able to influence the professional attributes of trainees by setting and maintaining a high standard of professional and personal values for him/herself.

Feedback

Bodies supervising training rely heavily on the formal feedback provided by the trainers assessing a trainee as they progress through training. However, for a trainee it’s the informal feedback based on the day-to-day observation which is more important than formal assessments. Trainees feel more comfortable and at ease with a trainer who is direct but friendly, while providing immediate informal feedback to trainees, particularly when the trainer feels that the trainee has not performed to the trainer’s expectations. Most trainees do have some insight into their errors and omissions and will be responsive and receptive to feedback if conveyed in a positive manner.

In summary, to become a good trainer, a consultant has to work hard to develop core qualities: knowledge, skills to convey that knowledge, interest and dedication for teaching, and respect for trainees; and must maintain and display high standards of professionalism to act as a role model for trainees, the future consultants.

Dr Ifikhar Ahmed
Specialist Registrar in Anaesthetics
Leicester

References:
Cambridge Final FRCA Courses 2008
Addenbrooke’s Hospital, Cambridge
Course Organiser: Dr R Tandon

Final FRCA VIVA Day
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Consultant-led, intensive VIVA preparation course giving trainees extensive VIVA practice for the exam
The aim of the day is to provide candidates with at least 8 hours VIVA practice to give the required preparation and confidence to pass the exams.
“A very good course with lots of exposure to all aspects of finals exam”
Registration Fee: £200.00

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Lectures are based on key-topics, including VIVA, SAQ & MCQ Practice
“Excellent topic selection, very useful for the exam”
“Very good layout for the exam in terms of anaesthesia goals and pathophysiology”
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Wednesday 21 May; Tuesday 14 October
Simulation Centre, Addenbrooke’s Hospital, Cambridge

This is a one-day course designed to refresh and update skills in managing patients with difficult airway.

Participants will be exposed to a combination of lectures and hands-on participation through eight small workstations, including simulation scenarios.

Aims: Effective management of airways, appropriate use of airway technology, emergency airway, use & handling of FOI

Registration Fee: £125.00

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2008 Dates: 28 April; 24 September 8 December
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Do you work well in a team within the delivery unit when faced with an obstetric crisis?
Would you like to do better and improve patient safety?

This course aims to prepare delegates to avoid and deal effectively with emergencies in obstetric practice using the high fidelity computerised medical simulator.

Skills will be developed in the management of the maternal airway, cardiac life support in pregnant women and crisis resource management.

Suitable for all grades of Obstetrician, Anaesthetist & Midwife

Registration Fee: £150.00

For further information, please contact: Mr Ashley List, Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 2SP; Tel: 01223 217059; Email: al450@medschl.cam.ac.uk
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Last chance to organise Added Years

With effect from 31st March 2008, you will be unable to commence a new Added Years contract. For those that have already bought the maximum number of years, this will not come as a disappointment. However for those yet to recognise the excellent value offered by this pension entitlement, the opportunity should be considered and if appropriate, acted upon without delay.

Too frequently, Added Years are considered and then dismissed as overly ‘expensive’. Whether aged 25 or 55, Added Years are likely to be the cheapest method of increasing one’s pension in retirement. Government backed, index linked and with no reliance on stock market performance, Added Years provide greater security and certainty for retirement than other options such as personal pensions; it is therefore likely that funds designated for retirement should be placed in Added Years prior to a different type of arrangement.

From the 1st April 2008, the revised NHS Pension Scheme will be introduced. As existing Added Years contracts are to be honoured, it is important to act quickly. Members of the NHS Pension Scheme are eligible to apply for Added Years before the pension changes take effect, even if the commencement date - which must coincide with your birthday - is some time after the changeover.

You must register your interest with the NHS pension agency which serves your country before March 31st. The contract for Added Years does not start until your next birthday, and you are not committed to proceed with purchase until that time – a “cooling off period” if you like, whose length will depend on when your birthday is. If you are at all interested in purchasing Added Years, you need to act without delay.

We are frequently advised by retiring consultants that the purchase of Added Years was one of the best ideas that they acted upon. It is no surprise that a benefit as generous, and therefore costly, as Added Years is being removed. You are therefore urged to investigate whether they are suitable for you and to act quickly before they disappear!

Please feel free to email me (joe.clark@cavendishmedical.com) if you feel that need assistance on this or any other matter.

Joe Clark

Joe Clark is an independent financial advisor with Cavendish Medical Ltd. This information is provided as a service to readers of Anaesthesia News.
March 2008

Cardiothoracic Intensive Care - Unique Problems III
Thursday 6 March 2008
Association of Anaesthetists, London

Optimisation of High-Risk Patients
Wednesday 12 March 2008
Association of Anaesthetists, London

GAT: The Consultant Interview
Thursday 13 March 2008
Association of Anaesthetists, London

Trans Oesophageal Echo (TOE) for Non-Cardiac Surgery and Intensive Care
Monday 17 March 2008
Association of Anaesthetists, London

Ultrasound for Vascular Access and ICU
Tuesday 18 March 2008
Association of Anaesthetists, London

New Aspects of Cardiac Problems in Surgical Patients
Wednesday 19 March 2008
Scone Palace, Scotland

Neuromuscular Disease & Anaesthesia
Tuesday 25 March 2008
Association of Anaesthetists, London

April 2008

Medicolegal Aspects of Anaesthesia
Thursday 10 April 2008
Association of Anaesthetists, London
AAGBI Seminar in conjunction with MPS

Neuroanaesthesia & Neurocritical Care - Update 2
Thursday 17 April 2008
Association of Anaesthetists, London
AAGBI Seminar endorsed by NASGBI for specialist training

