Scottish Standing Committee Open Meeting

Debate – should consultants be first on call?

Links with Ethiopia
ULTRASOUND TRAINING COURSES 2009

2009 course dates:
Advanced Ultrasound Guided Regional Anaesthesia
17 – 18 April — Bristol (A)
16 – 17 June — Liverpool
22 – 23 June — Brighton (A)
4 – 5 December — Nottingham

Introductory Ultrasound Guided Regional Anaesthesia
18 – 19 May — Norwich
6 – 7 July — Hitchin
23 – 24 November — Hitchin

Ultrasound Guided Venous Access
16 April — Hitchin
13 June — Hitchin
30 July — Hitchin
10 September — Hitchin
12 November — Hitchin

Ultrasound Guided Chronic Pain Management
11 May — Hitchin
14 September — Hitchin

Ultrasound Guided PICC Courses
28 May — Hitchin (2 half-day courses)

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

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

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 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.

Ultrasound Guided PICC Course
This half day course is aimed at all health care professionals involved in accessing arm and forearm fistulae. The course is a combination of lectures and practical hands on scanning. Strong emphasis is placed on participant involvement for both scanning and ultrasound guided needle access of target vessels. The use of ultrasound for early detection and identification of developing problems within fistulae will be addressed.

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.
£100 (half-day courses) includes VAT, refreshments and course materials.
(A) – Anatomy based courses with cadaveric prosections.

Contact: Jes Tiller on
+44 (0) 1462 444800
Email: education@sonosite.com
Web: www.sonosite.co.uk
© 2009 SonoSite, Inc. All rights reserved. NKT0726.02/09
We live in interesting times. Assailed by a financial crisis, beset by the coldest winter in 10 years and gripped by uncertainty over how our profession and specialty will deal with manpower problems, the portents do not look good. At least the Government has turned us all into bankers though I’m still waiting for my bonus which must be in the post; while the weather, so redolent of cold snaps in my youth, could only have provoked the headline “Snow in winter” within very recent times.

Those seeking real enlightenment into contemporary professional issues made up the audience at the SSC Open Meeting where problems ranging from staff injuries to informed consent and the aforementioned manpower concerns were all enthusiastically debated.

The meeting, always a model of punctuality, started at 09.30 with the committee’s convenor Dr Kathleen Ferguson calling us to order and introducing the first session chaired by Dr Mike Fried. The first talk on Needlestick Injuries was delivered by Dr Andrew Hartle. If you wanted confirmation that life gets ever more complicated then this talk would have sealed it. Charting his own growing involvement in the subject from an intensive care incident involving a trainee anaesthetist’s injury with a patient’s blood sample, he led us through the complicated legal and ethical processes that hampered a quick solution. He had to manage two patients instead of one and deal with a wide range of problems such as Post Exposure Prophylaxis for the staff member, the assessment of risk in an uncommunicative patient known previously to have had a massive blood transfusion, the wishes of the patient’s family and finally the Trust’s level of indemnity.

Clinically this all ended happily but future medico-legal difficulties can be illustrated by spotlighting the Human Tissue Act’s definition on what samples may be taken from patients. The old theological conundrum of how many angels can dance on the point of a needle has been replaced by whether plasma constitutes tissue or not - watch this space.
Prof James Ironside is the head of the national CJD surveillance group and a pathologist to trade. He instantly endeared himself to the audience by remarking that, in surgeons, he shared a common enemy with anaesthetists. In a lucid talk, entitled CJD Today, he took us through the history of prion disease, pointing out the agent was a parcel of modified protein without DNA replication but still capable of slow spread through a host’s tissue; especially neuronal and reticulo-endothelial matter. There is a naturally-occurring sporadic form which is very rare but the variant form is a 20th century disease due to intensive farming and especially livestock feeding practices. Cattle became cannibals, humans became meat averse and John Selwyn Gummer became a laughing stock. Once in the human food chain, cases of vCJD appeared quite quickly but appeared to peak in the early part of this decade. Unfortunately due to genotypical differences in how the prion is processed it is quite likely there will be a second wave of cases in the future. The focus now is in avoiding further iatrogenic transmission of the agent through contaminated blood products, surgical instruments or human derived hormone treatments.

The talk on Acute Percutaneous Coronary Intervention was a “two hander” with Dr Ian Starkey presenting the background in which good evidence of improved mortality with this technique had its implementation delayed by the belief that its reliance on fast efficient access was undeliverable. The subsequent talk from Mr. Scott McLean outlined the feasibility study which demonstrated the point that for much of the population, it is achievable and with a slickness that the NHS should be proud of. Patients with chest pain have an ECG performed in the attending ambulance linking directly to the hospital centre. This allows ST segment infarcts to be diagnosed on site, the catheter lab staff is assembled and the patient whisked straight in for angioplasty without passing A and E and without collecting £200 as it were.

Dr Alasdair Maclean, lawyer and doctor, intriguingly titled his talk Magic, Myths and Fairy Tales. Was he about to expose the whole edifice of medicine and the law as an artifice! Well no, his theme was the ever-changing landscape around informed consent and the law. He teased out some of the philosophical tensions underlying these changes and the differing view of the process they represented, from the levels of patient autonomy to the subtle shift from advice to information as corollaries to the consent process. He remarked that there was much less litigation in Scotland around consent and the question of who said what to whom. He drew two possible conclusions: either the doctors were fortunate to be working here or the patients were fortunate to have us!

The Open Forum this year invited Doctors Les Gemmell, Henry Robb, John Colvin, Richard Birks and Kathleen Ferguson onto the platform, inspecting the audience as batsmen would a fifth day wicket. Alistair Michie acted as both umpire and captain. Of course he went for pace at the start with a quick delivery on possible derogation by anaesthesia from the European Working Time Directive to avoid junior rosters becoming non-compliant. As the SSC...
committee meeting the day before had debated this very subject the responders were immediately on the front foot. The Cabinet Secretary has indicated it would be used only rarely in Scotland and in any case it is up to trusts and individual doctors to decide rather than the specialty as a whole. Dr Paul Wilson bowled the only googly of the day with a question on longitudinal job planning. The panellists’ footwork faltered momentarily until it was explained that it centred on a system of annualising sessional allocations at job planning. This raised the question of SPA entitlement and whether 2.5 sessions should be viewed as a right to be earned or as a starting position which could reviewed i.e. reduced! A case for the third umpire methinks.

High fliers in medicine are not uncommon. Few however could match Dr Alistair Newton, if only because he spends so much of his time airborne. Alistair is a consultant in Emergency Medicine based in the Royal Alexandra Hospital in Paisley. He told us of the evolution of the West of Scotland Emergency Medical Retrieval Service. The area’s expanse of rugged terrain is sparsely populated with few doctors and fewer hospitals. However accidents will happen and the safe retrieval of their victims has led Alistair and a group of his colleagues to set up an organised team dispatched to wherever the trouble may be. Once on site they help local health professionals stabilise casualties before transporting them to suitable major medical centre. This is usually done via the ambulance service’s helicopter but a fixed wing aircraft may be used. As a last resort the navy rescue plane may be called. It is not subject to civil aviation rules, so the pilots can exercise their own judgement on what is needed. Imagine living in a world without the Health and Safety clipboard brigade breathing down your neck! Initially, the medical input was unpaid but the service now has proper funding while the Scottish Government assesses its merits. A decision on its continuation or even expansion to cover the rest of country is awaited. Those of you given to exploring the wilderness may yet have more than a professional interest in its outcome.

Our guest speaker was Colin Suckling, the Freeland Professor of Chemistry at Strathclyde University and chairman of SACDA – The Scottish Advisory Committee on Distinction Awards. He certainly gave us value for money, delivering two talks for the price of one. His role as chairman of this committee guaranteed an attentive audience, especially as the process is under review. He thinks SACDA will be with us yet a while but aspects such as the financial structure, compatibility with the ACCEA system in England and links to the Discretionary Points system still have to be resolved. His major focus of attention was the proportionality of the Awards, especially the relatively few awarded to those working in smaller Health Boards. Anaesthetists also feel underrepresented in the awards but in both cases help may be at hand in the guise of central guidance to the committee from professional bodies and improved dialogue with Health Boards to boost the quality and quantity of applications.

The second part of his talk introduced us to Charles Suckling, his father, an innovative chemist with ICI. He was largely responsible for the development of Halothane (Fluothane) which revolutionized practice in the 1950’s. It remained the anaesthetic du jour for 25 years often appearing on charts under its sobriquet “GOH”. In special cases it was accompanied by a “FOP” in case anyone queried the monitoring. In those days only crows scavenged so identifying the anaesthetic vapour in use was easy for anyone with a sense of smell. Halothane’s distinctive bouquet remains with me to this day as does the huge impact it made on safe anaesthesia. Charles Suckling’s work in this arena was recognized by his peers and his work garnered many awards. He also inspired his son to follow a career in chemistry.

Outside the omens looked better. The sun shone, the Gods had smiled and the world seemed brighter. Roll on next year.

