Pain fellowship in Australia

National critical incident reporting for anaesthesia
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THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland
My interest in Pain Medicine developed during senior house officer training and was further reinforced by one-week sessions as a registrar. Research findings, particularly central changes and functional imaging increased my curiosity in this rapidly-growing and exciting field. I ultimately plan to pursue this career and wished to extend my experience. I found Brisbane suitable for both my academic and family requirements.

A lengthy job and visa application process resulted in a one-year Pain Fellowship at the Multidisciplinary Pain Centre (MPC), Royal Brisbane and Women’s Hospital (RBWH), Queensland. It is a tertiary referral teaching hospital and is affiliated with the University of Queensland and Institute of Medical Research. The MPC was opened by its current Director, Professor Tess Cramond in 1967. It was the second pain clinic established in Australia and recently celebrated its 40th anniversary.

The Multidisciplinary Pain Centre (MPC)

In 2003 the MPC moved to a custom-built unit located adjacent to the Professor Stuart Pegg Adult Burns Unit. The facilities include eight dedicated inpatient beds to which patients are admitted under Pain Medicine consultants; offices, outpatient consultation rooms, a procedure room with dedicated image intensifier, recovery area, patient education area, interview room and staff room.

The MPC provides a state-wide service for patients with persistent pain of malignant or non-malignant origin who are referred by a medical practitioner. The population of Queensland is 4.2 million and its area is more than six times that of the United Kingdom. It provides a consultation service for other units within the hospital including the burns unit and works in close liaison with the acute pain management service which functions separately. There is a twenty-four hour consultation advisory service for referring doctors and domiciliary nurses.

The staff of the Multidisciplinary Pain Centre includes specialists in pain medicine from several disciplines,
nursing staff for the ward, the outpatient clinics and the procedure room, two psychologists, two physiotherapists and two occupational therapists. There is a clinical/research coordinator for the Allied Health Staff. There are ten pain medicine specialists, two of whom are full-time, and come from the following backgrounds:

- anaesthetics   6
- psychiatry    2
- rehabilitation medicine 1
- addiction medicine 1

The MPC conducts two pain management programmes – a two-week inpatient programme for patients with medical co-morbidities or whose medication warrants stabilisation, and an outpatient programme on one day a week for eight weeks. The eight dedicated beds are used predominantly for patients on the inpatient programme and for cancer patients requiring advanced interventional techniques.

Every Monday, four new patients are admitted and assessed by the house officer, psychiatrist, psychologist, occupational therapist and nursing staff prior to discussion with the consultant for implementation of the management programme. The two-week period of admission can be utilised when appropriate to rationalise drug use in patients on high dose opioids. Patient assessment and discussion with the GP regarding the appropriateness (or not) of this medication is commenced prior to the admission.

Multidisciplinary meetings are held every Wednesday morning. Strategies recommended are documented very clearly in the discharge summaries to the patients' GPs. Multidisciplinary telephone case conferences are conducted for challenging cases to outline the patient's management plan and to ensure clear transfer of information.

Throughout the programme, patients attend classes with scheduled activities. They are encouraged to learn new coping strategies and to accept responsibility for the management of their pain. There is a strong emphasis on education, non-pharmacological management strategies, physiotherapy and hydrotherapy and participation in a management plan developed in association with the consultant under whom the patient is admitted.

Cancer pain referrals are received from either within the RBWH or from GPs across Queensland. The service offered includes advice on rationalization of medication and interventions, culminating in admission of challenging cases to the MPC.

The Pain Fellowship

The one-year Pain Fellowship necessitates working in an accredited unit, undertaking satisfactory in-training assessments, sitting the Faculty of Pain Medicine (FPM) examination and writing a case report. Prior to acceptance for the Fellowship, it is necessary to obtain approval that previous training and experience in Pain Medicine meets the required standard.

There is a structured training programme, including provision for the fellows to sit in with the psychiatrist for consultations. Working closely with the psychiatrist during patient assessment is a valuable opportunity to achieve a better understanding of the relationship between mood, personalities/personality disorders and pain.

While I was there, the MPC had two fellows instead of the usual four, which meant more exposure to a wide range of patients and a corresponding increase in work. The fellow on-call receives the initial referrals from other hospital units and departments and responds to call for advice from GPs all over Queensland. He/she also supervises the day-to-day duties of the house officer whose entire role is the care of the MPC inpatients. Weekend calls are non-residential, involving a ward round in the morning and an occasional telephone call seeking advice.
The fellows who are not on-call are involved in procedure lists and clinics. There are opportunities to attend amputee and radiation oncology clinics, nerve conduction studies and a local private hospital. To maintain general skills, the anaesthetists who comprise the majority of the fellows participate on the anaesthetic on-call roster which in my case was twice a fortnight.

Every Wednesday is an education day that begins with a CME presentation by one of the team members, closely followed by the Multidisciplinary meeting at which the management plans for new patients (week 1) and the discharge plans for other patients (week 2) are developed after input from all team members. These are recorded in detail in the hospital charts. Teleconferences with referring doctors form an important part of the unit meeting, helping doctors in rural areas overcome the tyranny of distance. All members of the multidisciplinary team contribute. The fellows and consultants spend the rest of the morning discussing a pre-listed topic based on the FPM curriculum. This demands extensive reading of up-to-date evidence based literature. Discussing past questions makes the challenging examination appear only slightly more manageable. The consultants in Brisbane are supportive of the exam preparations, with viva practice close to the exam. One of the consultants is a FPM examiner and one has been an examiner for ANZCA and FPM.

The Examination

And what of the examination itself? It is conducted in a different State each year - when I sat it, I travelled to Geelong, Victoria. It consists of:

- 10 out of 15 short answer questions
- an hour-long case with the patient examined in the presence of examiners followed by a 30 minute presentation of the history, physical examination and results of investigations
- three case scenarios and an investigation station
- three physical pain examination stations and one communication skills station

The three-day examination period is physically, mentally and psychologically exhausting! The highlight of course, is on the final day when the list of lucky numbers is pasted on the board at 16.30 hrs!

Catching up

Having put the exams aside, the last few months were spent catching up on travel and sight seeing. Queensland is a vast State with many interesting places to behold. There is a wide range of activities every weekend and, particularly for children the list is endless. There are world-class beaches that are very accessible – located on the Sunshine Coast to the north and the Gold Coast to the south. The coastal frontiers are particularly popular with surfers. A trip further north leads you to the breathtaking sight and experience of the Great Barrier Reef which is a “must see”.

The support I received on arrival was tremendous, the MPC assisting in every way possible to ensure that I settled into the programme. One of the particularly memorable highlights was a bouquet of flowers with best wishes for the exam on arrival to my hotel room.

The MPC training programme, plus a typical Aussie Christmas spent with a very hospitable family and the entire Queensland experience, made the whole year worthwhile. Highly recommended!

Dr Sarah Akol Aturia
SpR Anaesthetics
Oxford Radcliffe Hospitals NHS Trust
Patient safety has become a policy priority in the UK health service. Following the principles of human factors, patient safety includes the implementation of error management systems that can ‘learn’ about threats to safety, matched by practices to ‘understand’ their underlying causes. In the UK, this has involved the creation of the National Patient Safety Agency (NPSA) and the introduction of the National Reporting and Learning System (NRLS) throughout the National Health Service (NHS) in England and Wales. This system requires all health care providers to establish incident reporting procedures to enable local organisational learning and to also inform national learning.

Anaesthesia has developed over the years to become a very safe speciality, but adverse and “near miss” incidents still occur, and these often involve human factors. Anaesthesia needs to continue its proud record and work towards improved systems for patient safety by learning from these. The NPSA has embarked on four collaborative projects with differing Royal Colleges to improve patient safety in the relevant specialities. ‘Anaesthesia: Improvement through Partnership’ is a collaborative two year project led by the Royal College of Anaesthetists (RCoA) with the support of the National Patient Safety Agency (NPSA). The project is overseen by an Expert Consultative Group which includes representatives from the RCoA, Association of Anaesthetists of Great Britain and Ireland (AAGBI), the Association for Perioperative Practice (AfPP) and the College of Operating Department Practitioners (CODP). This group has developed the safety themes for the two-year collaborative project.