May 2008

Joint SAS Review Day
Friday 9 May 2008
Royal College of Anaesthetists, London
Run by AAGBI & RCoA

World Anaesthesia - Developing Links and Opportunities
Wednesday 28 May 2008
Association of Anaesthetists, London
Run by AAGBI & WAS

For further information and full programme details please see www.aagbi.org/seminars.htm
Association of Anaesthetists
Seminars Calendar

June 2008

AIM Seminar - Efficiency at any cost?
Wednesday 4 June 2008
Association of Anaesthetists, London

Leading Job Planning
Tuesday 17 June 2008
Association of Anaesthetists, London

Anaesthesia for Major Surgery - An Update
Tuesday 10 June 2008
Association of Anaesthetists, London

SAS Management Day
Wednesday 18 June 2008
Association of Anaesthetists, London

GAT - The Consultant Interview
Tuesday 24 June 2008
Association of Anaesthetists, London

July 2008

Anaesthetists and the Law - 1
Monday 28 July 2008
Association of Anaesthetists, London

Anaesthetists and the Law - 2
Tuesday 29 July 2008
Association of Anaesthetists, London

Delegates are invited to register for either one or both of the above days but priority will be given to those attending both.

To book a place on a seminar, please complete this form and return to: Gemma Williams, Team Administrator, Association of Anaesthetists, 21 Portland Place, London, W1B 1PY Tel 020 7631 8804, Email:gemma@aagbi.org or fax to: 020 7631 4352. For availability, see website www.aagbi.org or telephone 020 7631 8804.
We regret that we cannot accept telephone bookings.

Title of seminar ...........................................................
Date of seminar ...........................................................

Membership no ............... Male/Female .............. Title ...............
Surname ......................... First name .....................
Address .................................................................
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..................................................................................
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Postcode
Daytime phone ..........................................................
Post held .................................................................
Email .................................................................
Name of hospital (not trust) .............................................
Special dietary requirements ...........................................

Please pay by Sterling cheque drawn on a UK bank and made payable to the Association of Anaesthetists; Credit Card (only Visa/Mastercard/Delta); or Switch. One cheque per seminar application please.

Please debit my credit card (Visa/MasterCard/Delta) or Switch Card:
☐ Member £120.00
☐ Non-member £240.00
☐ Retired Member £60.00
OR special advertised price (selected seminars only) £............

Card/Switch Number ..........................................................
Expiry date ......................... Start date .........................
Issue no (Switch only) ............
Cardholder’s name .......................
Cardholder’s signature ................
Date .................................................................

Cancellation Policy
All cancellations must be received in writing. Written cancellations received at least fourteen days before the seminar will be subject to an administration charge of £20. Delegates cancelling after this date will be liable to pay the full seminar price unless the Association considers there to be exceptional circumstances that would warrant a refund.

Card Security Code ............. (The last 3 numbers printed on the signature strip on the back of your card)
The Association of Anaesthetists is always eager to encourage new seminars and is keen to develop our popular education programme.

We are interested to hear from potential organisers with ideas for topics so why not organise a seminar yourself? All we require is a programme and speakers - we will organise the rest.

In terms of our advertising deadlines, we require a confirmed programme and speakers five months before the date of the seminar – this is to allow delegates plenty of time to apply for study leave. Please note that speakers should be limited to five per seminar, preferably including the organiser. Please see our website for notes on organising seminars along with sample programmes.

Past organisers have found the experience very rewarding and have been impressed with the positive feedback.

If you are interested in organising a seminar please visit our website for a seminar form which can be printed out, filled in and returned to Ellen Morley at the Association. Please be sure to insert the contact details of all your speakers and any potential sponsors.

Once received, your programme must be approved by our Seminars Chair, Dr Val Bythell, after which we will reserve dates for you and the organisation will be directed by Ellen.

If you have any queries about seminars please contact Ellen, at ellenmorley@aagbi.org or telephone 0207 631 8834.

Core Topics - Throughout 2008

Core Topics 2008
Coming soon to a region near you:

Book your study leave now - for further information see:
www.aagbi.org/events/oneday/act.htm

28 April Exeter
19 June Manchester
1 October Edinburgh
10 December Birmingham
July 2008

GAT 2008 - Liverpool
2 - 4 July 2008
The Liner Hotel, Liverpool

Join us in Britain’s City of Culture for GAT 2008 which promises an exciting scientific programme as well as excellent social events. Don’t miss the trainee anaesthetist conference of the year.
www.aagbi.org/events/gatasm.htm

Call for Abstracts
REGISTRARS’ PRIZE
AUDIT PRIZE
ABBOTT HISTORY PRIZE
Abstracts are invited for presentation at the GAT Annual Scientific Meeting of the Association of Anaesthetists of Great Britain & Ireland. Please email entries to gat@aagbi.org, clearly indicating which competition you are entering. A confirmation email will be sent on receipt.
For abstract forms and further information, please contact gat@aagbi.org or 020 7631 8807/8812
Closing date for submission: 11th April 2008

September 2008

Annual Congress 2008
17 - 19 September 2008
Riviera International Conference Centre, Torquay

Not to be missed - Annual Congress comes to Britain’s picturesque South West coast bringing you a winning combination of lectures, workshops and social events to cater for all your educational needs.

Call for Abstracts
Original Research/Audit/Case Report or Series

Abstracts are invited for oral or poster presentation at the Annual Congress of the Association of Anaesthetists of Great Britain & Ireland. There will be three separate sessions for oral presentation – for original research, audit and for case reports or case series.

For abstract forms and further information, please contact secretariat@aagbi.org or 020 7631 8807/8812.
Closing date for submission: 6th June 2008.
Dear Editor...