1 gas/oxygen/halothane.
2 finger on pulse!
Hello and Welcome to the Fair City

Airway Workshop
- Broad coverage of airway skills and techniques
- An overview on how these skills can be applied
- Clinical scenario discussion
- Workshop manual provided

Limited Number of places so BOOK EARLY

Scientific Programme
- International speakers
- Sessions include ‘airway management outside theatre’, airway critical incidents, airway pathology, extubation
- Topical debates
- S.A.M. guest lecture
- ‘Breakfast Club’ - meet the experts

Contact Details
Barry McGuire, Consultant Anaesthetist, Dundee Chairman of Organising Committee
email: b.mcguire@nhs.net

Abbey Conference & Corporate / Secretariat
email: das2009@abbey.ie
phone: +353 1 648 61 30
fax: +353 1 648 6197

Book your study leave now

www.das2009.co.uk

Annual Meeting 2009
Perth Concert Hall
4th - 6th November 2009

Simulator Session
- Running alongside workshops
- Airway Training / Human Factors

Entertainment
- Welcome Reception in Perth Concert Hall
- Gala Dinner at Perth Race Course
- Accompanying persons’ tour
- Discover the sights of Scotland.

Please see conference web site for more details.

Free Papers
- Abstracts are invited for oral or poster presentation
- Closing date for submission: 31st July 2009
One of the things I like about our specialty is that anaesthetists have a rather more corporate view of things than some other specialties. There seem to be rather fewer of the raging egos you sometimes see in other specialties (although, even in surgery, thankfully less frequently now than formerly). I’m not sure whether our specialty attracts people with that kind of personality, or whether we become more corporate by the nature of our work – we are a group of specialists who co-operate to provide a service, so are more used to thinking about working as a team. This focus outwards extends beyond our work, and as a group, we seem to be pretty socially aware. In last month’s issue Anthony Carey highlighted the number of cycling anaesthetists there seem to be in every department, and I can’t help but feel there’s a Christmas BMJ article for the person who can prove that anaesthetists have within their ranks a surplus of Guardian readers.

If my theory is correct, I can’t be the only anaesthetist noting the waste every time I insert, for example, a CVP line (and not just the ones where I drop something vital on the floor and need a second kit) – all that paper wrap, the plastic trays – at home I’d be sorting it out and putting it in the correct recycling bin. In hospital, it all goes in the big bag to be disposed of in some significantly less green manner. So much more of the stuff we use now is disposable: our theatre complex produces a mountain of waste every day, and it’s easy to identify that much of it must be recyclable. A few hospitals have introduced very laudable schemes for some of it, but I suspect most are like mine, just trying to balance the books at the end of the year, with green issues pretty low down the list of priorities. I can’t help feeling the manufacturers ought to be encouraging re-use – could those big moulded blue plastic trays everything comes in now be reused? Perhaps the green maths might show that by the time it’s been picked up, cleaned in the appropriate manner and reused, it’s better just to have a new one every time. There’s minor re-use going on at local levels – some hospitals have arrangements with the local PDSA hospital to send bags of clean opened swabs, sutures etc along to help with charity veterinary work. Every hospital doctor who ever moves house speaks nicely to the theatre porters to get empty cardboard boxes saved for them, and I can’t be the only person who has found opened clean paper drapes handy for painting and decorating at home. But it’s just a drop in a very large ocean.

Another socially aware issue that your Association has taken an interest in is how its finances are invested. The AAGBI has been following an ethical investment policy for a few years now – after consultation with members at the AGM a few years ago, it was decided to exclude tobacco companies from the AAGBI’s portfolio. There have been discussions about extending this, but the difficulty with attempting an ethical policy is my ethics are different to yours. For instance there have been discussions about excluding armaments – sounds like a no-brainer, unless you have a son fighting in Afghanistan. Wouldn’t you want the British...
Army to have the best modern equipment, produced by well-funded companies able to invest in research and development? Alcohol? We all see the damage alcohol does – especially here in the West of Scotland – but most of us enjoy a glass of wine, and the AAGBI certainly serves it at its evening functions during meetings. Many anaesthetists smoke, so may already feel irritated by the anti-tobacco ethical stance of their association. Are the big supermarkets rapacious oppressors of small British and Third World farmers, or a wonderful resource giving the British consumer choices they never had before at a reasonable price? You can produce a checklist of ethical concerns, circulate it to 100 people, and get 100 different answers. Since Council members are elected, they should represent a reasonable cross-section of the electorate and hopefully their decisions and actions reflect the electorate.

As with just about everybody with any savings or investments, this year the AAGBI’s investment portfolio has not performed as well as previously. While this would have happened no matter how the investments were placed, would a non-ethical investment policy have left us better or worse off financially? (You can save this one as a tricky question to ask the treasurer at the Annual Meeting in September).

Is the primary investment responsibility to maximise returns in support of the work the organisation does, or is a compromise on returns acceptable in order to follow a more ethical policy? It’s a lot easier for an individual to make a decision like this in respect of their own finances than for an organisation to decide in respect of its members’ money. So far, the members have been broadly supportive of the ethical measures the AAGBI has taken in respect of its finances, but as ever, the Association is keen to hear your views.

I’ve mentioned cycling already – I’m a minor cyclist, having managed to cycle to work twice last year (it’s a start!). While they make all the right noises, many hospitals have not invested in the infrastructure required to make this easy. We have minimal secure storage, so bikes are left around office corridors (until infection control or the fire officer spot them), and I keep a special kills-all-known-germs shower spray in my locker for use before I get into the shower in the changing room, which doesn’t get used for months on end, and is consequently not very inviting. The rest of the time I drive to work in my four wheel drive – and anyone who writes a rude letter about this gets to try and drive up my road on a snowy day in a Smart Car.

So we muddle along, doing the best we can as individuals and as an organisation. I’m not sure we can save the planet, but we can at least try!

In this month’s Anaesthesia News we have a debate which I hope will interest you. Richard Griffiths and Kathleen Ferguson have nailed their colours to the mast and outline the pros and cons of consultants being first on call. Let us know your views on this thorny issue. We are hoping to run a series of these debates, so if you have a topic you would like to debate, let us know. We also have reports from Scotland, Ethiopia, Brighton… and Buckingham Palace.

Hilary Aitken
Editor
I commenced my first term as Honorary Membership Secretary in September last year and feel it is indeed an honour and a privilege to be involved with the many exciting developments at the AAGBI and to act as Linkman Coordinator.

Our membership numbers continue to rise and reached 10,063 by the end of March 2009. We are therefore maintaining our position as the largest specialist medical association in the UK and Ireland, and the size of our membership lends authority to our opinions. It is testament to the benefits of membership of the Association that our numbers continue to rise. However it is no time to rest on our laurels and the membership team strives to improve our services. We continuously seek your opinions to enable us to represent these views and to provide you with the services you need and want. To this end we continue to look at new ways of keeping in touch.

Dr William Harrop-Griffiths is leading a team that is working energetically to revamp our website. One of the many exciting initiatives will be inclusion of a Safety Section with safety alerts and the development of educational resources including audio and visual pod casts. The secure access module (SAM) has been very successful, and allows new ways of reaching the membership. A recent survey indicated that 4,600 of you have used SAM with 2,400 agreeing to have information and newsletters sent to them and 1,400 to be emailed selected AAGBI surveys. Many WSM London bookings were processed through the website this year and the GAT ASM booking will be online only.

Despite advances in technology we still believe that the Linkman Scheme which has been running successfully since 1974, has a vital role to play. We would like to thank all active linkmen for their contributions to the AAGBI and its members. Thanks to the work of my predecessor Ian Johnston, we have completely revised the AAGBI database of hospitals and active linkmen, thereby improving communications. So many hospitals or anaesthetic departments have merged in the last few years, this was very necessary work. A disability database has also been set up for those members with disabilities who wish to exchange information. There is no doubt that the role of the linkman is increasing and the involvement and contribution of many is exceptional. However we would like all to be active and keep you up-to-date with all the activities and views of the AAGBI. The website has a “linkman section”. This portal, which is only accessible to linkmen, enables us to convey relevant information to members via the linkmen. If you would like to know more about the linkman scheme or who your linkman is, please contact Julie Gallagher at juliegallagher@aagbi.org.

One of our previous surveys identified that some members are unaware of the range of benefits of their AAGBI membership. In this issue we have listed our unique membership package (see opposite page). Our trainees are our future so please encourage them to join. A package for new members is being developed which will include the reworked replacement to the old SHO guide, copies of recent guidelines and a voucher for free attendance at a seminar. Currently all new consultant members get a free Annual Congress place.

This year we will be holding the 35th Annual Linkmen Conference in Liverpool on September 22nd 2009, prior to the Annual Scientific Meeting. At this forum every anaesthetic department can be represented by a linkman. It is always a very interactive and informative event where linkmen can discuss their problems and concerns with their national colleagues. Can I encourage ALL linkmen to attend this, the most important event in the Linkman Calendar! See you all in Merseyside in September!

Dr Ellen O’Sullivan
Honorary Membership Secretary
(honmembsecretary@aagbi.org)
An FY1 in cardiac anaesthesia

This year the first three foundation year 1 (FY1) doctors spent four months as ‘anaesthetists’ in the cardiac surgery unit in Brighton. Here they share their experiences, while one of the consultants provides an overview.

From medical school to anaesthetics

When I arrived at the Sussex Heart Centre fresh out of medical school, nobody knew what to make of an FY1. My FY1 colleagues stared in disbelief when I explained that every time a nurse asked me to do something I got a treat in return. I particularly remember the high dependency unit (HDU) nurses thanking me individually every time I wrote blood results into notes. Furthermore, when a patient needed a cannula, they offered me cups of tea in exchange for my services. Gradually and naturally, as I settled in and grew accustomed to my new work place, I established my role and the nurses seemed to enjoy teaching me the ways of their world.