The Expert Consultative Group decided on the following work streams:

- developing a specialty-based reporting system to improve critical incident reporting by providing a single point of entry for data
- investigation of patient safety incidents arising from errors during the administration of injectable drugs
- the management of throat packs and in particular their retention following surgery.

SPECIALTY SPECIFIC INCIDENT REPORTING

For several years the RCoA has been very interested in developing a national critical incident reporting system which allows for shared learning in anaesthesia based on completion of standardised critical incident report forms. The RCoA issued guidance and templates for critical incident reporting in the anaesthesia environment in 2001; this was designed for local hospital use. To date, although some local reporting is taking place, the opportunity has not been available for this to fully develop into a national database of safety information. Recently the RCoA and AAGBI have expressed interest in developing a reporting system to improve patient safety in anaesthesia, which integrates the information required by anaesthetists with the NRLS and allows the RCoA and AAGBI access to the data to enable expert analysis and subsequent dissemination of patient safety advice to the specialty.

This initiative now provides the NPSA with the opportunity to meet the
requirements of the RCoA and AAGBI and also to develop a template for specialty-based reporting which may be transferable to other specialties. The system development has included the following key principles:

- user friendly
- specialty-specific
- sensitive to the confidentiality of the reporter
- complementary to the local reporting systems of the Trusts
- responsive – i.e. reported incidents will undergo analysis by an expert group to generate an appropriate response to improve patient safety.

If the piloting of this initiative proves successful then patient safety will be enhanced by:

- allowing the RCoA and the AAGBI to provide rapid feedback on previously unknown incidents
- providing reminders on severe incidents that occur rarely but are known
- permitting peer comparison through benchmarking
- learning from near-misses
- engaging anaesthetists in reporting patient safety incidents

**IV MEDICATION ERRORS**

Several published surveys have suggested that most practising anaesthetists have experienced at least one drug error\(^1\). The Expert Consultative Group decided that before making firm recommendations on how to prevent drug errors during anaesthesia, workplace evaluations will take place of two different methods proposed to reduce drug errors.

1. **Second-person double-checking**

Second-person double checking is an established method of minimising errors during blood transfusion. An editorial in *Anaesthesia* supported the use of double-checking during anaesthetic practice\(^2\). The objectives of the workplace evaluations will be:

   a) Will this practice be accepted by anaesthetists and other allied professionals?
   
   b) What may be the practical and/or cultural challenges or barriers in its introduction?

2. **Electronic double-checking using barcode methodology**

In New Zealand, Merry has developed a new drug administration and documentation system designed to reduce drug administration errors during anaesthesia. The system utilises bar-coding technology to provide double-checking prior to drug administration. Its effectiveness has been demonstrated outside the UK\(^3\). Work-place evaluation will be used to determine:

   a) Can this system be introduced success into NHS hospitals?
   
   b) What may be the practical and/or cultural challenges or barriers to introducing this practice?

The results and recommendations from the above projects will be widely publicised. Further patient safety projects will be developed by the Expert Consultative Group over the two year period; any suggestions would be welcomed by the Group and can be made via the AAGBI, RCoA or NPSA.

**Dr. Les Gemmell**
Chairman, AAGBI Safety Committee

**Prof. Ravi Mahajan**
RCoA Council Member, Chair of the Expert Consultative Group

**Joan Russell**
Head of Anaesthesia and Surgery Patient Safety Division NPSA


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**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*
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Inspiration strikes me for this column in many places – on this occasion it was while I was sitting in a hairdresser’s chair in Winchester. As hairdressers are wont to do, the very young stylist asked, “What do you do then?”, so I said “I’m an anaesthetist.” Cue slightly blank look. “I put people off to sleep for their operations.” A great smile broke out across her face. “Wow, that’s really cool!” She went on to say that she’d never met an anaesthetist before, and it was the sort of job she had never realised anybody actually did – although, when she thought about it, obviously somebody did. She was genuinely interested in what I did, how I’d got there, did I enjoy it; and the chat continued throughout my appointment. I’d obviously made her day.

Most anaesthetists will be used to fairly regular versions of this conversation, but the memorable thing for me was this young hairdresser clearly thought I had the coolest job on the planet. She was genuinely interested in what I did, how I’d got there, did I enjoy it; and the chat continued throughout my appointment. I’d obviously made her day.

Everybody knows what surgeons do, what paediatricians, GPs, and even what pathologists do, but repeated studies have shown that nobody really knows what anaesthetists do. Should we be bothered? One of the reasons the “National Anaesthesia Day” initiative didn’t continue, I suspect, is that most anaesthetists, like me, aren’t too exercised by it. I’m quite happy to turn up and do my job in a professional manner and do not require rose petals to be strewn in my path (although it would be nice on occasion). Is it important? As this is the official organ of the Association of Anaesthetists of Great Britain and Ireland, I’m probably supposed to say it is. It would be important if our professional colleagues didn’t really appreciate the complexity of our job either (and I have dark suspicions about whether some of them do), because that might partly explain anaesthesia’s historically poor showing when it came to CEAs, discretionary points and other awards. I think all the non white-coat-wearing (yes, I know white coats are verboten now; it’s a figure of speech), ward-round-leading specialties do suffer a bit in that regard. It’s to do with the forms, for which meeting local targets score highly. I always feel like writing “turned up, anaesthetised what was on the list, didn’t complain too much, not many dead”, but suspect this isn’t quite adequate to score highly in this section.

Other than that, I feel fairly relaxed about not being accorded my status as a “Top Doc” (tabloid catch-all term for any consultant not accused of a criminal offence). It’s downright handy on holiday, when I’m pretty happy not to correct anyone who assumes I’m some sort of technician or nurse, thereby sparing me all the interesting rashes, musculoskeletal injuries, gastrointestinal upsets and other minor ailments that may afflict fellow travellers. The hospital I work in receives its fair share of stabbings and shootings,

Actually, we are doctors...
so it’s not unusual to have the boys in blue waiting in recovery to speak to those treating the afflicted. They always want to speak to the surgeon (who will have to subsequently find time to appear as a witness at the trial), but I’m very happy for them to assume I’ve made no major contribution to the patient’s care, and therefore they don’t need to speak to me.

I am well aware that the surgeons tend to do better than anaesthetists in the receipt of gifts and cards for services rendered, which is mildly annoying, but I can cope. All anaesthetists have tales such as the one about the student nurse who asked me if you could study anaesthesics at Langside Technical College, or the patient who asked a colleague whether his daughter could get into anaesthetics seeing as how she hadn’t got the grades to study nursing. These are mildly annoying at the time, but have much more value as a tale to be retold afterwards – I think we’re big enough to deal with this sort of thing. We do what anaesthetists have historically always done – just get on and do our job in a competent and professional manner. Am I being too complacent? As David Bogod highlights in the article on page 34, at the inception of the NHS it was not a “given” that anaesthetists would be awarded full consultant status along with other specialties, and it is due to the efforts of our predecessors in the role that this was achieved. Quietly and competently getting on with things probably wouldn’t have met with success - they must have had to do a whole lot of trumpet-blowing at the time. There have also been various suggestions over the years that others can do parts of our job just as competently, I suppose we should take that as a compliment – we make it look easy.

So I was quietly pleased that this young hairdresser was impressed by what I do – I suppose surgeons get this all the time, but for me it was a rare treat. And yes, I did give her a tip!

We have some proper science in this issue of Anaesthesia News. In the second part of Jonathan Cracknell’s series about veterinary anaesthesia for the wide variety of species he encounters as a vet at London Zoo, it’s the reptiles, and he includes some hard respiratory physiology which made my brain hurt. I’m sure you’re enjoying the great photos which accompany these articles, plus the fascinating nuggets Jonathan reveals about his practice. This month: what to do with an amphibian, some KY jelly, and some isoflurane...