Editor’s Choice letter

Go-faster gases

At Christmas, we may spend a little more than we should on fripperies and toys. This year Santa brought a pair of “Racing Grandpas”, and we had some fun with them on the kitchen floor while annoying the cook and waiting for our feast.

"Racing Grandpas" are wind up toys that depict two old men on their four-wheeled disability scooters, out to burn some rubber. Their disability is clearly pulmonary, as they both wear nasal cannulae, but that seems not to hinder their need for speed. But a closer examination notes their fixed rictus and ecstatic expression (Figure 1). The back of the scooter carries two gas cylinders, which may be a clue to their mental state. Both cylinders are green, and one carries the clear label "O2", an American convention. The other is marked "N₂O"! (Figure 2)

Either Grandpa or his souped-up scooter is supercharged with nitrous!

John Davies
Dept of Anaesthesia
Royal Lancaster Infirmary

London Blue Plaques

David Zuck has provided a History Page (Anaesthesia News January 2008) that is not only interesting but offers a practical experience for both Londoners and visitors. Who could resist stopping for a drink at the John Snow pub? Snow was originally teetotal so it seems incongruous to have a pub named after him but he was persuaded by friends in later life to drink wine for the benefit of his health.

The concentration of plaques in the capital is evidence that before the NHS it was difficult, even in London with its many teaching hospitals, to make a living solely from the practice of anaesthesia and almost impossible anywhere else in the UK, with the result that expertise and innovation was concentrated in a small area. While there were other famous anaesthetists in London who deserve plaques, and some obvious candidates come to mind, there are also several from other parts of the country who should be commemorated in this way. One or two at least already have been; Joseph Clover has a plaque above what was his father’s shop in the village of Aylsham in Norfolk, unveiled 15 years ago by Dr Aileen Adams while President of the History of Anaesthesia Society. And there is Simpson’s house in Edinburgh, with its plaque beside the front door. Other names that spring to mind: Featherstone in Birmingham, Hickman in Ludlow, Lee in Southend, Minnitt in Liverpool and Pask in Newcastle. An application has been made to put a plaque on G.T. Smith-Clarke’s birthplace in Bewdley. Although sponsored by the Alvis car fraternity, his medical engineering skill as incorporated in his ventilator will also be commemorated.

It seems local councils are increasingly willing to allow plaques to be placed on the birthplace or long-term residence of notable inhabitants. This sort of memorial is more durable, more cost effective and possibly more likely to have a longer-term influence on public consciousness than National Anaesthesia Day!

Adrian Padfield
Sheffield

Editor’s note: do other readers have suggestions for well-known anaesthetists who could be commemorated in their area, or have they succeeded in having memorials erected already? Let us know at anaenews@aagbi.org

This month’s Editor’s Choice letter wins a copy of Emergencies in Anaesthesia, (RRP £19.95) donated by Oxford University Press.

OUP gives AAGBI members 20% discount on many textbooks ordered online – visit the website at www.oup.co.uk/promotions/medicine/websoaagbi
**The good old days!!**

After decades of being presented with patients labelled allergic to medication solely because of well known side effects, it was interesting to read the comments of Dr Stoddart and Dr Lomax (1,2). I do not wish to start a chain reaction but I thought the following unusual cause of allergy labelling might be of interest.

As a newly appointed Consultant Anaesthetist in the early 1970s I was invited to anaesthetise for a regular list of NHS dental cases at a local surgery. The list consisted of ten to twelve adults who had repeatedly declined treatment for conservation and extractions. Previously the GAs had been administered by the senior dental practitioner.

All went well for a few weeks. Then a patient presented who claimed to be allergic to nitrous oxide. As I had never met this before and had equipped myself to deal with all eventualities, I proceeded, cautiously, using oxygen, nitrous oxide and halothane as usual and administered an uneventful anaesthetic.

Over the next year or so patients intermittently appeared claiming allergy to nitrous oxide. All my anaesthetics included nitrous oxide and were uneventful.

Eventually I asked one of the younger dentists what it was all about. “Well,” he said, “when Mr X gave the anaesthetics he occasionally had such difficulty with the airway that the patient became very cyanosed and he had to abandon the anaesthetic. When the patient demanded to know why the treatment had not been carried out he used to tell them it couldn’t be done as they were allergic to nitrous oxide…”

After about two years this stopped. I presume I had been able to reassure all patients as to the suitability of anaesthetics containing nitrous oxide. After five or so years I decided less than £1 per GA (after practice expenses) was inadequate for the job and I moved on to pastures new.

Mark Crosse  
Retired Consultant Anaesthetist.


*Editor’s note: This may have been a common practice – as a child I too was labelled “allergic to nitrous oxide” following a dental GA. This may have been because I kicked the dentist...*

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**How old is too old for paediatric wards?**

Dr Aitken predicts floods of letters from "outraged" members re paediatric nurses. (Editorial and Gas Flo article, Anaesthesia News, January 2008). May I support Flo: she has described the situation in my hospital with clinical precision, even down to the age divide. The only paediatric patients (less than age 16) who are not admitted to the be-banned sanctum sanctorum are those girls under 16 who are having a termination of pregnancy. Lumpen teenagers otherwise have to dally with Noddy.

Richard Knight

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**When in Rome...**

During a short break to Rome for my wife’s birthday, we came across this car with the logo as illustrated whilst heading for the Coliseum. It seems that Roman anaesthetists are attempting to find novel ways to advertise regional anaesthesia!

Dr Amit Pawa  
SpR in Anaesthesia  
London
Multiple Choice in Anaesthetics (circa 1965!)