We had all applied for the rotation specifically because we were interested in experiencing some anaesthetics before we made career pathway choices. It may seem inappropriate to put a newly qualified doctor into the highly specialised world of cardiac anaesthesia, but being within the cardiac department rather than the main anaesthetic department allowed a huge breadth of experience. We could work in theatres with the anaesthetists or on HDU with the patients postoperatively. Both areas were extremely friendly, with senior advice almost immediately accessible. This came from HDU nurses, surgical and anaesthetic registrars, and consultant anaesthetists based on the unit.

We were rarely asked to make any decisions due to the complexity and fragility of the patients, but this suited us. It was very much a consultant-led department and trainees of all grades would confer with the consultants on many decisions. It was not our role to make these decisions, but to assist in anything that was happening and learn volumes from everyone on the unit. This allowed flexibility in the job. As we were not given direct responsibility for the patients we could float into general theatres when the unit was quiet. We had a vast variety of anaesthetic opportunities available, and were able to sample obstetric, paediatric, orthopaedic and general surgical lists.

Learning the lingo

Consultant: So how has the patient been overnight?

Registrar: Well we have reduced the balloon pump to 1:2, 0.1 of norad, 0.5 of milrinone. Index 2.8, but he’s on 80% with 12 of PEEP and PCV with inverse ratio and plateau pressures of 31. Saturating 94% with pCO2s of 8 and pH 7.25 (after 100 of bicarb), but lactate’s dropped to 3. NG feeds up to 70, bowels not open since yesterday, urine output good, off support. Plan today is to wean inotropes, remove balloon and decrease FiO2 after recruitment manoeuvres. Take out the PA catheter and pop a whizzy stick in.

FY1: pardon?

We were daunted by this foreign tongue at first, but soon became excited and addicted to learning about the management of sick patients. Perhaps we felt a little like medical students at first, not feeling able to contribute. Even mundane FY1 jobs that give us a role in other posts, such as phlebotomy and organising imaging, were not routinely required. The radiologists come to the patient and the bloods are taken and back before we had even started our day. This, it turned out, gave us plentiful time to learn. The registrars were brimming with their FRCA viva spiels and the consultants equally keen to teach.

Procedures

One of the key aspects of the job has been the opportunity to learn many practical procedures, each closely supervised by Consultants or Registrars.

As the sole FY1 in the department and with no senior house officers vying for attention, we were in a rare and privileged position to receive regular one-to-one teaching. We were encouraged to insert so many central
and arterial lines that they now seem simpler than regular cannulae. We have also been fortunate to learn pulmonary artery catheter insertion, intubation, and assisted with tracheostomies and DC cardioversion.

In addition to learning anaesthetic skills, the post also enabled us to practice essential foundation skills: procedures such as urinary catheterisation, nasogastric tube insertion, preparing intravenous drugs, bag/mask ventilation and chest drain insertion. These skills may only be encountered on general wards quite sporadically, but could be practised on a daily basis, allowing us to complete them with confidence compared to our peers when we re-entered general surgery or medicine.

Taking our experience to the wards
Reflecting back on our medical and surgical rotations we can see how useful our time in anaesthetics has been. We are perhaps less startled when we see horrifying blood results or gases and better able to interpret them. We can begin to formulate appropriate management plans and if necessary offer to set up invasive monitoring.

When the first of us completed her anaesthetics rotation, the medical rotation came as a shock. She soon learned that not only must she carry a folder stuffed with different request forms, but have the drug cards and observation charts to hand, whilst simultaneously writing in the patient’s notes which were balancing on the side of the commode, and fishing out the relevant referral form from said folder. While her FY1 colleagues had acquired this skill a long time ago, she dropped her open folder no less than three times on her first medical ward round.

One aspect future foundation doctors may consider when choosing this job is the lack of on-call commitment. While this allows a full and active lifestyle out of work and more opportunities for supervised daytime learning, we have some concerns that we fall behind our peers in basic on-call learning. We have some concerns that even if we fall behind our peers in basic on-call learning, we have some concerns that perhaps a formal way. It is probably easy for the consultants to forget how basic our anaesthetics knowledge is: we received only a few weeks’ exposure several years ago at medical school. Perhaps a short session each week in theatre could be used for discussing the basics of physiology and pharmacology for example. We covered general anaesthesia when we accompanied one anaesthetist to day surgery in a small district hospital fortnightly, and more teaching like this would be valued.

Overall this has been a brilliant placement that we would recommend to all future FY1s, whether considering a career in anaesthetics or not. Other than procedures and clinical experience it has been particularly useful in demonstrating how well a multidisciplinary team works. We became friends with the theatre staff, operating department practitioners (ODP), HDU nurses, porters and of course anaesthetists, all equally keen to support and teach us.

A Consultant’s View
Our cardiac surgery unit performs about 700 – 800 operations per year and lives on one level of the hospital that consists of two theatres, an eight-bedded ITU/HDU, a 19-bedded ward and two interventional cardiology labs. There are five consultant anaesthetists, four surgeons, six middle-grade surgeons and three ‘SHO’ level surgeons who are dedicated to the ward and assisting in theatre. Anaesthetic SpRs rotate to the unit every 3 months for their cardiac anaesthesia module. Because their training is largely focused around the operating theatre and during the daytime only, the cardic HDU relies on the consultant anaesthetists to provide immediate cover during and out of hours. Since August 2007 we have also had an FY1 doctor in “Anaesthesia and Perioperative Care” as part of the anaesthetic team.

It certainly seems odd to have an FY1 in such a specialised area, and not everyone was sure it was the right place for an FY1. However, a look at the goals of foundation training(1) suggested that cardiac surgical patients might easily provide the requisite clinical experience.

In the job plan for the post the emphasis was very much on learning to manage postoperative patients with multiple comorbidities; spotting the sick patient and initiating investigation and treatment and getting to grips with ‘the cardiovascular and respiratory systems’. It was not to train them to give an anaesthetic, although there would be opportunities to learn about anaesthesia. In truth, we wrote a great deal of flexibility into the plan to allow it to evolve to the needs and interests of the individual doctors who would rotate through the post. Looking back on the first year the following observations can be made:

- Being a small, self-contained and friendly unit provided a very supportive
environment that allowed the FY1s to rapidly settle into the post. Being the only FY1 in the unit led to a bit of an ‘only child’ situation in terms of attention from senior staff; something one hopes has resulted in greater learning opportunities.

- The post rapidly evolved its core roles: co-ordinating investigations; collating results; organising interventions and documenting management plans on the ITU/HDU ward rounds. This is a good example of a job finding its own niche: although there is usually a consultant anaesthetist on the unit in the mornings, in the afternoon the first medical port of call was the surgical middle-grades who also have commitments in outpatients, on the ward and in theatre.

- The most popular aspects of the job appeared to be spending time in the anaesthetic rooms putting lines in and learning airway skills. This included attending a day-surgery list every other week with one of the consultants.

- All three felt a valued part of the team. Indeed all three of them joined us in this year’s Three Peaks Challenge which we did in June this year, getting silver medals (20 – 22 hours) and raising money for the Sussex Heart Charity.

- Two of the three are pursuing anaesthesia as a career and the third has it as her second choice.

- All three took part in an on-going audit of blood product use, gaining an insight into the difficulties of changing established clinical practices.

The only problem with having FY1s with us was the occasional competition for practical procedures in the anaesthetic room or on the unit. Some SpRs didn’t want to deny the FY1’s request to put in a central line, while at the same time feeling they were being deprived of an opportunity.

A recent external review of Foundation Training in our Trust highlighted our post as demonstrating ‘excellence’, so it seems the FY1s get as much out of the placement as we do out of them. The only question being asked now is not ‘is it an appropriate FY1 job?’ but ‘how many more FY1s could the unit accommodate?’!

Nevil Hutchinson
Consultant Anaesthetist

Natasha Goodman
Allie Green
Katherine Horner
FY1s in cardiac anaesthesia
Royal Sussex County Hospital
Eastern Road, BRIGHTON

Reference

All three FY1s were successful in getting ST posts in anaesthesia or Acute Care Common Stem posts.
The Association of Paediatric Anaesthetists (APA) and the Royal College of Anaesthetists (RCoA) have been collaborating on a major review of the paediatric section of the syllabus for the Certificate of Completion of Training (CCT) in anaesthetics. The introduction of the European Working time Directive (EWTD) rota changes in 2004 has led to a perceived reduction in the minimum achievable paediatric caseload during training, and thus a lack of confidence among trainees and newly-appointed consultants in dealing with children.

A joint initiative between the APA and GAT was set up in an attempt to quantify the caseload achieved under current training conditions, and to assess the level of confidence among trainees in managing younger children. This information will be used to develop specific age-group and caseload criteria to incorporate into the revised CCT in anaesthetics syllabus. Investigating and exploring training issues such as this is one of the major reasons the GAT Committee exists.

The Current Syllabus: Gold Standard

Trainees who aspire to a full-time career in paediatric anaesthetics should complete a minimum of six months training in the specialty, and trainees intending to work in a District General Hospital should acquire the competencies listed for higher training: this does not necessarily have to be undertaken as a single dedicated block [1].

Methods

The GAT e-mail database was used to send a link to a web-based survey to all Specialist Registrar (SpR) members of the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Two requests to participate were sent and the survey was open for three months from November 2008 to February 2009.