Anaesthesia News’s coverage of the arts seems to be expanding. Earlier this year we brought you a review of the film “Awake”. It now transpires that another recent blockbuster might have involved anaesthetists – read why on page 25. In addition we have not one, but two poems. The first may or may not be by that peerless Scottish bard (the one without a supper named after him), McGonagall, and the other one was definitely written by Hugo Wellesley from Bristol.

On a more serious note, there’s good advice about maternity leave and related issues in this month’s GAT page, and an account of OOPE in pain medicine in Australia. Happy reading!

Hilary Aitken
Editor

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**ANAESTHESIA APHORISMS**

Submitted this month by John Asbury, Glasgow, and Ramana Alladi, Ashton-under-Lyne.

As far as possible know what the surgeon is intending to do, and what his backup plans are.

Excellence in anaesthesia is doing a lot of small things better.

I have learnt most of my anaesthetics in the recovery.

Don’t be a slave to numbers on monitors, but remember they will be your judge if something goes wrong.

Nobody is objective about pain, but it is the patient who experiences it, so listen to him.

If you are going to need to transfuse the patient during the operation, check the blood really is there, and that it’s really for your patient.

Never use a drug that you have not drawn up or seen being drawn up.

You can train anybody to give an anaesthetic but giving a good anaesthetic takes special skill.

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Ultrasound Training Courses 2008

2008 course dates:
US Guided Regional Anaesthesia – Introduction
10-11 November – Hitchin

US Guided Regional Anaesthesia – Advanced
2-3 October – Liverpool
5-6 December – Nottingham

Critical Care
19 November – Hitchin

Ultrasound Guided Venous Access
13 November – Hitchin

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

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

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

Ultrasound Guided Venous Access
This one-day course 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.

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

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Pregnancy is a very exciting time. Adjusting to your (or your partner’s) changing body and planning your future at the same time as working in a demanding job can be challenging. Negotiating your way through the apparent maze of paperwork surrounding rights and benefits on maternity leave and pay can be difficult to fit in between antenatal appointments, busy shifts and preparing for a new arrival.

This article aims to clarify some of the main issues facing pregnant anaesthetists and provide guidance on your rights and responsibilities towards your employer.

Maternity Leave:

- You must notify your employer in writing before the end of week 25 of your intention to take maternity leave and the date when you wish this to commence (this can be changed with 28 days notice). This should include the MAT1B form which you receive from your midwife or GP and which states your expected date of delivery.

- You have the right to a reasonable amount of paid time off to attend antenatal appointments. What is considered reasonable is not defined in law and here sense and consideration to the working of your department should be applied.

- Doctors are entitled to paid and unpaid maternity leave of up to 52 weeks if they intend to return to work afterwards. To be eligible for this you must have completed 12 months continuous service in the NHS by week 29 of the pregnancy.

- Occupational Maternity pay gives 8 weeks full pay followed by 18 weeks half pay then 26 weeks unpaid leave. Statutory Maternity Pay (SMP) is paid in addition for 39 weeks regardless of whether you are returning to work or not.

- SMP is claimed by your employer on your behalf. Your employer can only do this if you have completed 26 weeks continuous service within the same trust. If you have recently moved NHS trust as part of a rotation then you are entitled to Maternity Allowance (MA) not SMP. The amount paid is the same, but you have to apply via your local Job Centre Plus.

- During Maternity Leave you retain all of your contractual rights and benefits. This includes annual pay increments, study budget and accrual of annual leave; it does not include pay. You can attend courses during your maternity leave and claim funds from your study budget. Your annual leave must be taken within the normal calendar year and excess leave cannot be carried on to the next year.

- If after maternity leave you do not wish to return to work your NHS

1st trimester: It is wise to inform your employer but you are not obliged to do so until 25 weeks of pregnancy. As soon as your employer knows you are pregnant they are obliged to perform a risk assessment. You are entitled to stop on call duties (see below). If you wish to return to work on a Less Than Full Time (LTFT) basis apply early. The application may only take 3 months but funds are not so readily available.

17 weeks: Stop payments for childcare tax vouchers. Your maternity pay will be significantly reduced if you do not temporarily stop these payments from 17-25 weeks.
employer is entitled to retrieve the maternity pay awarded. This is at the discretion of the employer. To avoid this you must return to work for at least 3 months within 15 months of the commencement of your maternity leave.

Employer's Responsibilities

- The laws that protect you at work only apply once your employer knows you are pregnant.
- Once your employer knows you are pregnant a risk assessment must be conducted. If any risks are identified they must be removed or alternative working arrangements agreed to protect the safety of you and your baby at work.
- If you are unable to undertake on-call duties, it is the trust’s responsibility to arrange locum cover.
- Once you have informed your employer in writing of your intention to take maternity leave they are obliged to confirm in writing within 28 days your paid and unpaid leave entitlements, annual leave owed and expected date of return to work.

Occupational Hazards

Anaesthetists work in many different areas of hospitals and thus face a variety of potential hazards:

Shift working/On-call commitment:
On-call commitments can be very demanding to a pregnant trainee anaesthetist. You are entitled to stop your on call commitment as soon as you discover you are pregnant. In some cases this will not be a choice but an essential move to ensure a healthy pregnancy. If you do give up your on call commitment early in your pregnancy, the following months may not count towards your CCT.

Some studies have shown that long working hours can reduce foetal growth and increase the risk of preterm delivery while other studies have shown no effect.

Anaesthetic gases:
These agents have previously been shown to increase the risk of spontaneous abortion and congenital abnormalities. This risk has now reduced considerably with the advent of scavenging systems and the introduction of newer, safer volatile anaesthetics. However, particularly in the first trimester, it may be prudent to avoid lists with high exposure to anaesthetic vapours such as paediatric lists involving inhalational inductions.

Radiation:
Ionising radiation is toxic and teratogenic to the foetus. The most dangerous period is the first 8 weeks of gestation. At diagnostic dose levels the only adverse effect of radiation on the conceptus which is likely to pose a significant risk is cancer induction. The National Council on Radiation Protection limits X-ray exposure during a pregnancy to a total dose of 0.5 rad (A Chest X-Ray gives a radiation dose of 0.008 Rad). It is important to take precautions when exposure to radiation during the workday happens. If in doubt you should always consult your local Occupational Health Department. Specifically a 5mm lead apron which wraps around should be worn if within 6 feet of X-ray exposure.

Limiting exposure by avoidance of certain theatre lists is not always possible, practical, or strictly necessary.

MRI:
No evidence of any harmful effects of magnetic resonance upon the foetus has been demonstrated.

Methylmethacrylate (bone cement):
There have been concerns regarding the possible teratogenic effect of occupational exposure to this substance although there is little evidence to support this.

Manual Handling:
The hormonal changes of pregnancy make the pregnant body more susceptible to injury. It is advised that manual handling should be avoided and prolonged standing limited after the 24th week of pregnancy.

Certificate of Completion of Training (CCT)

The Royal College of Anaesthetists (RCoA) will need to be informed of your intention to take maternity leave, so remember to notify them. Your CCT date will be suspended until your actual return to work, which allows for unplanned extended maternity leave to be factored in. Upon returning to work you must notify the training department of the RCoA of your return date and if you are returning on a LTFT basis. Once these details are known, a new CCT date will be issued.

If your maternity leave is post-fellowship, you may be able to claim up to 3 months of your maternity leave as training. This

25 weeks: You must inform your employer in writing with the MAT1B form when you wish your maternity leave to start.

29 weeks: Earliest time you can start maternity leave. Most trainees have stopped night work at this point

36 weeks: If you are off work with a pregnancy related illness, compulsory maternity leave starts now.

Have you informed the Royal College of Anaesthetists (RCoA)?
is only applicable once, and cannot be claimed again in subsequent pregnancies. You will require a letter of support from your Regional Advisor stating that during your maternity leave you continued to undertake non-clinical commitments e.g. attended courses, wrote up research, completed audits etc. The RCoA may then allow up to 3 months to count towards your CCT. You must apply for this time to count more than 6 months before your completion of CCT.