The following MCQ was discovered by ENT surgeon David Enderby, who drew it to the attention of Bernie Liban, AAGBI Council member. It was originally published in “Hospital Medicine” in June 1967. David Enderby is the son of Hale Enderby, a well-known anaesthetist of this era, but he does not believe his father compiled the questions. Attempts have been made to identify copyright holders, to no avail. If any reader either compiled this, or knows who did, please contact Anaesthesia News so that due acknowledgement may be given.

For the benefit of younger readers, the answers are on page 28.

1. Which of the following drugs may cause adverse reactions when pethidine is administered?
   a. Nardil
   b. Valium
   c. Parnate
   d. Serpasil

2. Who was the first person to administer an anaesthetic to a reigning British monarch?
   a. Boyle
   b. Hewitt
   c. Snow
   d. Simpson

3. Who introduced cyclopropane into anaesthetic practice?
   a. Morton
   b. Magill
   c. Waters
   d. Sword

4. A Mapleson A circuit is known as:
   a. Magill attachment
   b. T-piece
   c. Westminster circuit
   d. Non-rebreathing attachment

5. Which of the following boiling points are correct?
   a. Methoxylurane 102.30C
   b. Azeotrope of ether – halothane 51.50C
   c. Halothane 45.20C
   d. Trilene 87.50C

6. Thermoregulation in the EMO vaporiser depends upon:
   a. A bimetallic strip
   b. CaCl2 crystals
   c. A compensating bellows
   d. Use of a large radiating surface

7. Stored blood contains no:
   a. Platelets
   b. Factor VIII (AHG)
   c. Xmas factor
   d. Fibrinogen

8. A mismatched blood transfusion during anaesthesia may cause:
   a. Shivering
   b. Tachycardia
   c. Excessive bleeding
   d. Hypothermia

9. Advanced liver disease may cause:
   a. Resistance to curare
   b. Resistance to morphia
   c. Resistance to thiopentone
   d. Resistance to gallamine

10. Phase II neuromuscular block often follows succinylcholine administration to a:
    a. Patient with myasthenia gravis
    b. Myotonia congenita
    c. Neonate
    d. Patient with familial periodic paralysis

11. Which drugs are largely excreted unchanged in the urine?
    a. Gallamine
    b. Propanidid
    c. Pethidine
    d. Hexamethonium

12. Which agents sensitise the heart to adrenaline?
    a. Propanolol
    b. Halothane
    c. Vinesthene
    d. Ethyl chloride

13. Lowering the body temperature:
    a. Increases the solubility of CO2
    b. Shifts the O2 dissociation curve to the left
    c. Causes sensitivity to curare
    d. Causes rhythm in the EEG

14. Which of the following conditions preclude the use of epidural anaesthesia?
    a. Pre-eclamptic toxaemia
    b. Anticoagulant therapy for venous thrombosis
    c. Cardiac failure
    d. Haemorrhagic shock
15. The complications of epidural anaesthesia include:
   a. Headache
   b. Backache
   c. Transverse myelitis
   d. Hypotension

22. Which of the following are explosive in air?
   a. Methyl-propyl-ether 10%
   b. Ethyl chloride 10%
   c. Cyclopropane 2%
   d. Ether 2%

23. What methods may be used for the measurement of O₂ concentrations in a gas?
   a. Polarography
   b. Paramagnetic effect
   c. Infra-red analysis
   d. Severinghaus electrode

24. The Jorgensen technique uses sedation with:
   a. Papaveretum and scopolamine
   b. Pentobarbitone, scopolamine and pethidine
   c. Droperidol and phenoperidine
   d. Promethazine, pethidine and chlorpromazine

25. The pressure in a half-full N₂O cylinder is:
   a. 370 lb/sq in
   b. 600 lb/sq in
   c. 750 lb/sq in
   d. 1500 lb/sq in

26. Which of the following many complicate brachial plexus block?
   a. Phrenic nerve block
   b. Recurrent laryngeal nerve block
   c. Pneumothorax
   d. Total spinal anaesthesia

27. An increase in physiological dead space occurs with:
   a. Emphysema
   b. Trendelenberg position
   c. Haemorrhagic shock
   d. Intubation of the trachea

28. To lessen the risk after anaesthetics in patients suspected if having a “full stomach” one should:
   a. Pass a Ryle’s tube and aspirate stomach contents
   b. Pass a no. 12 oesophageal tube and aspirate
   c. Use an anti-emetic prior to induction
   d. Use pressure on the cricoid cartilage during induction

29. The myasthenic syndrome occurs in:
   a. Patients with carcinoma of the lung
   b. Patients with a low serum potassium
   c. Patients with renal failure
   d. Patients with collagen diseases

30. Hyperbaric oxygen is of proven value for the treatment of:
   a. Gas gangrene
   b. CO₂ narcosis
   c. Carbon monoxide poisoning
   d. Cardiac arrest

31. Amniotic fluid embolus may cause:
   a. A fibrinogenaemia
   b. Bronchospasm
   c. Cauda equina syndrome
   d. Haemolysis

32. Cyanosis following tracheostomy may be due to:
   a. Laryngeal spasm
   b. Intubation of the right main bronchus
   c. Herniation of cuff over end of tube
   d. Fall in pulmonary compliance

33. Complications of tracheostomy may include:
   a. Paralysis of vocal cords
   b. Difficulty in swallowing
   c. Mediastinal emphysema
   d. Erosion of the left subclavian artery

34. Which of the following are non-barbiturate hypnotics?
   a. Brietal
   b. Epontol
   c. Surital
   d. Viadril

35. Which two of the following drugs should be available for emergency resuscitation?
   a. Sodium bicarbonate
   b. Picrotoxin
   c. Isoprenaline
   d. Ephedrine

36. On a body weight/dose scale, the neonate is:
   a. More sensitive to curare
   b. More sensitive to barbiturates
   c. More sensitive to C₉
   d. More sensitive to the phenothiazines
Advanced ultrasound guided regional anaesthesia training courses – 2008

These courses are organised by the ultrasound user interest group of ESRA UK & I Zone (RAGBI) in conjunction with SonoSite Ltd for the advanced training in ultrasound guided regional anaesthetic techniques. Previous experience in regional anaesthesia is essential.