The Survey

1. What is the anticipated date of your CCT?
2. What are your future career aims?
   - General anaesthetist
   - Paediatric anaesthetist in a specialist centre
   - Anaesthetist with a special interest in paediatrics
   - Anaesthetist with a special interest other than paediatrics
   - Intensive Care Medicine
   - Other:
3. Have you or will you complete higher or advanced training in paediatric anaesthesia by completion of your CCT? If not, why not?

4. How many paediatric cases have you done?
   Total
   <1 year
   1-5 years
   5-16 years

5. What percentage of these cases were
   Solo
   Supervised by a consultant anaesthetist
   Supervised by a non-consultant anaesthetist

6. What would be the age of the youngest patient you would be happy to anaesthetise solo when on-call?

7. What would be the age of the youngest patient you would be happy to stabilise solo prior to transfer to definitive care?

**Results**

182 trainees completed the survey following 2698 e-mail requests, a disappointing response rate of 6.7%.

86.9% of these will obtain their CCT within the next 5 years. 33.2% are planning a general career in either a DGH or a teaching hospital; 22.6% are developing a different specialist interest (obstetrics/cardiothoracic/pain/regional) and 21.2% are training in Intensive Care Medicine (ICM). This leaves 23% working towards a career in paediatric anaesthesia, with 28% of these aiming to work in a specialist centre.

63.6% of trainees will have completed higher or advanced training in paediatric anaesthesia by their CCT date, the converse of which means that 36.4% of trainees will not. Of these, 3.4% will have a dual CCT in ICM and state that they will not have the time to complete paediatric anaesthesia training as well.
The question relating to solo/supervised cases proved difficult to answer in a meaningful fashion as most trainees’ logbook data does not differentiate the grade of supervisor. However, it would appear that around two thirds of cases completed are supervised and one third are done solo.

The questions relating to confidence in anaesthetising children solo when on-call and stabilising critically ill children prior to transfer generated interesting debate. 22% of trainees are only happy to anaesthetise children over 5 years of age when on-call; 16% are happy to anaesthetise under-1 year olds in the same context. Hence the majority are happy to anaesthetise children over 5 years of age when on-call but many qualified this with statements pertaining to the ASA grade and general condition of the child at presentation. There was a 50:50 split among trainees regarding stabilising critically ill children prior to transfer, 50% being happy to stabilise children under 5 years of age. Again, there were many qualifying statements regarding the condition of the child, and 7% of respondents pointed out that all anaesthetists are qualified in resuscitation and are therefore obliged to assist in any situation.

Discussion
Paediatric anaesthesia is still a popular subspecialty among trainees and competition for consultant posts continues to be strong. It is clear that the minimum achievable caseload has reduced considerably over the last few years, primarily due to the implementation of the EWTD regulations [2], although a wide variation in these numbers has been demonstrated by this survey. A lack of confidence in dealing with children on-call may be inferred by the fact that 22% of respondents are unhappy to anaesthetise a child of less than 5 years, and nearly 50% would be unhappy to stabilise a child of less than 5 years prior to transfer to definitive care.

This survey has a number of limitations, not least the difficulty in interpreting data received from such a small percentage of respondents (6.7%) and attempting to apply it to the wider context of training. The GAT e-mail database does not easily allow targeting of specific trainee sub-groups as it records year of membership, not year of training. We place strict limitations on the use of this database as we understand that people do not wish to be bombarded by constant e-mail traffic; equally GAT exists to represent our membership and we cannot do this without accurate and up-to-date data. It would appear from some free text responses to our questions that logbook data is perceived as particularly tiresome to fill in. There were also a number of technical difficulties encountered with the survey link which may have prevented further responses. The data analysis relies on the accurate recording and reporting of data by respondents, some of which was incomplete.

Conclusions
The information gained from this survey suggests that previously accepted minimum achievable caseload criteria may be impractical under current training conditions. Using this data, the APA and the RCoA can try to move forward and develop new, more achievable age-group and caseload criteria for the paediatric section of the CCT in Anaesthetics syllabus. It is hoped that, with revision of the syllabus, focused and effective training in paediatric anaesthesia will improve the confidence of trainees and new consultants when managing children. Improved confidence in managing children is vital by the time trainees acquire their CCT as the majority of consultants are required to provide emergency cover for paediatric patients when on call.

References
1) CCT in Anaesthetics IV: Competency Based Higher and Advanced Level (Years 5, 6 and 7) Training and Assessment. A manual for trainees and trainers (August 2008)

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
Travels with Tracrium

In 1981 I was fortunate to become involved in an early clinical trial of atracurium under routine operating conditions in a busy small hospital. This was a practical trial, as it would soon become obvious if a new agent caused delays in induction and recovery or provided poor operating conditions, and lists continuing much later than usual would rapidly lead to protests from my Surgical and Nursing colleagues. As a result of this trial, I was invited to speak at a number of meetings.

My most nerve-racking journey was to London in 1982 to read a paper at the first atracurium symposium. This was the first time I had read a paper at an important meeting. In spite of suitable premedication before lunch, when I was about to read my paper two hours later my pulse was over 160. However, I succeeded in raising a laugh both at the start and end of the paper, and was asked by the chairman to repeat my closing remarks; this I did “for the benefit of those of you who have just woken up”.

Another paper was read a few days later in the Royal Festival Hall (capacity several hundred) at the Sixth European Congress of Anaesthesiology. There were about thirty people present. It was bad for the ego (but probably good for the soul) to be told by a former registrar, by then an Associate Professor of Anaesthesiology, that it was too early on a Saturday morning for him to bother to come.

Following the launch of the drug, I attended several meetings in anaesthetic departments in England and Wales (and had my first and last encounter with Newcastle Brown Ale).

In 1983 I went to the 4th International Congress of the Belgian Society in Brussels. When I asked a Belgian colleague why almost all the papers were in English, he replied that if the Professor in his own University read a paper in his own language he risked half of the Belgian audience walking out owing to the two languages problem. Coming from North Wales at a time when militant Welsh language enthusiasts were active, I could appreciate the problem. A week later I travelled to Switzerland, where I had six minutes to present the same information as I did in 15 minutes in Brussels. Overrunning by 20 seconds resulted in a bell being rung in mid sentence.

One of the hazards of these travels was arriving at the airport with no local currency, sometimes not knowing where I was to stay, and not being met by the company’s representative as arranged. This first occurred in Libya, where I was to be met by a “tall young man wearing a British Caledonian T-shirt.” Eventually the only person left in the airport was a short, elderly gentleman wearing a suit, who was looking for me. Most of the company’s staff had seen the promotional video, in which I had given the anaesthetic; he had not.

I had been told that all those attending would be anaesthetists. At the first Libyan meeting I discovered that 90% were not. I therefore started with “The Idiot’s Guide to Anaesthesia” (put them to sleep with thiopentone, keep them asleep with N₂O, alive with O₂, pain killers, muscle relaxants, halothane, intubation, ventilation, reversal etc.) This was later developed into a training video for drug reps when it was realised that many of them knew the theory of the elimination of atracurium but had no idea why muscle relaxants were used in anaesthesia.

Next, when travelling from Bahrain to the Gulf States, I was delayed leaving the airport by luggage problems (three flights in simultaneously and only two carousels). Luckily I knew the hotel where I was staying, and the taxi driver “negotiated” an exchange rate for the wrong sort of dinars.

The third occasion was at a small Norwegian airport. Although I had given the company my itinerary, it was incorrectly assumed that I was travelling from London. As the computer at the airport had broken down, the gentleman meeting me could not find out about any flights or connections from the UK. He returned to the airport just as I was arranging to pay a taxi to the hotel in pounds. Luckily I lost my luggage only once, resulting in having to read my paper in Antalya, Turkey, attired in a garish shirt bought at the hotel and a tie borrowed...
AAGBI Member is awarded the OBE

Dr Julia Moore, Consultant Anaesthetist at Wirral University Teaching Hospital, has been honoured by the Queen for her services to medicine and to the community on Merseyside.

In addition to her role at Arrowe Park Hospital, Dr Moore has worked for the Department of Health since 1999. As National Director of e-Learning for Healthcare she is leading the development of e-learning to support postgraduate medical training across the UK. One of her flagship projects is e-Learning Anaesthesia (e-LA).

She was awarded her OBE in the Queen's Birthday Honours list and is pictured with her husband after receiving the award at Buckingham Palace in October 2008.

from the only other British speaker at the conference.

On one of my visits to Dublin I found that the audience was entirely composed of pharmacists. At that time they controlled the hospitals’ budget for drugs. Atracurium was expensive, and while doubling the cost of the muscle relaxant in an individual anaesthetic in relation to the total cost thereof is infinitesimal, doubling the bill for muscle relaxants for a large hospital appears huge to the budget holder. It was a very genial meeting, and the alcoholic premedication had rendered the audience suitably relaxed. Nobody noticed that the slide of the formula was (deliberately) projected upside-down!

There were occasional language problems. In Saratov (Russia) I was positioned in front of the screen where I could not see the slides and had to signal to the projectionist to change them. The inevitable happened - I got out of sync with the slides. Luckily I had run through the paper with the interpreter, a lecturer in English at the Medical School, a couple of times. She translated what was on the screen not what I was saying until I eventually got back into sync with the slides.