Medical Defence/GMC/Pensions

You must continue to pay your General Medical Council membership fee during maternity leave in order to remain on the list of registered medical practitioners. The medical defence organisations (Medical Defence Union, Medical Protection Society) regard maternity leave as a ‘career break’ and thus you are not required to pay your subscription fee as you are not undertaking any medical practice. (This may be claimed retrospectively if you were unaware of this.) You and your employer continue to contribute to the NHS pension scheme. This is automatic for your period of paid maternity leave, but if you are planning to take some unpaid maternity leave, you may need to take specific action to ensure this period counts towards your pension. Consult your Human Resources department or the BMA in advance to check the pension arrangements for unpaid maternity leave.

Returning to Work

Recently ‘Keeping in Touch days’ have been introduced to allow a smooth return to work. These can be arranged by mutual agreement between employer and employee; neither party can insist on them. They will be paid at basic daily rate for hours worked and you are allowed a maximum of 10 days. SMP continues as long as 10 days are not exceeded. You have the right to the same job on the same terms and conditions as prior to your leave. You are also entitled to time off such as unpaid parental leave and family emergency leave.

Paternity leave

Finally let’s not forget the fathers-to-be. Paternity leave entitles fathers or the mother’s husband/partner who will be responsible for the baby to 10 days leave (not to be taken as odd days) after the arrival of the baby. Same sex partners will be included, and the same rules apply if the child is being adopted.

To be eligible for paid leave you must have been continuously employed by the NHS for at least 26 continuous weeks. Your intention to take paternity leave must be given to your employer by the 15th week before the Expected Due Date.

You also have the right to a reasonable amount of paid time off to attend antenatal appointments. What is considered reasonable is not defined in law and once again, sense and consideration to the working of your department should be applied.

Dr Susan Williams (GAT Committee Member) & Dr Ceri Lynch (ST2 in Anaesthetics, Royal Glamorgan Hospital)

References


40 weeks: Birth of baby!

1st 2 weeks: Compulsory maternity leave

1st 8 weeks: Full pay (less Statutory Maternity Pay (SMP) or Maternity Allowance (MA))

8-26 weeks: Half pay plus SMP or MA

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Real anaesthetists treat more than one species: Part two

Jonathan Cracknell BVMS CertVA CertZooMed MRCVS
Zoological Society of London

As I said in last month’s article: I am a zoo veterinarian. I have an interest in zoo and wildlife anaesthesia and as such have had to use techniques developed in the human field and in the domestic veterinary field and adapt them for the patients under my care. Zoo and wildlife anaesthesia is becoming a field in its own right with textbooks now being written and residencies that focus only on this discipline. In the last article we had a brief look at the techniques used for anaesthetising invertebrates and some of the lower vertebrates. In this article we will be reviewing herptile anaesthesia and delving into the world of the higher vertebrates by assessing the techniques used in avian anaesthesia.

Herptiles, which is likely to be an unfamiliar term to most people, is the collective name for all amphibians and reptiles. Amphibian anaesthesia requires a basic knowledge of the unique physiology of this unusual taxonomic group. Amphibian respiration can occur through the usual pulmonary system as in other species but they also have adaptations allowing alternative routes of respiration; through gills in the larval stages or in some adults through cutaneous passive diffusion (which is the main route for carbon dioxide elimination in many species), and possibly also buccal or literal mouth breathing through the mucous membranes, although it is a moot point whether this is respiratory or olfactory in origin. The importance of each method varies between species and the environment that they are found in. The cutaneous capillary system is a useful site for the uptake of anaesthetic agents and the anaesthetist must ensure that the skin is not obstructed with gels such as KY jelly as this can lead to respiratory acidosis. Pulmonary respiration is not necessary for most amphibians undergoing anaesthesia, as cutaneous respiration will prevent clinical hypoxia. The anaesthetist must keep the respiratory surfaces moist. Tricaine methane sulfonate (MS222) baths have been used in the past and have been found to have a wide margin of safety across the different species. However a
newer technique utilises the cutaneous capillary system: KY Jelly is mixed with isoflurane and the resulting gel-volatile mixture is applied directly to the skin. This results in rapid induction with the gel being removed when the animal needs to be at a lighter plane or applying more to increase the depth of anaesthesia. Intubation is also possible and is the preferred method for maintenance of anaesthesia in longer procedures.

The concept of the preferred optimal temperature zone (POTZ) is an important one for herptile, or any ectothermic or poikilothermic animals. Ectotherms are defined as animals that require an external heat source to regulate their own body temperature, compared to poikilotherms, which are defined as having a variable body temperature that varies with the external environment. These are two terms often used interchangeably but actually have different meanings. The two are similar for herptiles but certain other species such as humming birds can be endothermic and at the same time poikilothermic. Since metabolism of anaesthetic agents is based on metabolic rate, which in turn is based on body temperature, the ideal range for an individual species is the POTZ and anaesthetists should aim to maintain their ectothermic patients at these published ranges.

POTZ is one of the most important aspects of managing the reptile patient under anaesthesia. There exists a large diversity of physiological adaptations across the different reptilian species and there is no such thing as a “normal” reptile. Fluctuations in osmotic pressure, pH, electrolyte composition, and respiratory function that would be lethal for other vertebrates are normal for many reptiles. The major determinant of respiratory and acid-base values for a reptile is temperature, and the pulmonary system is best thought of as the organ of acid-base management rather than an oxygen transport system in reptiles and amphibians. In fact the oxygen requirements of reptiles are approximately 10-100 fold lower than mammals. As blood pH is inversely related to temperature, reptiles must have a physiological organ that can compensate for the changes in acid-base and this is achieved through the animal’s ventilation: as temperature decreases, the ventilation rate stays constant but the oxygen consumption (based on metabolic rate) decreases, this results in a relative hyperventilation for

_There is considerable variation in size and shape of herptile patients. In addition anaesthetics are often complicated by nutritional and poor husbandry related diseases such as nutritional secondary hyperparathyroidism which can be seen here in this Veiled chameleon._

_Chelonian anaesthesia is complicated by the viscera being contained in a shell. Ventilation is achieved using IPPV or moving the legs in and out._
the oxygen requirement which results in a lowering of PaCO₂ in the arterial blood and alveoli (reptiles don’t have alveoli or lung structure as in mammals: the reptilian lung is more like a vascular-lined carrier bag): when the temperature increases the opposite happens. These changes work hand in hand with the concept of relative alkalinity i.e. the idea that the actual pH is not important but the degree of change from normal alkaline pH that would be expected for neutral water at varying temperatures. Lost yet? Basically there is no normal blood pH value for a species but there is little change in bicarbonate concentrations between temperatures; ventilation maintains the pH changes at different temperatures. Clinically this is important as reptiles have a huge capacity to function with anaerobic metabolism and can hide severe respiratory disease until beyond the animal’s ability to compensate. Hypoxia is the drive for respiration and if a reptile is maintained on 100% oxygen, in recovery they will not breathe at all. IPPV is essential in all reptilian species as a result.

So with all of that in mind the major contenders are the chelonia (the tortoises and turtles), the squamata (lizards), serpents (snakes) and the crocodilians. Each provides its own challenges: moving the limbs in and out to ventilate the tortoise’s lungs (although external cardiac compressions are not possible for obvious reasons), using the tongue reflex and righting reflex in snakes instead of limb tone, and maintaining intravenous cannulae in the smallest of lizards, often opting for intraosseous cannulae instead. As with other species a plethora of anaesthetic agents are used for the reptiles with propofol, alphaxalone, or a combination of alpha-2-agonist cyclohexamine and opioid being favoured. In the case of snakes recovery can be extremely prolonged when using injectable agents and a useful technique is to intubate them conscious and ventilate them with volatile anaesthetics for induction. Care must be taken with venomous species but this can be achieved with the use of snake tubes that prevent the handler from becoming bitten (although injectable agents are even safer).