<table>
<thead>
<tr>
<th>Course Dates</th>
<th>Location</th>
<th>Organisers</th>
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<tbody>
<tr>
<td>11-12 April</td>
<td>Bristol (A)</td>
<td>Dr Barry Nichols</td>
</tr>
<tr>
<td>19-20 June</td>
<td>Brighton (A)</td>
<td>Dr Susanne Krone</td>
</tr>
<tr>
<td>3-3 October</td>
<td>Liverpool</td>
<td>Dr Steve Roberts</td>
</tr>
<tr>
<td>5-6 December</td>
<td>Nottingham</td>
<td>Dr Nigel Bedforth</td>
</tr>
</tbody>
</table>

Faculty will vary depending on location

Pre-course material to be sent 2-3 weeks prior to the course – including US physics, anatomy of the brachial / lumber plexus and current articles of interest, plus a pre-course questionnaire and MCQs.

Post course questionnaire – 30 days Cost: £350 / £450 (A) including a handbook of procedures and a CD.

Programme

Day 1
- Ultrasound appearance of the nerves
- Machine characteristics and set-up
- Imaging and needling techniques
- Common approaches to the brachial plexus / upper / lower limb
- Workshops – using phantoms / models / cadaveric prosecutions (A)

Day 2
- Consent / training and image storage
- Upper / lower limb techniques
- Abdominal / thoracic techniques
- Cervical plexus / spinal / epidural / pain procedures
- Workshops – using phantoms / models / cadaveric prosecutions (A)

(A) = Anatomy based courses / with cadaveric prosecutions

Please call: Sarah Wood on +44 (0)1462 444800 or email education@sonosite.com

3rd National Outreach & Peri-operative Care Symposium
Thurs 3rd & Fri 4th April, 2008
Manchester Central Convention Complex
(formerly G-Mex/Manchester International Convention Centre)

A program of relevant & interesting topics presented by leading experts in their field.
Aimed at the everyday anaesthetist & anaesthetic trainee, with or without an interest in critical care.
Of considerable interest to specialist nurses in the critical care/outreach environment.

Just some of the topics:
- Improving Surgical Outcomes
- Cardiac Protection
- Post-operative Residual Curarisation
- Cardiac Protection in Non-cardiac Surgery
- Consent & the Anaesthetist
- Peri-operative Care of the Morbidly Obese
- Peri-operative Risk Scoring
- The Pregnant Patient for Non-obstetric Surgery

Subsidised rates for anaesthetic trainees, nurses, pharmacists & physios
- Consultant/NCG's: £395
- Trainees: £250
- Nurses/Pharmacists/Physios: £195

Please contact Georgina Hall for details
Tel: (0151) 522 0259
Mobile: 07901 717 380
E-mail: med symp@btinternet.com

This meeting is organised from the Dept of Anaesthesia, Wirral University Teaching, Hospital NHS Foundation Trust and is not for profit.
The Irish Standing Committee held its 19th Annual Open Meeting and Seminar in Dublin on 10th November 2007. At this meeting Dr Rory Page took over as Convenor. He is the 6th Convenor following Des Riordan, William Blunnie, PJ Breen, Sean McDevitt and myself.

The four years I spent as Convenor of the Irish Standing Committee were challenging and enjoyable. My first seminar was entitled “The times they are a-changing...” and this reflected the times approaching. Little has changed. Faced with a renegotiated Consultant Contract fast approaching and a new Medical Practitioners’ Act about to be implemented I feel “we ain’t seen nothing yet”!

The Irish Standing Committee was established in 1988 to ensure that a safe and comprehensive anaesthetic service is available to all in Ireland and to pursue the medico-political objectives of anaesthesia in our jurisdiction. Did we achieve this aim over the last four years? We have produced four “glossies” in that time: “Response to the Hanly Report”; a joint paediatric document —“Care of the Critically Ill Child in Irish Hospitals”; “Interhospital Transfer of the Critically Ill in the Republic of Ireland—Guidelines for the referring units”; and this year “Assistance for the Anaesthetist” 1. The latter was launched at the meeting with a presentation delivered by Dr. Brian Pickering. The purpose of this review is to place in context the current status of anaesthetic assistance in Irish hospitals and to make recommendations for the future development of this service. Our core findings are informed by the results of our national survey of availability of assistance for the anaesthetist, conducted during 2006-2007 and the resultant committee discussions. A joint committee is being formed with the Irish College of Anaesthetists to steer the implementation of the recommendations of the document. I feel all the booklets produced reflect the overall theme of the AAGBI - improving the quality of patient care.
care, as reflected in the strapline of the AAGBI for its 75th anniversary year “75 years advancing patient safety.”