In Cadiz I was surprised to find the promotional video playing in the foyer of the lecture hall with a picture of myself speaking perfect Spanish. Among the highlights of my travels were seeing not only the Spanish Riding School in Vienna, but also the Spanish Riding School in Jerez, a “behind the scenes” visit to the late Shah’s palace in Tehran, and a post conference party in Iceland, where an eminent Scandinavian anaesthetist demonstrated his skill as a conjurer.

My last “travel” was more an “adventure with atracurium”. In the summer of 1996, at the age of 74, I was in Kurdistan shortly before fighting broke out between the two main Kurdish political parties. Muscle relaxants were in short supply, and I came across a box of atracurium. The ampoules were several years time expired, and the cold chain non-existent. As the effect of temperature on atracurium is the breakdown into inert products, I risked using it. It worked.

Apart from the occasional attempts of USA academic departments trying to score points off each other rather than contributing to the knowledge of the other delegates, my main impression of international anaesthetic meetings was how friendly everyone was regardless of political or religious beliefs - if only international political conferences could be carried out in a similar manner.

David Rowlands
Retired Consultant anaesthetist
There are many stories of doctors and nurses who, with misplaced altruism, travel to developing countries taking with them ideas that aren’t helpful, equipment that isn’t useful, and attitudes that annoy the local professionals. Clare, one of our senior ICU nurses, felt hesitant when asked whether she would like to help a semi-rural Ethiopian hospital train staff in an intensive care unit. She wasn’t at all sure that what she was doing would be of any help. Now that the ICU is up and running, however, Clare tells me that she is in no doubt about its positive effect and that there’s barely a day goes by when she doesn’t end up thinking about her time there.

As a consultant in intensive care medicine I was asked to visit Jimma University Hospital for two weeks in November 2007, and like Clare I wasn’t at all sure whether or not to go. I was under no illusions that I had anything special to offer, especially not in just two weeks. What do I know about anaesthesia and intensive care medicine in Africa that will be of any help? In the end I decided to go only after I had met Dr Yemane Ayele, Chief Anaesthesiologist from Jimma, who visited us in Nottingham over the summer as part of the Nottingham-Jimma Link.

The Link
Nottingham-Jimma link was set up with help from THET (the Tropical Health and Education Trust) and at over 15 years old is the oldest of a number of links around the country (other examples include Links between Bristol and Uganda; and Middlesbrough and Malawi). The Link is a partnership designed to continue over many years and whilst I could only manage to go for two weeks that has to be put in the context of many different health professionals travelling out for varying periods of time over many years. The Link also funds groups of Ethiopian doctors, nurses and other professionals to come to Nottingham each year: that was how I had already come to know Yemane when he visited our ICU (and said of our patients, “My God, they’re all so old”).

The Visit
Arriving in Ethiopia was something of a culture shock. In the arrival hall of Addis Ababa airport there was a huge banner celebrating the arrival of the new millennium (this was in 2007). It wasn’t until a few days later that I discovered that Ethiopia uses the Julian calendar, so for them 2007 was the millennium. About the same time I also discovered that in rural Ethiopia the clocks are set to daylight hours, so that 6 PM
(sunset) becomes 12 o’clock, as does 6 AM, (sunrise). This makes arranging meetings, not to mention just reading patients’ notes, something of a challenge.

Language was only occasionally a problem: the English spoken by the doctors was generally excellent, although the nursing staff and anaesthetic trainees were often less fluent. In order to be clearly understood I started having to avoid linguistic contractions: don’t became do not, wouldn’t became would not, and so on; by the end of two weeks I felt like one of the cast of Guys and Dolls. Certain words also had different connotations in Jimma. Patients on the ICU never died, they only ever expired (apparently this was an issue a few years ago when a visitor from Jimma to Nottingham was issued a hospital ID badge which had an expiry date written below his name).

Despite minor differences, communication was rarely a problem, and I was asked to provide many lectures and teaching sessions. Jimma has recently set up a direct-entry (ie direct from high school) BSc in Anaesthesia. Ethiopia, like many developing countries, has a huge need for people with intermediate skills who can provide services to rural or semi-rural communities, and non-medical anaesthetists, as opposed to medical anaesthesiologists or even nurse-anaesthetists, could help fill that gap. Unlike doctors and nurses they are also less likely to be “poached” by developed countries or NGOs (NGOs can pay up to several times the government salary for a doctor). Much of my time was spent teaching anaesthetic trainees about different aspects of general anaesthesia including monitoring, regional anaesthesia, and paediatric anaesthesia.

The teaching was a two-way street. I attended medical ward rounds and learned about malaria, tuberculosis, HIV, tetanus (previously I had treated two cases of tetanus, and during my visit that number doubled). Although resource-poor, the medical staff were far from knowledge-poor.

The hospital campus itself was open and for the most part full of grassy and pleasant places to sit and talk (the exception being the very old buildings where the sewage outflow was broken). They have an open-air staff canteen with an amazing view. It was odd to see stray dogs around, and vervet monkeys running across the rooftops, but not so different to the foxes, squirrels and pigeons back home.

The ICU itself is a simple but modern building with six beds, three ventilators (Servo 900c), and the ability to run inotropes (peripheral adrenaline only). Monitoring includes SpO$_2$ and blood pressure (and ECG when they had electrode stickers) as well as urine output (no catheter bags though, so IV fluid bags get recycled); and trends are charted. Equipment is serviced and maintained by Menschen Für Mensch, a German charity with strong links in Ethiopia who helped fund the building work. The unit takes a mix of medical and surgical, adult and paediatric patients. A larger proportion of medical patients are admitted than in other African ICUs where post-operative care is more dominant.

Jimma ICU looks and feels very different to Nottingham. Visitors aren’t allowed on the ICU so relatives stand and look, and talk, through the windows. Level 2 patients are mostly propped up in bed hunched under a blanket (no matter what the temperature, either on the unit, or their own core temperature). Patients are often left intubated when they are first weaned from the ventilator because of a lack of anaesthetists to re-intubate them in an emergency (they have low flow tracheal gas insufflation instead using a modified suction catheter to deliver oxygen to the distal end of the endotracheal tube - a neat trick). Despite the differences the care delivered is very good.

**Summary**

Jimma Hospital has achieved something quite impressive. At the time Jimma ICU was formed it was only the third such government run unit in the whole of Ethiopia, and the only functioning unit outside Addis Ababa. It has continued to remain open and functioning ever since. Admittedly there are problems: a lack of drugs (especially opiates), intermittent electricity, limited
equipment, and a limited number of staff - but the overall story is one of success.

I don't imagine for one moment that I made any great influential changes to anaesthesia or ICU in Jimma. In fact I am quite certain I learnt more than I taught. But I do feel that the continuing support of the Link has helped.

Compared with other visiting charities the Link is more low-key, more of a partnership that helps facilitate local changes and developments, but it would be very wrong to overplay the value of the Link. The ICU exists because Menschen Für Mencshen invested in the construction and the equipment; because there was the local desire to set up the project; because of a VSO volunteer: Mai Wakatsuki (who also helped develop the BSc course in Anaesthesia, and wrote an excellent article about Jimma in the February '05 edition of Anaesthesia News). Most of all the ICU works because Yemane and his senior nurses put so much into it. What the Link has added is in helping with motivation and training - and some appreciative international interest. The odd bit of targeted, useful equipment doesn't go amiss either.

Just as in the UK there will always be the argument that the money for an ICU could be spent elsewhere on prevention or rehabilitation. However if you're going to the effort of treating a sick patient there is little point in leaving them in an understaffed, overcrowded ward, where they will get little care. Jimma have managed to make a little extra resource go a very long way.

Acknowledgements
Claire Hepworth, Senior Staff Nurse, City Campus, Nottingham University Hospital
Dr Mai Wakatsuki, SpR in Anaesthesia and Intensive Care, Wessex School of Anaesthesia
Dr Yemane Ayele, Consultant Anaesthesiologist and Director of Intensive Care, Jimma University Hospital, Ethiopia

Figures and tables

Figure 1.
Source of Jimma ICU admissions

Table 1.
Jimma ICU admissions (Julian calendar dates)

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>118 (49.6%)</td>
<td>244 (52.1%)</td>
</tr>
<tr>
<td>Age range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>1 (0%)</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>&gt;1-5</td>
<td>8 (37.5%)</td>
<td>11 (54.5%)</td>
</tr>
<tr>
<td>&gt;5-15</td>
<td>6 (33.3%)</td>
<td>17 (52.9%)</td>
</tr>
<tr>
<td>&gt;15-40</td>
<td>61 (47.5%)</td>
<td>153 (53.6%)</td>
</tr>
<tr>
<td>&gt;40-60</td>
<td>30 (56.7%)</td>
<td>44 (45.5%)</td>
</tr>
<tr>
<td>&gt;60</td>
<td>11 (63.6%)</td>
<td>13 (30.8%)</td>
</tr>
</tbody>
</table>
MERSEY COURSES

Primary MCQ Week
14.00 Sunday 10th May – 16.00 Friday 15th May
No Limit to Places

Intense Analysis of 900+ MCQs
Physics Measurement Equipment
Physiology
Pharmacology
Long Hours – Casual Dress – Good Company
£300

Final Viva Weekend

Intense Revision & Viva Practice
14.00 Friday 12th – 16.00 Sunday 14th June
Limited to 78 Candidates

Long & Short Cases
Basic Sciences
Six Full-Length Vivas per Candidate
Under as near Examination Conditions as can be mustered
Plus
Revision of Examination Booklets & Laminates
Best Pass Rate to Date - 93%
Worst Pass Rate to Date – 76%
£250

Aintree Hospitals, Liverpool
Breakfast, Lunch, Refreshments, Water & Sweets.