Then there are the birds. Again there is considerable variation and diversity across the many different species. The most obvious and important point for the anaesthetist is that the avian lung is a firm, fixed structure that cannot expand or deflate like the mammalian lung. Birds have a series of air sacs, subdivided into the cranial and the caudal air sacs. The air sacs provide no role in gas exchange but act as bellows to force air through the tubular networks of the lung. The airflow in the lung is unidirectional and on inspiration air passes through the lung and into the caudal airsacs, on expiration the air passes through the lung, with the next inspiration the air is drawn into the cranial airsacs, and on the following expiration the air passes out into the atmosphere. In so doing a single inspiratory breath stays within the bird for two respiratory cycles and air continually passes through the lung tissue on expiration and inspiration making this the most efficient respiratory system of terrestrial vertebrates. Respiratory rates vary from 7 (ostriches) to 140 (humming birds) breaths per minute, and heart
rates ranging from 200 to 1000 beats per minute are not uncommon, meaning that monitoring equipment designed with human beings in mind often has limited ability to provide accurate data. Normal avian body temperatures are usually in the range 40-44°C.

An important consideration when anaesthetising a bird is positioning of the patient. If positioned incorrectly then the air sacs will become compressed and ventilation will be compromised. Ventral recumbency is thought to be the most compromising, then dorsal, with lateral being favoured. However surgical requirements sometimes mean that this is not possible and it is recommended that IPPV be maintained throughout any prolonged avian procedures. The air sacs can be useful though, as air sac cannulae can be placed allowing ventilatory support in dyspnoeic patients or for birds undergoing maxillofacial surgery. This effectively means intubation not via the trachea but directly into the caudal air sacs, with the tube being sutured in place. On the subject of intubation one quirk of avian anatomy springs to mind: the variation in tracheal anatomy. Some birds have a crista ventralis or median laryngeal septum which reduces the size of endotracheal tubes that can be used. In some birds this is a true division of the trachea, with birds such as the penguins having tracheal bifurcation immediately caudal to the larynx, and some birds having tracheas that are coiled and can be 4-5 times the length of the entire bird. This makes the concept of anatomical dead space one that suddenly takes on a new meaning!

Avian anaesthesia is usually undertaken with facemask inductions using volatile agents. However intravenous techniques are more common in the larger species to overcome the problems of physical restraint. The often extremely fast metabolic rate and clearance of anaesthetic agents in birds does provide some problems with injectable anaesthesia, to the point that TIVA is often not possible, especially for surgery. This is unfortunate, for as soon as you open up the coelom (birds have no diaphragm and therefore no abdomen or thorax) for exploratory coelomotomies, the surgeon is exposed to the volatile agents being used for maintenance.

The lower vertebrates and the birds offer several challenges and the anaesthetist must understand the level of variation in physiology and anatomy that will ultimately affect the success of his anaesthetic. In the next article the more familiar mammalian patients will be discussed.
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By the time of the Crimean War (1854-56) the Russians had already used ether with great success on the battlefield during their Caucasus campaign in 1847. Chloroform was introduced later that year and rapidly replaced ether as the anaesthetic of choice in military surgery, the much smaller volume which was needed and the fact that it was not explosive being major advantages under battlefield conditions. During the Crimean War the Russian surgeons used chloroform in all operations, however minor, and also for painful dressing changes, in both the Crimea itself and at Bomarsund in the Baltic campaign. The French surgeons were initially more cautious, having had mixed experiences with chloroform during the siege of El Agouath in 1852, but their use of this agent soon increased rapidly, both in the Crimea and in Algeria where they were also fighting at this time. Indeed the French military surgeons probably used anaesthesia more extensively during the 1850s than did their civilian counterparts, many of whom were concerned by the reports of fatalities attributed to chloroform.
The use of chloroform by British military surgeons in the Crimea was initially restricted by concerns about its safety in patients who were suffering from shock. It has often been claimed, especially in popular writing and in television documentaries and docu-dramas, that its use was completely forbidden by Dr John Hall who was the Principal Medical Officer in Turkey and the Crimea. This is not correct. The caution which Dr Hall issued at the start of the war was concerned only with the use of chloroform “in the severe shock of serious gunshot wounds, as he thinks few will survive where it is used.” Hall’s advice was, therefore, very far from being a blanket prohibition on the use of chloroform. To understand his concerns we have to recognise that ideas and beliefs about traumatic shock in the mid-nineteenth century were very different from our modern concepts. Hall believed that pain was a natural stimulant which would alleviate the shock associated with gunshot wounds. An anaesthetic, however, was self-evidently a depressant and would therefore aggravate the shock. In the early days of anaesthesia this belief was held by a number of surgeons including such eminent men as the celebrated French surgeon Alfred-Armand-Louis-Marie Velpeau.

Concerns about the use of anaesthesia in patients who were shocked were largely limited to those who needed major amputations. A more frequent reason for withholding anaesthesia stemmed from the unpredictable risk of sudden death, especially in those patients undergoing more limited surgery. Many British surgeons considered that the risk could not be justified in those having amputations of fingers or toes. Information is available on the use of chloroform in 1,353 amputations by British surgeons during the war. Chloroform was used in 43 per cent of cases where the amputation involved only fingers or toes but in 76 per cent of larger amputations. This latter figure is very similar to the practice of civilian surgeons in America at this time. Quantitative data on anaesthesia for minor amputations by civilian surgeons at this time is lacking but there is evidence that some surgeons did not use it at all or were very selective in its administration.

In summary, the use of chloroform by British surgeons in the Crimean War was much less extensive than that of the Russian surgeons and probably less than that of the French. It has sometimes been suggested that this restricted use reflected a belief that a soldier should be able to “bite the bullet” and tolerate the pain of surgery “like a man”, but there is in fact no documentary evidence for any such suggestion. Rather, the reasons for withholding anaesthesia were, in the light of contemporary knowledge, entirely rational. German textbooks of military surgery in the 1860s and 1870s usually advocated limiting the use of anaesthesia to major, painful or prolonged operations, which suggests that the practice of German military surgeons at this time was similar to that of the British surgeons during the Crimean War. This was also the practice of many surgeons during the American Civil War of 1861-65. However, by the late 1870s the stocks of chloroform held at regimental and divisional and divisional levels in the British Army had increased 2-3 fold suggesting that the use of anaesthesia had become more prevalent by this time.

Henry Connor
Retired Physician, Hereford

References:

It is reported that the following was discovered written on some brown paper lining a wardrobe that was sent for auction recently in Dundee. As this is the home town of William Topaz McGonagall, best-known for his poem commemorating the Tay Bridge Disaster, it has, naturally been attributed to him. The repeated aa bb cc, etc. nature of the rhyme strengthens this suggestion, as does also its twelve-line structure, two short of the standard sonnet, rising to a climax at the end of the sixth rather than the eighth line.

If any reader knows more about the provenance of this poem, please let Anaesthesia News know.

The Broad Street Cholera Disaster
Attributed to William McGonagall

While hundreds died of ricey squitter,
And all the doctors did was witter,
'The cause can only be miasma,
Somehow it gets into the plasma,'
John Snow cried 'No! Lets stop the slaughter!
Shut down the pump, it's in the water!'
He was not heeded, received no praises,
Until he was pushing up the daisies.
But now his fame resounds perennial,
And especially on this, his sesquicentennial.

Submitted by David Zuck
Dear Editor…

DIY Anaesthesia

I recently covered the night shift during a “Pride” festival and was surprised by the number of GHB overdoses. Two of the many admissions were totally unresponsive to pain and required intubation. In hindsight it would have interesting to attach a BIS monitor to assess anaesthetic depth. Fortunately all patients recovered over a number of hours and were discharged without any serious ill effects.

Gamma Hydroxybutyrate has a very similar structure to the neurotransmitter GABA and is presented as a colourless, salty tasting liquid. It is taken to produce euphoria and relaxation, but at higher doses can induce profound anaesthesia. It is now rarely used as anaesthetic agent because of its long duration of action and high incidence of PONV. When consumed with alcohol or other depressants there is a serious risk of respiratory failure. (1,2)

Toxbase recommends naloxone as a partial antagonist to GHB (3) but the effect on this small case series was fairly unimpressive!