This year’s seminar had a session entitled “Scourges in our time” with a very erudite talk from Professor William Hall on avian influenza. The second speaker, Dr Jenny Porter, spoke of her personal experience as an anaesthetist in Toronto during the SARS epidemic. Then we heard from Dr Roger McMorrow, an SpR from the Irish College Training Scheme who was a member of the Xtreme Everest Expedition. This was a fascinating personal account of an ascent to the summit of Everest and also of the amazing research conducted en route. I personally look forward to the results of the numerous physiological experiments undertaken during this expedition. One can only marvel at what this team achieved. The last session was a talk by President-elect of AAGBI, Dr Dick Birks, on milestones in the first 75 years of the AAGBI. Much was based on Tom Boulton’s excellent book on the history of the AAGBI. It is a formidable legacy and one which I hope present members of the AAGBI, including myself, can live up to.

As the Irish representative of the Section and Board of Anaesthesiology, UEMS (Union of European Medical Specialists), I have attended two meetings during the past year. One was held at the ESA meeting in Munich and the second meeting was held in November in Istanbul. The Anaesthesiology section of UEMS has subcommittees in key areas including CPD, Manpower, Quality and Accreditation. Dr. Jannicke Mellin-Olsen has succeeded Professor Hans Knape as President and I was elected Secretary/Treasurer of this group. The SBA is impressively active with well-attended meetings and much work being done between meetings. The group has prioritised the issue of patient safety and held a symposium on this in Istanbul. I feel this group is going from strength to strength and will be a major voice in promoting safer anaesthesia throughout Europe.

During my term as Convenor I had enormous support from the AAGBI Executive. They attended the annual Open Meeting and Seminar and always contributed hugely. The Convenor presents a report of activities to the AAGBI council regularly and the present Honorary Secretary, Dr William Harrop-Griffiths and President, Dr. David Whitaker have been extremely helpful in advancing our issues. In addition we were delighted that the Annual Congress in the 75th anniversary year was held in Dublin. The latter was an extremely successful Congress with a record attendance. We sincerely hope that the AAGBI will not wait another thirty years before holding their annual Congress in Dublin again!

It has been an enormous honour and privilege to serve as Convenor of the Irish Standing Committee. I wish my successor, Dr Rory Page, all the best for his forthcoming term and know that, like me, he will find it rewarding.

Dr Ellen O’Sullivan, Past Convenor, Irish Standing Committee.

References:
1. These publications can be accessed at http://www.aagbi.org/aboutaagbi/irishstanding/publications.htm
### MERSEY DATES

<table>
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<tr>
<th>Event Description</th>
<th>Dates</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Final FRCA SAQ Weekend (March)</td>
<td>Friday 14 – Sunday 16</td>
<td>No Limit</td>
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<tr>
<td>Final FRCA SAQ Weekend (April)</td>
<td>Friday 11 – Sunday 13</td>
<td>No Limit</td>
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<tr>
<td>Final FRCA Viva Weekend (March)</td>
<td>Friday 28 – Sunday 30</td>
<td>Limited</td>
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<tr>
<td>Final FRCA Viva Weekend (June)</td>
<td>Friday 6 – Sunday 8</td>
<td>Limited</td>
</tr>
<tr>
<td>Final FRCA (Booker) Crammer (April)</td>
<td>Sunday 6 – Friday 11</td>
<td>Limited &amp; Closed</td>
</tr>
<tr>
<td>Final FRCA (Booker) Crammer (September)</td>
<td>Sunday 28 – Friday 3 October</td>
<td>Limited</td>
</tr>
<tr>
<td>Final MCQ Week (March)</td>
<td>Saturday 29 – Thursday 3 April</td>
<td>No Limit</td>
</tr>
<tr>
<td>Primary FRCA Viva Weekend (April)</td>
<td>Friday 18 – Sunday 20</td>
<td>Limited</td>
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<tr>
<td>Primary FRCA MCQ Week (May)</td>
<td>Sunday 18 – Friday 23</td>
<td>No Limit</td>
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<td>Primary FRCA OSCE/Orals Week (May)</td>
<td>Friday 2 – Friday 9</td>
<td>Limited</td>
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<td>Primary &amp; Final FRCA Selective Week (April)</td>
<td>Basic Sciences Revision</td>
<td>Limited</td>
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Details & Applications – www.msoa.org.uk - Classes & Courses
The Ethiopian Society of Anesthesiologists Professional Association (ESAPA) held their founding conference on 29-30 September, 2007, which is the millennial year for Ethiopia.

This was a momentous occasion for anesthesiologists in Ethiopia, who met four years ago to discuss the formation of a professional body. It took them four years of perseverance before they managed to be formally registered with the Ministry of Justice in November 2006. It is so easy for us to take for granted our own established professional bodies. Their primary aim for the formation of a society was to “raise the standards of the medical practice of anesthesiology and improve the care of patients”. A simple and laudable, yet all encompassing and appropriate statement of intent. This is however anything but a simple goal. The statistics are difficult to comprehend in our own country. Ethiopia has a population of 75 million people with just 20 medical anesthesiologists and 300 nurse anesthetists. In the United Kingdom we have approximately 9,300 medical anaesthetists for a population of 60 million. So, very quickly, it is easy to see the challenges that the ESAPA faces.

Their founding conference in September was a milestone for this young enthusiastic society. The first day saw the Chairman, Dr Demek Kebede, in full traditional dress, open the meeting. I was able to present a College Shield and congratulatory message on behalf of Dr Judith Hulf, the President of the Royal College of Anaesthetists. Dr Samuel Teffera then gave a talk on what he perceived as the role of the anesthesiologist. This he concluded with what he felt being an anesthesiologist meant to him, which he kindly agreed to allow me to publish in this article.

Affection – Necessity – Efficiency – Sensitivity – Totality – Honesty – Elegance – Sureness – Intuition – Observation – Links – Openness – Genius – Yield. If we were all to work and live by these values I am sure that departments and hospitals would run far more smoothly.