Caveat
All Courses are very demanding and are thus considered unsuitable for trainees not sitting the respective examinations imminently.

Details Assessments Application Forms

WWW.MSOA.ORG.UK

Candidates for these courses will be expected to have Completed
The Homework Programme
Which will be sent to them on Confirmation
Cambridge Anaesthesia Courses 2009

Cambridge University Hospitals NHS Trust, Cambridge

Final FRCA VIVA DAY
12 June & 27 November 2009

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

For further information, please contact: Miss Lucy Bailey,
Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP;
Tel: 01223 217059; Email: lkb39@medschl.cam.ac.uk

Addenbrooke’s Simulation Centre

Cambridge Airways Course
24th June / 6th October 2009

A full-day course for Anaesthetists to refresh and update skills in managing patients with difficult airway
Registration fee: £125.00

Anaesthetic Emergencies for ST1s/SHOs
8th May / 22nd July / 6th November 2009

A simulation-based teaching course using scenarios and video debriefing by experienced anaesthetic faculty in a non-judgmental, friendly environment
Registration fee: £150.00

Obstetric Crisis Resource Management
9th March / 13th May / 17th November 2009

Learn how to manage obstetric emergencies using a high-fidelity computerised medical simulator
The course is suitable for all grades of Obstetrician, Anaesthetist and Midwife
Registration fee: £150.00

For further information on Simulation Centre courses, please contact: Miss Debbie Clapham,
Postgraduate Medical Centre, Box 111, Addenbrooke’s Hospital, Cambridge CB2 0SP;
Tel: 01223 348100; Email: dlh48@medschl.cam.ac.uk
Final F.R.C.A. Examination
Intensive Preparation Course

The University Hospitals Bristol
MCQ/SAQ
Preparation Course

Monday 20th to Friday 24th July 2009

This five day course includes sessions on examination technique, intensive therapy, new drugs, current topics, and practical subjects (ECGs, X-rays), as well as mock examinations and performance analysis. Conducted by national and local experts at Burwalls Conference Centre, Bristol.

For further details, please contact:
Jane McLean
Department of Anaesthesia
Bristol Royal Infirmary
Marlborough Street, Bristol BS2 8HW
Telephone: 0117 928 3801 (Direct Line)
e-mail: jane.mclean@UHBristol.nhs.uk
Course Director: Dr M A Taylor FRCA

Some Accommodation Available
Course Fee £450
Includes course dinner, coffee, lunch and teas

THE INTENSIVE CARE
SOCIETY FORTHCOMING EVENTS 2009

ANNUAL SPRING 2009 MEETING
MONDAY 18TH - WEDNESDAY 20TH MAY 2009
Manchester Central Convention Complex, Peterfield, Manchester

The ICS Spring Meeting will take place in the Manchester Central Convention Complex with a two and a half-day programme that will commence at 14:00 on Monday 18th May. A faculty of international and UK experts will deliver a stimulating programme with parallel CME sessions enabling you to keep up to date with all the latest developments in the field. Hot topics will include:

- Hospital Acquired Infections
- What is Quality Intensive Care?
- The Long Stay ICU Patient
- Radiology for the Intensivist
- Ethical Issues in Intensive Care
- Liver Diseases
- Pro Con Debates
- Brain Injury

In addition there will be the regular Trainees, Members, Nurses & AHP forum, the Gleston lecture, the Annual ICS Spring Dinner and Dance and a range of industry sponsored sessions.

CPO accreditation: TBC

To register, view full details of the meetings programme and for further information please visit www.ics.ac.uk/meetings.

ICS SEMINARS - 2009 PROGRAMME
CHURCHILL HOUSE, LONDON

We are pleased to announce our forthcoming events running from April to October. Participate in a unique learning environment and learn from a series of presentations and practical based sessions delivered by a group of experts in their field.

LUNG ULTRASOUND: Tuesday 21st April
VENTILATION UPDATE: Thursday 4th June
ECHOCARDBIOGRAPHY: Friday 4th September
DIFFICULT DECISIONS: Tuesday 13th October

REGISTRATION FEES:
Consultants
£140 (ICS Members) £230 (non ICS Members)
SAS Doctors, Trainees and Nurses
£110 (ICS Members) £195 (non ICS Members)

To register for any of these seminars and view full programme details please visit our website www.ics.ac.uk/meetings. All seminars will take place at Churchill House, 35 Red Lion Square, London WC1R 4SG

For further details of these and future meetings, please visit the ICS website at www.ics.ac.uk or contact the events team at:
The Intensive Care Society Churchill House, 35 Red Lion Square, London WC1R 4SG
Tel: +44 (0)20 7280 4350 Fax: +44 (0)20 7280 4369 E-mail: events@ics.ac.uk www.ics.ac.uk
I am writing this article from a purely personal viewpoint; these are not the views of either my colleagues in Peterborough or the AAGBI.

I don’t think that anyone would deny that medical careers and especially training have altered dramatically over the last 25 years; I use this time frame as I qualified in 1984.

I want to consider three aspects of the argument, and then hopefully summarize with a workable scheme that could be incorporated into a medium sized district hospital, which will be the case when the Peterborough City Hospital opens next year. There may have to be different models for different types of hospital, as there is at present.

The most important factor in this argument is the consumers of healthcare in the U.K., the patients. I suspect that when asked who they would like to anaesthetise them for their emergency operation most members of the public would opt for an experienced doctor who had finished training. Is this an unreasonable request? Anaesthesia has progressed quite nicely along this route and I believe that since CEPOD in 1989, later to become NCEPOD, our specialty has lead the way in implementing recommendations. For example the most recent hip fracture anaesthesia network figures show that in a sample of 1,180 hip fracture patients 61% were anaesthetized by consultants. I wonder what the comparable figures for 1984 were? The only operations taking place after 22:00 should be life and limb threatening procedures. An efficient emergency and trauma service should enable most of the work to take place in the day with well-staffed theatres and laboratory support.

This leads on nicely to training and to pose the question “what are trainees doing in hospital at night when first on and does this enrich their training?” If recommendations from NCEPOD are followed it follows that consultant presence is likely to be needed when procedures take place. For many nights, being on call for theatres as a trainee is a waste of training time and erodes the time allocated by the EWTD. The trainees need to maximize their training during the day, doing lots of cases or attending clinics for specialty training.

My successor as College Tutor in Peterborough spotted an obvious anomaly when looking at logbooks from our own trainees compared to those who rotated from Leicester. It was the practice for the SHOs in Leicester to go home at 22:00 and not be resident on call, allowing them to work the next day. They had twice as many cases in their logbook as the home grown Peterborough SHOs, whose on call was not adding significantly to their caseload.

For the motion

With a workable scheme that could be incorporated into a medium sized district hospital, which will be the case when the Peterborough City Hospital opens next year. There may have to be different models for different types of hospital, as there is at present.

The most important factor in this argument is the consumers of healthcare in the U.K., the patients. I suspect that when asked who they would like to anaesthetise them for their emergency operation most members of the public would opt for an experienced doctor who had finished training. Is this an unreasonable request? Anaesthesia has progressed quite nicely along this route and I believe that since CEPOD in 1989, later to become NCEPOD, our specialty has lead the way in implementing recommendations. For example the most recent hip fracture anaesthesia network figures show that in a sample of 1,180 hip fracture patients 61% were anaesthetized by consultants. I wonder what the comparable figures for 1984 were? The only operations taking place after 22:00 should be life and limb threatening procedures. An efficient emergency and trauma service should enable most of the work to take place in the day with well-staffed theatres and laboratory support.

This leads on nicely to training and to pose the question “what are trainees doing in hospital at night when first on and does this enrich their training?” If recommendations from NCEPOD are followed it follows that consultant presence is likely to be needed when procedures take place. For many nights, being on call for theatres as a trainee is a waste of training time and erodes the time allocated by the EWTD. The trainees need to maximize their training during the day, doing lots of cases or attending clinics for specialty training.

My successor as College Tutor in Peterborough spotted an obvious anomaly when looking at logbooks from our own trainees compared to those who rotated from Leicester. It was the practice for the SHOs in Leicester to go home at 22:00 and not be resident on call, allowing them to work the next day. They had twice as many cases in their logbook as the home grown Peterborough SHOs, whose on call was not adding significantly to their caseload.

For the motion

“Consultants doing first on call is part of the solution to EWTD”
The figures are quite startling, indicating a doubling of general anaesthesia cases when the trainee leaves at 22:00.

There are going to be differences depending on the type of hospital and the service that is provided. Large teaching hospitals with tertiary referral services tend to have the more experienced trainees but are also likely to need consultants. Smaller units have for many years had consultants first on in the hospital. The important points are that if consultants are first on they must be paid for it and have adequate time off. The surgical specialties will have to follow suit and this will enable the trainees to have good quality, high volume training during sensible hours.

Why has the non-resident on call been “The Holy Grail” of U.K. consultant hospital practice? I don’t think that being on call from home is all it’s cracked up to be. I have recently relinquished ITU duties and I never felt particularly comfortable at home when there were problems on the ITU. I think that the same applies to obstetrics and calls to A&E.

In most of Western Europe and the USA consultants are resident: I have experienced this in Holland and the USA. Most medical decisions need to be taken by consultants; we are dealing with older, sicker patients and in the case of ITU, a diminishing resource.