Dr T Hughes
SpR
Medway Maritime Hospital

2. www.admin.ox.ac.uk/ouss/drug/ghb.shtml

And for my next trick…

During an emergency laparotomy for a case of small bowel obstruction it was noted by the surgeon that the stomach was still full although I had inserted a naso-gastric tube at the beginning of the case. During insertion it appeared to pass easily enough. I dutifully applied suction but little came out so I attempted to withdraw the NG in case it had become kinked. Much to my surprise it was stuck!! After the wave of panic subsided I fished the NG tube out through the mouth only to find it had impressively become knotted (see picture).

Funnily enough I could not find this particular skill in the college CCT documents!

Dr Dipesh Odedra
Anaesthetic SpR
Leeds

Semi-permanent nail varnish

A 28 year old primiparous patient presented for emergency obstetric surgery for post partum vaginal bleeding.

She was wearing “Calgel” nail varnish, which conventional nail varnish remover/acetone failed to remove. She reported that the varnish would need to be removed by the salon which initially applied it. Fortunately, her toes were painted with conventional nail varnish which was removed to allow pulse oximetry recording.

The product literature produced by the manufacturers Callbrook Cosmetics UK Ltd (http://www.calgel.co.uk/pro/index.html) reports that Calgel is a new non-removable product which is cured by exposure to ultra violet light making it highly durable. Calgel can be removed with a specialist removal product available from the company. In practice this takes up to 20 minutes of soaking – practically impossible in an emergency situation.

To assist in monitoring of patients we suggest that nail varnish should be removed prior to elective admission and emergency admission to hospital.

Dr Elizabeth Hall
Specialist registrar in anaesthesia
Royal Victoria Infirmary,
Newcastle upon Tyne

Written consent was obtained from the patient.

Poetry Corner

A recent personal experience of a hospital-acquired infection resulted in the penning of this doggerel; could it represent a potential new angle for the handwashing campaign?

I’m feeling rough - it's Norwalk.
My guts are going wild.
I've been sent home. I want me mum.
I feel like a small child.
I've thrown up twice whilst on the loo.
Will my kidneys fail?
I could be one of Mr Belloc's Cautionary Tales.
That nice old boy on J ward's Ruined my weekend plans.
Thinking back, he did feel sick;
I wish I'd washed me hands.

Hugo Wellesley
SpR, Bristol.
Technology and Theatre efficiency

Anaesthetists have always been techno friendly and fond of gadgets. We share our experience with a gadget that we introduced into our theatre environment which has improved efficiency.

Our theatre complex comprises five operating theatres, with one theatre, mainly used for gynaecology procedures, isolated from the rest. Normally we have 8-9 cases in one session in this theatre, and we encountered regular delays, leading to list over-runs. Some of the reasons were:

1. Lack of porters leading to delays in sending and getting the patients.
2. If the porter was busy, this was often not conveyed to the theatre staff.
3. If the porter was on another job, one of the theatre staff working in that theatre needed to go to collect the patients, thus losing the skilled theatre staff.

To avoid this we introduced the use of a two-way radio system, one of which is carried by the anaesthetic team in that theatre and one by the porter. Once the patient is ready to be sent for, the porter, who already has a copy of the list, is contacted via the radio. The porter immediately acknowledges the message and collects the patient. If he is busy with other work, he lets the team know so that someone from theatre can go. Therefore we do not waste time looking for the porter any more.

Since the introduction of this gadget we finish our list earlier than previously, and do not impact on the afternoon list. We are using our theatre staff effectively and use of this technology has made a big difference in improving our theatre efficiency.

Dr. Harshal Wagh
Dr. D. Acharya
West Herts NHS Trust

From our showbiz correspondent

Many readers of Anaesthesia News will have enjoyed “Mamma Mia”, one of the big summer movies of 2009. The film, and the stage show from which it is derived, is unusual in that the Abba songs existed first and the plot, about a young girl hoping to discover which of three of her mother’s ex-boyfriends is her father, was devised to fit around the songs. What readers may not realise is that a number of different plots were outlined and discarded before settling on the one which we have enjoyed on our cinema screens this summer.

Anaesthesia News has learned that one of the discarded outline plots involved an NHS hospital, with particular focus on the real heroes of any such institution – the anaesthetists.

Sadly the full plot synopsis has not survived, but we have obtained the director’s notes of the musical numbers which were intended to form the backbone of the film.

Mamma Mia – in this scene, the midwives inform the obstetric anaesthetic team that the 150kg parturient has decided she’d like an epidural.

The Winner Takes It All – the cardiologist who heads up the hospital awards committee explains why the anaesthetists have missed out (again).

Knowing Me, Knowing You (there is nothing we can do) – two consultant physicians discuss the options for the patient with difficult venous access who really needs a CVP line.

Waterloo – the ward nurses explain the reason that the first patient on the list is not ready for theatre. Instead of omitting his diuretic, they have given it twice.

SOS – one of the anaesthetic trainees has rather over-estimated his skills in managing a difficult airway.

Take a chance on me – The anaesthetist tries to be reassuring in pre-op assessment to a patient with more risk factors than life expectancy

Chiquitita (tell me what’s wrong) – with the Portuguese interpreter only working office hours, the anaesthetist tries to find out why the parturient from Brazil is screaming hysterically

Does Your Mother Know That You’re Out? - the anaesthetic department greets the first consultant surgeon who has been appointed from the shortened training scheme.

Voulez vous? Yes, a nice cup of tea please.

Gimme Gimme Gimme (a man after midnight) - the HDU nurses badly want the Hospital at Night Team to review a sick patient.

I Do, I Do, I Do – the Clinical Director asks who wants to do the waiting list initiatives.

Dancing Queen – the senior orthopaedic surgeon surprises his colleagues in a number of ways at the Christmas party.

We can only regret that this magnificent piece of film history did not come to fruition. If any readers out there unearth more pieces of this plot (and we feel sure you will), please let Anaesthesia News know.
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For further information and registration consult the APA website: www.apacbi.org.uk or contact: the APA Event Coordination Team on 02076318804 or email: apa2009@aagbi.org
A few years ago, medical management structures were fairly simple. The Medical Director role was a statutory requirement for a Trust Board. All trusts had to have (and still do) among their executive directors a qualified doctor (the Medical Director) and a qualified nurse (usually called the Director of Nursing). Most specialist departments (e.g. surgery, medicine, pathology, anaesthesia) were headed by a Clinical Director, who usually would have some degree of management responsibility to the Chief Executive, along with the manager for that service (usually either a nurse or a senior PAM (Professions Allied to Medicine).

Back in the mid-1980s, when general management started and doctors were being encouraged to take a lead role in management, many Units (this was before Trusts) had Clinical Directors in the role described above. Before that, departmental chairmen were part of the cogwheel structure, sitting on a Medical Executive (or Advisory, or Staff) Committee, arguing for resources and defending their departments within the hospital system.

However change is ever-present in the Health Service. Management numbers are constantly being reviewed and “reduced”. My own view is that there are indeed now fewer folk who actually do any managing, but the increase in administrative numbers and spending has been caused by an increase in the numbers of Bean-Counters, Box-Tickers, Target-Achievement-Advisers, Management-Facilitators etc etc ad infinitum. It seems that the managers cannot be trusted, though they are held accountable and can be sacked; and others are put in parallel to them, duplicating or contradicting, monitoring or even subverting the usual channels. Increasingly there is pressure to reduce the numbers of people making any real contribution to running the service, and therefore to reduce the numbers of sub-units, directorates, divisions, or whatever, within the Trust, which itself has probably merged with the next Trust down the road.

The fashion is also to believe that specialist directorates act in isolation, and the pejorative term for that is a silo. If only patient pathways were put first, say the modernists, and the silo-inhabitants were made to realise that they have to work together with inhabitants of other silos. Of course anaesthetists (as well as most other support specialists, and in fact just about all other specialists within the NHS, even surgeons) have been indulging in team-working, extra-silotic (?) relations all along. Anyway the outcome has been to re-draw the medical management structures.