The rest of the day was spent discussing how the society should develop and what roles it should take in the future. It was interesting that many of their frustrations and problems at work were similar to those experienced in
most anaesthetic departments in our own country, for example, status and recognition of anaesthetists, theatre efficiency, management intrusion, unrealistic surgeons etc.

We also had the opportunity to introduce and discuss other potential healthcare educational partnerships. They have applied to join the World Federation of Societies of Anaesthesiologists (WFSA) and become part of the international family of anaesthesiologists with further refresher courses planned for next year.

We introduced them to the Primary Trauma Care course group and hopefully this valuable course will be introduced to Ethiopia. Many of the anesthesiologists have worked with Operation Smile over the last few years and this close collaboration will continue.

The second day was largely scientific sessions with lectures from Wayne Barry (Canada), Keith Streetfield (Australia) and the author. The conference was sponsored by the WFSA, Canadian Anesthesiologists’ Society, Operation Smile UK and Epharm Ethiopia. We were looked after very well and invited to a fabulous traditional dinner and entertained by the local musicians and dancers. It was a privilege and also very humbling to be present at the founding conference of a new society of anesthesiologists and to see so few people endeavouring to achieve so much. I am sure that we would all wish them well for the future.

Dr Philip McDonald
Consultant Anaesthetist
St Richard’s Hospital, Chichester
Under pressure to ensure prompt commencement of a theatre list, I went to see my patients pre-op. The first patient on the list was a one-year-old Portuguese child, whose mother did not understand English at all. Not being able to speak Portuguese myself, I enquired with the NHS staff members in the ward whether any of them could communicate with the child's parent in Portuguese. Unfortunately I was not able to find a Portuguese-speaking staff member in the ward. I then called the NHS interpreter service to engage the services of a translator, who could communicate my description of the anaesthetic procedure to the parent of the child. It took forever to get through to the switchboard, and upon seeing that I had a further two cases on my list, I decided to check on the other patients and return thereafter to the Portuguese child and parent.

On my return to the Portuguese patient I realized that I was already running late to start the list promptly. I tried the interpreter service line again, and was eventually connected with the Portuguese translator. I explained the anaesthetic and pain relief procedures in English, to the translator who then (I believe) translated the procedures in telephonic communication with the mother. The patient's mother then consented to the anaesthetic procedure. I had no way of knowing or indeed establishing whether the translation was accurate and complete nor whether the patient's mother felt comfortable with the procedure as the translator did not convey any further questions from the mother to me.

When they subsequently arrived in the anaesthetic room, the mother was looking quite terrified and the child was clearly distressed. As I could not immediately locate a vein on the child, I decided to conduct an inhalational induction. Using gestures and signs to communicate with the patient's mother I placed a face mask on the child's face to begin the anaesthetic procedure. The child immediately started crying and so did his mother. The language barrier proved too problematic despite my attempts to communicate with the patient's mother in a calm, authoritative and soothing voice.

The circumstances of this case stayed with me throughout the day, and as the mother of a one-year old child myself, I was saddened by the whole episode. I decided to investigate how such events may be better managed in the future.

I began by seeking to identify the relevant Trust policies for the treatment of ethnic minority patients encumbered by an inability to communicate in English. I also began to wonder whether the Royal College of Anaesthetists (RCoA) provided any guidelines on dealing with cases such as this.

It must certainly be distressing to a parent to be faced with a very young child requiring an operation together with all the related anaesthetic procedures. What must it be like for a parent with an inability to communicate with staff caring for her child? The language barrier rendered me helpless as a mother, but more so as an anaesthetist, in this situation. As a mother I was quite distressed upon learning that the child had been fasted for over fifteen hours - the operation was originally scheduled for the previous evening and had been postponed to the morning list.
The Federation of Independent Practitioner Organisations Charter

The Federation of Independent Practitioner Organisations (FIPO) launched a charter towards the end of last year, which can be viewed on the FIPO website at http://www.fipo.org.uk/docs/patientcharter.htm. The AAGBI is a member of FIPO, and AAGBI Council has endorsed this charter.

The stimulus and background to the Charter are the changes in clinical practice and a gradual loss of professionalism in both the independent and NHS sectors. This is most clearly seen in the independent sector, with an intrusion by certain insurance companies into patient referral routes and clinical and professional issues. The Charter underlines a number of important principles:

- The primacy of the doctor-patient relationship
- Maintenance of patient referral pathways
- Fully informed patient choice
- Treatment that is most appropriate for each individual’s condition
- Continuity of care
- Professional audit and quality outcome assessments
- Transparency in all matters between consultant and patient

The Prime Minister recently underlined the importance of referral to an individual of the patient’s choice rather than to a service or to a clinician chosen by a Trust or an insurance company when he pledged to create: “an NHS which is personal to the patient not just because it’s available at a time to suit you, with the clinician of your choice, in the setting and environment which meets your needs, but also because it works directly for your needs and wishes” (speech given on 7/1/08 - http://www.number10.gov.uk/output/Page14171.asp).

If you would like to know more about FIPO, go to www.fipo.org

Will Harrop-Griffiths,
Honorary Secretary

and no one explained to the mother that her child could have had some food and drink in the evening. The problem was exacerbated by the non-availability of the interpreter service outside of the 8am to 5pm time zone.

One of the trusts that I joined during my SpR rotation asked me to complete a form stating other languages I spoke, and whether I would act as an interpreter if required, to which I agreed. Unfortunately on enquiring, no one knew anything about these forms and where they were kept. I am sure that if such a database could be kept electronically then each trust would save hundreds of pounds in translation services. This would definitely assist the care of ethnic minority patients and staff working with them.