Finally my solution for running an on call system in a hospital, where ITU, obstetrics, and A&E are on the same site is as follows. Consultant on site at all times for general duties - this person would primarily cover main theatre, but would also be available to a trauma team and also to obstetrics out of hours. The resident consultant would come on at 20:00. The trainee for theatre would leave at 22:00, by which time most of the emergencies will have been sorted out. The on call facilities will have to be upgraded from the present accommodation. En suite facilities with a kitchen and good Internet connection is mandatory.

Does this mean that a consultant, once appointed will be resident for the rest of their career? Well here is the carrot. I think that there only needs to be about 12 on a rota, with prospective cover to keep up necessary skills. The twelve most junior consultants will share the burden of the resident on call. In a department of 40, there are now 27 potential generalists in Peterborough, as there are 10 on the separate ITU rota, there will be a “conveyor belt” system. As someone retires, one more is appointed to the resident rota and one leaves and takes part in the second on call tier, which will be used as a back up for the resident on call. These “older” consultants will also do the bulk of the daytime emergency and trauma work at the weekends. There are many hospitals where parts of this system are now operating.

In summary, I believe that anaesthetic consultants should be resident to provide the best care for emergency patients and to ensure trainees maximize their training opportunities during the day, within the confines of the EWTD.

There will be a two and maybe three tier consultant system in place. Call it what you like, a return to the senior registrar grade, but there must be recognition that trainees must be trained. Once trained, an on call commitment is needed and will probably last in the region of 10 to 15 years. As the consultant career progresses there is the recognition that again, most of one’s work will take place during the day, both during the week and weekends.

As a specialty we are not alone facing these problems. There are already hospitals in the U.K. where general surgical registrars are no longer resident at night, and these hospitals are not small. Obstetric surgical consultants are resident in a number of units in the U.K. To me it makes perfect sense to have fully trained doctors dealing with the workload outside normal working hours.

I hope that this article is looked at in 5 years time; I predict that most of what I have said will have come to fruition.

Against the motion

Kathleen Ferguson
Consultant anaesthetist
Aberdeen

The concept of partial pressures described by Dalton in the 1700s is a perfect analogy for the complexities of consultant life today. The pressures of providing good medical care, maintaining good practice, fostering good relationships with patients and colleagues, management, research, audit and teaching duties, preparing for relicensing and revalidation, are all part of the whole and each exerts their pressure on our working and personal lives: a situation best summed up as the “consultant squeeze”. Can the analogy be extended further by suggesting that the addition of first on-call duties might simulate diffusion hypoxia?
From the time of appointment to a consultant post, we accept and expect that our roles will change and evolve. As experience, ability and confidence grow in the practitioner, so the consultant job matures to deliver on the additional roles necessary for the stability and progress of the profession. Until now, no-one would have considered Consultants might provide first on-call duties in maternity, ICM and general on-call rotas. Why not? Perhaps because it was not considered an appropriate use of consultant time and skill: skill and expertise developed over years. What evidence do we have for this assertion? Many of the components of the first-on role are task-based and repetitive. During the day in many ward-based and intensive care settings, several of the front line tasks that were undertaken by PRHOs and other juniors in the past have been taken over by nurses and supporting staff: tasks such as administration of intravenous drugs, venesection, filing laboratory reports.

Audit and research underpin quality in clinical practice. There is a real threat that activities of this sort would decrease since SPA time is most likely to be squeezed by the increases in direct clinical care more out-of-hours work would bring. This rationing is already underway with consultant posts with seriously limited SPA allocations being advertised and appointed. Any hope of reclaiming this time in the near future must surely seem unlikely if not impossible, given the identified service gaps. What little time might be afforded to audit and research in itself will hamper the quality of the output since good research and audit demand time.

Less SPA time also means less time to teach. This would have profound effects on undergraduate and postgraduate teaching programmes where historically anaesthesia has a major influence. Many anaesthetists begin their teaching portfolios as trainees and continue to develop and expand their expertise throughout their consultant careers. This potential loss of availability for teaching and training is ill-timed since the revised PMETB standards (2008) will require more effort for training and better trained trainers; alongside a requirement for deaneries to “QM” (quality manage) this with consequences for programmes and thus departments who fail to deliver on the standards.

Accruing age, experience and seniority within a department leads to participation in management roles. With less time, there is real risk that new consultants would not consider themselves adequately prepared and safe for independent practice. Most would acknowledge that even as the training and service stands at present, the transition to consultant from trainee is a gigantic step. Much of the time in the first few years as a consultant are used to consolidate clinical skills and to establish credibility in practice. Assuring patient safety requires appropriately prepared and developed clinicians. We cannot afford to skimp on this.

So what does a consultant deliver that would potentially be lost if the on-call delivery was placed at the consultants door? There is a very real clinical threat facing trainees and consultants, in particular consultants in their first few years of appointment. Without the experiential learning accrued in both in-hours and out-of-hours training time, there is real risk that new consultants would not consider themselves adequately prepared and safe for independent practice. Most would acknowledge that even as the training and service stands at present, the transition to consultant from trainee is a gigantic step. Much of the time in the first few years as a consultant are used to consolidate clinical skills and to establish credibility in practice. Assuring patient safety requires appropriately prepared and developed clinicians. We cannot afford to skimp on this.
available there is a risk that doctors will be less likely to take up managing services with the likely outcome of non-medical managers taking over. This may be an advantage as in many instances what medical managers do might be carried out by administrators but may also be seen as a potential threat to medical involvement in decision-making. We already see this with regard to waiting times, for instance, with managers exerting control over clinical priority and activity driven by arbitrary target intervals. Do we need or want more of this?

For the last 5 years we have been asked to prepare for revalidation. All practitioners must maintain adequate evidence of their practice. It all takes time.

The BMA and the AAGBI have both published on the adverse effects of antisocial working times on the circadian rhythm disruption in shift workers and the knock-on effects to well-being and performance. These adverse effects appear to be exaggerated in older practitioners. Why then would we consider increasing the proportion of antisocial work undertaken by consultants when we require them to be practising at the top of their game for the benefit of the service?

Recruitment might be adversely affected if anaesthesia and intensive care medicine guaranteed that senior members of medical staff could look forward to be out working all night!

As the EWTD sets to bite, despite years of warning, the health services across all four home nations have been caught in flagrante. They are now forced to consider delivering out-of-hours health care using their most expensive commodity, the consultant. They face the loss of expertise for complex work – the concept of having consultants doing work that requires their advanced levels of knowledge, skills, experience, behaviours, values and expertise. There are implications for patient safety here too. Consultants will be doing work that a well-trained but less advanced practitioner might be able to undertake effectively and safely. The Health Departments have been exercised over defining the nature of the “trained doctor” required to be created in order to deliver the service. It cannot be wise to change the role of the consultant when we still have little indication as to the nature of this sub-consultant grade.

Are there alternatives to first-on call consultants? Yes is the answer - but few that appear palatable. One potential way forward is to consider reconfiguration of services, with rationalisation of duplicated systems in localities. Always a political hot potato, especially where government favours “choice” in health care, but it is arguably time that we insist upon action to address the waste this arrangement encourages.

Simple measures often make vast changes. We could all identify potential efficiency savings in running the service in our own departments, specifically achieving better care within available resource. If 08.00 – 20.00 hrs was run more effectively how big a need would there be to change 20.00 – 08.00hrs?

Most changes in healthcare delivery are lubricated by cash but as this, like the oil that fuels us, begins to run out our reliance on simple options becomes increasingly questionable. At the end of the day, what we see is rather like the internal combustion engine. More is sucked into the consultant cylinder as the space is reduced with resultant squeeze. Increasing pressure will, with one small spark, result in a big bang, the blow from which will be resounding. As the early engineers discovered to their chagrin, the structures comprising the engine need to be strong enough to withstand the forces generated and well enough designed to deliver the required effect. Let us then be careful in considering solutions to EWTD that we provide a carefully and logically constructed argument that deals systematically with all aspects of the complex and complicated environment that is the consultant post; or we too may find we have blown a hole in the system with consequent serious loss of power.

I’d like to acknowledge the help given to me by Dr David Noble, originator of the idea of the “squeeze”, and Dr Peter Johnston for his clear thinking.

CALLING ALL SAS DOCTORS – JOINT SURVEY

The first major SAS survey, a joint project between the RCoA and AAGBI, should be arriving in your anaesthetic department soon! This survey will aid the RCoA and AAGBI SAS Committees in serving the needs of SAS doctors in anaesthesia efficiently and appropriately. Results will be announced as soon as they are available.

It is important that as many SAS doctors as possible complete this survey in order to ensure its success.

Surveys will be distributed to anaesthetic secretaries in May 2009; if you do not receive a copy, please speak to your departmental secretory or contact the AAGBI Secretariat on 020 7631 8807/8812 or at secretariat@aagbi.org.

Many thanks in advance for your participation and we look forward to receiving your completed survey.
THE FINAL FRCA SAQ EXAMINATION
TUESDAY SEPTEMBER 1ST 2009
&
THE FINAL FCARSI E&SAQ EXAMINATION
MONDAY SEPTEMBER 7TH 2009

The Mersey Writers Club

Membership of the Club will Expose You to the Subtleties & Intricacies of the Written Papers of the Respective Examinations.