A common pattern, reported by an increasing number of members of AIM (Anaesthetists in Management) has been to reduce the sub-Trust structure to only three Divisions: Emergency Services, Elective Services and, Specialist (or maybe Support) Services. My former Trust has such a structure. Despite all representations to the contrary, anaesthetists were seen merely as suppliers of gases to patients having elective surgery, although everyone knows that the first person to be called in when an emergency gets out of hand is an anaesthetist, and many specialist services would not be able to function without a team of specialist anaesthetists.

In terms of hospital hierarchy, the senior clinician in the management structure of the anaesthetic department may well not be an anaesthetist, and may have difficulty understanding the implications of our work patterns and relationships. Therefore the term Clinical Director of Anaesthetics can be misleading. In fact, unlike, say, ten years ago, it may very well be difficult to identify this person.
Letters sent as mail-shots to the Clinical Director, Anaesthetics Dept, St Muffin’s Hospital could be opened by anyone from the Medical Director to the anaesthetic secretary. (If it was actually the latter, of course, there wouldn’t be much of a problem).

This becomes important when you want to target the doctor within a hospital or trust who is actually in charge of anaesthesia. You may want to contact anaesthetists about training opportunities, seek their views or experiences, or pass on safety warnings or new developments. The Clinical Director (CD) with responsibility over anaesthetic services may well be a dermatologist. The person who has actually as much responsibility (although probably not as much power, fewer SPAs, and a smaller chance of gaining Discretionary Points) as last year’s anaesthetic CD may now be called a Clinical Lead, Specialist Co-ordinator, or whatever. And as trusts merge, and anaesthetic departments come together in happy (or unhappy) unions, passing information from national bodies to hospital departments, and thus to individual anaesthetists, becomes increasingly difficult. Furthermore the number of quasi-management roles available for anaesthetists is increasing all the time.

It is important, therefore, for all of us to realise that there are not just “Medical Managers” and “other doctors”, but that we all have a part to play. The CD cannot do it all, any more than the College Tutor can do all the teaching within a department. There are important duties to be carried out, which can, and must, be delegated within departments, both to new consultants (and senior trainees and career-grades) as an introduction to increasing responsibility; and also to those who have had a senior management role: much as they are now looking for a quieter life, they cannot be allowed to have their experience and skills lost.

As always, these are exciting times. Get (and stay) involved...and don’t get too confused by the titles!

Dr W A L Rawlinson, MA BM BCh FRCA
Recently retired consultant anaesthetist, former Medical and Clinical Director
Currently Hon Secretary and Treasurer of AIM (Anaesthetists in Management)

Meet the new AAGBI Council members

Three new Council members were elected earlier this year, and officially took up their roles at the AGM in Torquay in September.

Isabeau Walker
Isabeau is a consultant at Great Ormond Street Hospital and specialises in paediatric cardiac anaesthesia. Her early years were mainly in district hospitals and she spent a short time as a consultant at Lewisham hospital. “Trainees are the future of our speciality, and I find teaching them hugely rewarding. I value the NHS enormously – it has trained me, employed me for more than 20 years, provides high quality healthcare for my family, and in future will pay my pension – it is important to look after it. I have a long-standing interest in healthcare in the developing world and my main research interests relate to patient safety in anaesthesia in the NHS and abroad. Apart from that - mother, cyclist, enthusiast, and trying not to fall off my scooter on the way to work. I will do my best to further the interests of the Association and its members!”

Richard Griffiths
Richard is a consultant and “very much a generalist” in Peterborough. Married to Melanie, not the actress, but a physiotherapist, and has two teenage daughters. He was born in Pontypridd, and although brought up in the Home Counties, is a passionate Welsh rugby supporter, which he found very enjoyable earlier this year. He is a keen runner and has completed the Medoc Marathon 5 times. He cycles to work when the weather permits, 13 miles from Stamford, the nicest stone town in England. His family complains that he gets up too early and that he is addicted to exercise, both of which are probably true.

Paul Clyburn
Paul is a consultant obstetric anaesthetist at the University Hospital of Wales, Cardiff. Until recently a part time taxi driver for his children, he now helps run a guest house for them as although they’ve left home, they frequently return accompanied by friends, boyfriends, girlfriend etc. for long weekends. He has a long-standing passion for rugby, which was only slightly dimmed by the dismal performances of the Welsh team in the 90s, but has been re-ignited by their recent Grand Slams, punctuated (or punctured) by their hopeless performance in the World Cup. Paul also enjoys trying to keep fit to offset his other great passion - for fine wines, and has the ambition of not coming last (again) in this year’s Cardiff 10k charity run.
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Tel: 029 2074 3110  e-mail: purdymar@afrc.ac.uk

THE INTENSIVE CARE SOCIETY FORTHCOMING EVENTS 2008

THE STATE OF THE ART 2008 MEETING
MONDAY 15th - TUESDAY 16th DECEMBER 2008
HILTON LONDON METROPOL, EDGWARE ROAD, LONDON

Registration is now open for The State of the Art 2008: the Society’s premier annual meeting. Following the success of the 2007 meeting, a faculty of international and UK speakers will present a wide range of hot topics including:

- The circulation in sepsis
- New technology for the ICU
- Acute Pancreatitis
- ICS clinical trials.

Submissions of abstracts of free papers will be accepted for presentation in the clinical practice and research sessions. Applications for the award of the ICS Research Gold Medal are also invited.

Trainees, Nurses and Allied Professionals who are members or applying for membership will receive the same rate as the 2007 meeting. The offer is for early bird registration only.

To register, view full details of the meetings programme and further information on abstract submission please visit our website at www.ics.ac.uk/meetings

CPD Accreditation: 10 points

ICS SEMINARS - AUTUMN 2008 PROGRAMME
CHURCHILL HOUSE, LONDON

We are pleased to announce our forthcoming Seminar programme for Autumn 2008. Participate in a unique learning environment and learn from a series of presentations delivered by a group of experts in their field.

INFECTION - MONDAY 27th OCTOBER 2008
CPD Accreditation: 4 points

WHO BENEFITS FROM INTENSIVE CARE - WEDNESDAY 5TH NOVEMBER 2008
CPD Accreditation: 15G

NEPHROLOGY - WEDNESDAY 19TH NOVEMBER 2008
CPD Accreditation: 4 points

REGISTRATION FEES
Consultants
£130 (ICS Members) £215 (non ICS Members)

Trainees and Nurses/AHP
£100 (ICS Members) £180 (non ICS Members)

To register for any of these seminars and view full programme details please visit our website www.ics.ac.uk. 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: +44 020 7280 4350 Fax: +44 020 7280 4369 E-mail: events@ics.ac.uk  www.ics.ac.uk

Anaesthesia News October 2008 Issue 255
29
The Wylie Medal

Miss Charlotte Melton, a medical student from Plymouth, receives the Wylie medal and cheque from Dr David Whitaker. The title of her prizewinning essay was “The use of Bispectral Index Monitoring (BIS) to Prevent Awareness during Anaesthesia”.

The Wylie Medal is awarded to the most meritorious essay concerning anaesthesia or associated clinical practice written by an undergraduate medical student at a university in Great Britain or Ireland. Prizes of £300, £150 and £50 are awarded to the best three submissions. The Wylie Medal is named in memory of Dr W Derek Wylie, President of the Association of Anaesthetists 1980-82.

Revolutionary development of 720 Degree “Appraisal”

Scoop O’Lamine

Dr Ivan O’Brain has recently won an NHS management award for developing a revolutionary appraisal method. He was warmly congratulated on this achievement by his anaesthesia colleagues who are always extremely supportive of any measure which means Dr O’Brain will be spending more time away from the workplace. “Even my Clinical Director Dr Isle Killim has been most generous with my allowance for this vital work” claimed Ivan. Apparently it was considered by both the Trust and the Medical Defence Organisation better for patient safety for Ivan to concentrate on administrative duties.

Most of Ivan’s early work has been with a colleague, ex-Postgraduate Dean Professor Dea Ranged, lately an expert process designer for MMC. “Working with a true innovator like Ivan is such an opportunity to really make a difference to the NHS, using the well-tried educational principles we employed to such great effect in MMC and MTAS.”