As an anaesthetist I am concerned about the following issues:

1. How do I verify the accuracy and completeness of the translation provided by the ‘Language Line’, to every word I have described of the anaesthetic procedure?
2. What are the legal implications of using an interpreter, on the phone, to convey pre-op assessment information to a patient?
3. How can my Trust and indeed the greater NHS services ensure that non-English speaking surgical patients and parents of very young surgical patients are accompanied by a translator?

Puja Sodhi
SpR Anaesthetics
Leicester

Acknowledgement: Thanks to Dr.Gareth Jones, Consultant Anaesthetist, Leicester Royal Infirmary

HELP FOR DOCTORS WITH DIFFICULTIES

The AAGBI supports the Doctors for Doctors scheme run by the BMA which provides 24 hour access to help (www.bma.org.uk/doctorsfordoctors). To access this scheme call 0845 920 0169 and ask for contact details for a doctor-advisor*.

A number of these advisors are anaesthetists, and if you wish, you can speak to a colleague in the specialty.

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

*The doctor advisor scheme is not a 24 hour service
Notice from Mersey

It has been brought to our attention that we have created confusion throughout the constituency by changing the name of

The Mersey Selective Course
to

The Basic Sciences Revision Course.

In view of the advice of many MSA alumni, the enquiries from potential candidates and the reported comments of a number of College Tutors, we are reversing the change and henceforth this highly respected course will be signalled once again as

The Mersey Selective Course

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

The Next

Mersey Selective Course
14.00 Sunday 13th – 1600 Friday 18th April

PROVISIONAL PROGRAMME

Physics Revisited    Electricity Revisited    Measurement Revisited
Pharmacodynamics    Pharmacokinetics
Oxygen & Carbon Dioxide Fundamentals    Acid Base Conundrums
Cardiovascular Physiology    Respiratory Physiology
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Statistics for the FRCA
Physiology of Altitude    Physiology of Depth    Physiology of Exercise
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MCQ Revision Exercises

LIMITED TO 30 PLACES*

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Breakfast - Lunch – Refreshments

Details, Assessments & Application – www.msoa.org.uk – Classes & Courses

*Candidates will be sent a
Revision & Preparatory Homework Booklet
Introducing the SonoSite® S-Nerve™ ultrasound tool, designed specifically for anaesthesia.

Incredible image quality in an easy to use system that is ready to scan in 15 seconds. See what you inspired.
One day in the life of Ivan Ezegas

Got in at midnight, comrades. Had a day’s rest (don’t want to be done for sleeping in charge of an anaesthesia machine) and I went to see my patients for tomorrow’s orthopaedic operations. It was a big list: three knees and day cases. Katorga! And they told me this surgeon was very slow. Luckily, we agency people have devilish cunning – time is money and we also charge for pre-op visits.

The door to the orthopaedic ward was locked and on it was a long list of people not allowed to enter. It included anyone who had been to any other ward, anyone with an infection, anyone who knew anyone with an infection…….it went on. I ran down the list, looking for my name. Russians were there but no mention of Moldania so I rang the bell.

Amazingly, they let me in. Must have been a tea break. A baffled staff nurse examined the list, then my name badge: ‘Anaesthesia Provider 2nd Class. E.I. Ezegas III’. After we agreed that even the suspicious kulak Ivan was not there to steal the computer or molest the patients she was happy to inform me that none of my patients was on the ward. All this security made me giddy – like I had been through a time warp and arrived in 2030 already. No, I checked; it was still 2008.

“Tomorrow” She said.

“But what about my knee replacements?” I asked.


That was it. Sadder and wiser I turned away, to rise and come back the morrow morn (as one of your great English poets once said).

Going out, I passed the empty beds for tomorrow’s patients. How did it save money to have empty beds? They’d save on the evening meal but as the leftovers were sold as pig swill for good money, no economy there. The sheets would not be cleaned more often in 7 days than 6 days and the same staff were on duty. So, whether or not there was a patient in a bed, no difference.

In fact, it will cost them more because I will come in half an hour earlier, when I would rather be in bed or sending a text message to Mrs Ezegas telling her to get up and milk the cows. (Anyway this morning I found that the first case had already been sent to theatre. The second case took time: he had gone into AF after pre-assessment and he was unhappy about being cancelled; wanted to know everything. His bed would soon be empty – more money saved!!)

I know about health economics. Went on a course at the Plovdiv Institute of Management in 1969. This is what happens: the Uberkomandante has a certain amount of money to spend. Ministry Headquarters is asking how much is being spent per bed so he sends a runner to count how many beds there are. He goes around. Some beds are occupied, some empty and occasionally there is an empty space where a bed should be. Is that a bed or not a bed? Possibly stolen. So, answer to HQ: it costs $$$ per bed.

HQ ‘Makes a Model’. The Model says beds cost $$$ each. Uberkomandante is told to save money and so they make a sub-Model - worthy of the great genius Mudaksvilli himself: only full beds cost $$$, empty beds cost $ and empty spaces cost 0, so the Model says money will be saved by having more empty beds or empty spaces.

If you ask how much something costs, now they answer “The Model says this” or “The Model says that”. If you save money in The Model you then claim to have saved real money. Of course, no money has actually been saved at all but that does not matter: the flow of real money is impossible to measure and anyway, the budget is based on The Model. The Model says this much was saved and everyone goes away happy.

In his spare time, Uberkomandante plays an Internet game called ‘Second Hospital’ where he creates a virtual budget for a virtual hospital and competes, on line, with other Uberkomandantes to find out who can create the hospital with the most empty beds and conduct the most operations with no medical staff at all.