31 WC Members sat the FRCA exam in October 2008
27 passed the SAQ Paper
3 of those who failed have admitted they faltered* and did not stick to the Discipline of The Mersey Method

CLUB EIGHT
Opens on June 1st - Registrations Close May 29th
Interested trainees are invited to attend

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liverpool</td>
<td>Saturday 9th May</td>
<td>10.00 – 14.00</td>
</tr>
<tr>
<td>Dublin</td>
<td>Saturday 16th May</td>
<td>10.00 – 14.00</td>
</tr>
<tr>
<td>London</td>
<td>Friday 22nd May</td>
<td>14.00 – 18.00</td>
</tr>
<tr>
<td>London</td>
<td>Saturday 23rd May</td>
<td>10.00 – 14.00</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Sunday 24th May</td>
<td>10.00 – 14.00</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Saturday 29th May</td>
<td>10.00 – 14.00</td>
</tr>
</tbody>
</table>

No Charge to attend Introduction – No Obligation to Join

Note: Prospective Members must either attend an Introduction Session or have attended an SAQ Weekend Course.

One Fee for Membership of £400 will entitle the Member to Remain in the Club and to attend Any or All of the Mersey SAQ Weekend Courses - Free of Any Further Charge until Successful in the SAQ or E&SAQ Examination

For Details, Registration, Club Rules & Commendations.

www.msoa.org.uk

Writers Club Motto
“In the Discipline Lies the Reward”
In the medical profession, job hunting is hard work which requires determination and perseverance, and it is therefore all the more disappointing if your application is unsuccessful. However, is it possible that you applied for a job and had been shortlisted but did not know, because you never received the interview letter posted to you by medical staffing, because it had posted to the wrong address or to another individual with a similar name? Both of these things have happened to me.

Why do such incidents happen?

There are no published reports on this issue. It is likely that a change in contact details is the most common reason for candidates not receiving an interview invitation. Various factors may be important including change of address due to frequent rotation, use of mobile phones as a contact point, or unfortunate timing of leave. However, on occasion problems at human resources such as inadequate training or staff shortages can contribute to errors. If the medical staffing officer dealing with the application process goes on leave or is off sick, with consequent delegation of the job to someone else, there seems to be a high risk of errors occurring.

How to prevent it happening?

In my opinion, in most cases the blame lies with the applicant. Applicants must take steps to avoid communication failures that could lead to losing an interview opportunity, especially if there is an impending change of address or period of leave. The best way to avoid the problem is to keep in contact with human resources, ensuring that your application has been received safely, and to keep yourself informed about the shortlisting schedules.

What to do if it does happen?

Managing this situation depends upon whether the interview date is still available or passed.

The interview is still available:

There are only three possible stakeholders that can be held responsible for communication errors: you, human resources at the prospective employer, or a third party (eg internal or external postal services). If the communication failure is due to error or omission in your part, offer an explanation and apology, and check whether it is still possible to attend. However, if the converse is true and human resources are at fault, then it might be reasonable to ask for some accommodation to be made, such as rearrangement of the interview to a later date. It would be prudent to seek guidance from a senior consultant about this.

Whether successful or not, a formal letter to the human resources director is warranted to notify them of the problem encountered. Such a complaint should not prejudice your future application to the same employer.

The interview date has already been passed:

This is a truly disheartening experience, and little can be done to rectify it. However, it is important to ask for the matter to be investigated. This should aim firstly, to identify problems with one’s contact details, secondly, to explore redress if human resources or third party is responsible. Support from family, friends and colleagues will be helpful at this time. You may also require professional support from organisations such as the BMA regarding any formal complaint about the process.

Challenging the interview panel decision

I could not find any published report of an interview panel decision being set aside following an error of this sort. Although it may seem an appropriate thing to do, NHS trusts are not legally obliged to follow such a course. Nevertheless, if the candidate feels strongly about the “lost interview” and had valid reasons to believe that he had a good chance of being appointed if he had attended the interview; if he is certain that no omission on his part contributed, and that human resources was solely responsible for the error, then there may be a case for referral to an employment tribunal. However, legal advice and guidance from the BMA and senior consultant colleagues must be sought before following such a course.

In summary, the phenomenon of “lost interviews” is fact and not fiction. Attention to details while completing application forms, giving appropriate consideration to your circumstances, and keeping in touch with human resources following the closing date can reduce the risk of this happening. Guidance and support from consultant colleagues is important and to some extent necessary, to manage a “lost interview” event.

Dr Iftikhar Ahmed, Specialist Registrar, Leicester Royal Infirmary, Leicester
Dear Editor...

More on the history of epidural anaesthesia

I enjoyed the History Page on epidural anaesthesia by Drs Birk and Wharton (March 2009). We should thank surgeons for many things (eg our College), but not for continuous epidural anaesthesia. Before the 1939-45 war there were very few full time anaesthetists and local anaesthesia was in the hands of the surgeons. In the decade after 1945 there was an explosion in academic anaesthesia, mainly in the English speaking countries and therefore recorded in English language literature.

The most important figure in establishing continuous epidural anaesthesia was Robert Andrew Hingson, charismatic and deeply religious, also trained in Public Health, who made the treatment of obstetric pain one of his life’s works. His first trials in 1942 used a needle in the caudal canal (1). In 1944 he tested the lumbar approach (2) using a ureteral catheter and in 1949 recommended continuous lumbar epidurals in labour (3). The first author of the latter paper was Flowers, a young obstetrician who readily acknowledged the more senior Hingson’s role (4).

Hingson moved from John Hopkins, Baltimore to University Hospital, Cleveland where he introduced a 24 hour service staffed with a senior and a resident anaesthetist. All mothers were charged $25, whatever anaesthesia they had (or none), to fund the service.

Many British anaesthetists trained in obstetric anaesthesia in the US (Moir and Rosen in Cleveland, Selwyn Crawford in New York’s Columbia Presbyterian) while others were self-taught (Andrew Doughty and Bruce Scott). With the widespread use of lumbar epidural anaesthesia in the obstetric unit from the 1970s onward, every anaesthetist has been thoroughly trained in the technique which has now spread to every area of anaesthetic practice. The public, and our specialty, has much cause to be grateful to Robert Hingson.

Professor Michael Rosen
Cardiff

References:

Red Nose Airway Challenges (Left to right)

1. Severe trismus - dental abscess or fractured mandible?
2. How many signs for a difficult airway? (and not much room for a nasal fibreoptic....) - Micrognathia, small mouth & limited opening, no neck, poor dentition. Nares not present
3. Mandibular dislocation - over zealous jaw thrust?

Let’s hope Red Nose Day raised plenty of money this year

Georgie Thompson
ENT / Head & Neck Anaesthetic Fellow
Northwick Park Hospital
THE EUROPEAN SOCIETY OF REGIONAL ANAESTHESIA & PAIN THERAPY (UK & I)

ANNUAL MEETING
Including cadaver, landmark and ultrasound regional anaesthesia workshops

Monday 11 May–Tuesday 12 May 2009
The Anatomy Department, University of Liverpool and The Mersey Maritime Museum, Albert Dock, Liverpool

Call for Abstracts for Poster Competition

Workshops are now fully booked but there are spaces on the scientific meeting - book today to reserve your place.

Scientific meeting sessions include RA and outcome, courtroom drama, ultrasound for central/paravertebral blocks, debate on epidurals for orthopaedic surgery, and Bruce Scott Lecture by Prof Alain Delbois

For more details/registration/abstract form go to www.ragbi.org

www.ragbi.org

BRITISH SOCIETY OF ORTHOPAEDIC ANAESTHETISTS

14th ANNUAL SCIENTIFIC MEETING
6th – 11th NOVEMBER 2009
VENUE: NILE CRUISE, EGYPT

CALL FOR ABSTRACTS FOR POSTERS BY 1ST SEPTEMBER 2009

Details of the Scientific Programme are on the BSOA Website
(www.bsoa.org.uk)

ENQUIRIES TO:
Kirti.popat@rmh.nhs.uk
020 8909 5560

CPD ACCREDITATION:TBC

Sponsor: Egypt Air

Call for Abstracts for Poster Competition

Workshops are now fully booked but there are spaces on the scientific meeting - book today to reserve your place.

Scientific meeting sessions include RA and outcome, courtroom drama, ultrasound for central/paravertebral blocks, debate on epidurals for orthopaedic surgery, and Bruce Scott Lecture by Prof Alain Delbois

For more details/registration/abstract form go to www.ragbi.org

www.ragbi.org
Don’t miss out, send your abstract today to be judged at Annual Congress 2009 - the best will be eligible for publication in Anaesthesia.

Prizes will be awarded to the authors of the best free paper in each of the three categories, as judged by a panel of experts, and the authors of the best poster(s).

Authors of abstracts will be contacted by 24th July to tell them if their abstracts have been accepted. Some authors will be invited to present their work orally, and the remaining successful authors will be invited to present a poster.

Abstracts should be labelled as “AC-1st author-brief topic” (e.g., “AC-Smith-morphine”) and emailed to secretariat@aagbi.org, with the signed submission form sent by fax to +44 (0)20 7631 4352 or emailed as a scanned image to the same e-mail address. After the deadline, there will be a preliminary review of the abstracts received to determine which ones are to be accepted for presentation at Congress.

We particularly welcome abstracts from Staff and Associate Specialist Grade doctors.

The closing date for abstract submission is midnight on Friday 29th May 2009 and full details can be found at http://www.aagbi.org/events/congress/09ac_free_papers.htm.