“Our first recommendation is to give appraisal a good shake up!” explained the dynamic duo. When investigating whether there was any evidence of benefit from appraisal, the pair decided to shadow Mr Roger Thumpit to understand how orthopaedic appraisal worked. These appraisals were typically rather short (average 4 minutes), full of laughter and grunting and often conducted in a group at an alehouse where the conversation readily turned to rugby or motorized vehicles.

“We felt that optimized reflective practice was not witnessed during these encounters and that the process needed more brought into line with Deanery and General Practice Principles where an average of three hours is set aside for preparation, a further three hours for the appraisal process and then a day off afterwards for recovery, reflection and writing up of the final objective development learning plan.”

Ivan explained “We plan to call this new version of appraisal for acute trusts “Appraisal”. The three Ps stand for Preparation, presentation and perfection. In addition this brilliant new concept will include a revolution in multisource feedback – the 720 degree review.”

At present appraisal only includes 360 longitudinal feedback – latitude will be added to the discussions. Just as a ship could not navigate without determining both reference points, how could medical staff really expect to manage just from sampling peers during conventional 360 degree feedback. The new technique will involve asking more younger and older colleagues (vertical feedback) as well as peers (horizontal). GMC chief executive Dame Gill Strictly feels considerable excitement at this new development. “Multisource reflective feedback with repeated sampling will transform appraisal – some additional time and costs may be noted, but the gains will be great.”

Reaction about the proposals from expert patients’ groups has been mixed. Some have been delighted with the concept of better-regulated doctors, others anxious that waiting times might increase. Expert orthopaedic patient Mrs Connie Fused was particularly negative. “I have just seen Mr Thumpit – what is going on? He was polite and took far too long with me. Before I knew what was going to be removed, now he wants me to help him make up his mind. I want my real surgeon back, not some mealy mouthed non-judgemental twit.”
THE FINAL FRCA SAQ EXAMINATION
April 2009
Prospective Examination Candidates are Invited to Join

The Mersey SAQ Writers Club
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Learn & Practise
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Membership of the Club will Expose You to the
Intricacies of the Short Answer Question Paper

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You will also be expected To Set Questions & To Mark Answers

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Any or All Mersey SAQ Weekend Courses
Free of Charge
Until Successful in the SAQ Paper

Interested Trainees
MUST ATTEND (Free of Charge)

An Introduction to The Writers Club and The Mersey Method

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www.msoa.org.uk
for

Details, Plaudits & Application to Attend an Introduction Day

“If you feed the children with a spoon, they will never learn to use the chopsticks”
Birmingham Anatomy to Sonography Course (BATS)

Course Dates: 3 December 2008; 24 June 2009; 1 December 2009

This one-day, intensive course offers anaesthetists the opportunity to improve their understanding and practice of regional anaesthesia of the upper limb, lower limb and trunk by correlating cadaveric anatomy with sonographic imagery.

Participants will enjoy the chance to improve their anatomical knowledge in unique cadaveric workshops, and will also be able to gain hands-on scanning skills in workshops led by regional and national experts.

5 CME points approved

This course is held in association with the Department of Anatomy, University of Birmingham and the Royal Orthopaedic Hospital Department of Anaesthesia.

Registration Fee: Consultants £175  Trainees £145
For further information see our website:
www.batscourse.co.uk

SAS Audit and Research Prize

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) invites applications for the SAS Research and Audit prize. This is exclusively for SAS doctors to encourage them to undertake research and audit. Entries will be judged by the Research Committee of the AAGBI. All SAS doctors who are members of the AAGBI are eligible to apply for the prize.

An audit project should be carried out under the supervision of a consultant and have been approved by the Trust. A research project should also be supervised by a consultant and approved by the local ethical committee and Trust.

Applicants should submit a summary of their audit or research of no more than 1000 words, 3 figures and 3 tables. It should be presented in the style of the journal *Anaesthesia*.

The winning entrant will have an opportunity to present their work at a national scientific meeting held by AAGBI. Other entrants may be asked to display a poster at the same meeting (as judged by the Research Committee of the AAGBI).

Please email entries along with full contact details of the author to secretariat@aagbi.org

If you have any additional enquiries, please contact 020 7631 8807.

THE CLOSING DATE FOR ENTRIES IS
9TH JANUARY 2009

Oxford Primary FRCA Course

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Email anaesthetics@nda.ox.ac.uk
AAGBI support for higher award applicants

Time to act!

The AAGBI is recognised by the Advisory Committee for Clinical Excellence Awards (ACCEA) as one of the professional organisations that can nominate anaesthetists, intensivists and pain physicians for national Clinical Excellence Awards (Bronze, Silver, Gold and Platinum levels), and can also support applications for higher awards in Scotland and Northern Ireland.

The AAGBI has established an objective assessment and ranking process in accordance with strict ACCEA guidelines. The AAGBI will convene a group that will assess and rank the submissions for each award level. The group will include senior national award holders, local award holders and lay representation. The ranked list of nominations will be formally submitted to the ACCEA or equivalent body for applicants from Scotland or Northern Ireland. Any anaesthetist wishing support from the AAGBI should follow the instructions and timetables below.

England and Wales

ACCEA - Clinical Excellence Awards

The 2009 National Clinical Excellence Awards round for England and Wales will close a month earlier this year at 5.00 pm on Friday 19th December 2008.

If you would like your application to be considered for support by the AAGBI, please email your completed and carefully checked application form to president@aagbi.org by Thursday 16th October 2008. Please note that the application and nomination process is conducted in line with regulations described in the ACCEA website (http://www.advisorybodies.doh.gov.uk/accea) - we recommend that you read the relevant guides published on the website before submitting an application form.

Scotland

SACDA - Scottish Advisory Committee on Distinction Awards

The deadline dates for the 2009 SACDA round are not yet available but will be published on the SACDA website (www.sacda.scot.nhs.uk).

If you would like your application to be considered for support by the Association in accordance with the relevant guidelines as published on the SACDA website, please email your completed and carefully checked application form to president@aagbi.org by Friday 19th December 2008.

Northern Ireland

Northern Ireland Clinical Excellence Awards Scheme

After many years of significant under-resourcing of CEAs, the Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI) recently announced a new funding structure for local CEAs (Steps 1 – 9) using a formula of 0.25 CEA points per eligible consultant to be distributed at local Trust level. Steps 10 – 12 will be determined at national level. Anaesthetists are actively encouraged to apply for all levels of awards now that ring-fenced funding has been injected into the scheme from 2008 onwards.

The timetable was published on the website www.dhsspsni.gov.uk in August, with a deadline for applications forms of 26th September 2008 and supporting citations by 31st October 2008. If you have submitted an application and would like it to be considered for support by the AAGBI, please email a copy of the application form you submitted to president@aagbi.org to arrive by Thursday October 16th.

General notes

Please be aware that your employing hospital or regional committee may have earlier deadline dates for the submission of your application form – we cannot emphasise too strongly the need to read and follow application instructions closely.

Further details about the schemes have been published in previous issues of Anaesthesia News, particularly August and September 2004, and a PowerPoint presentation, which has been updated for 2009, is available from the members’ section of the AAGBI website (www.aagbi.org).

For those seeking guidance for future years, the AAGBI will continue to run ACCEA workshops the next being at WSM London 2009 (14th-19th January 2009) and Annual Congress Liverpool (23rd - 25th September 2009).

William Harrop-Griffiths
Immediate Past Honorary Secretary, AAGBI
ANAESTHETISTS AND THE NHS

Continuing our series of articles to mark the 60th anniversary of the NHS

As the National Health Service celebrates its 60th birthday, it behoves us to consider, along with the broader questions that will exercise many commentators over the next few months, a simpler issue: What has the NHS ever done for us? (with apologies to Monty Python).

It is certainly true that anaesthetists, with a few notable exceptions, were not on an equal footing with their surgical and medical colleagues before 1948. Since the inception of the NHS, however, the standing of anaesthetists within the larger medical community has been high, and is arguably on the rise. At the time of writing, anaesthetists are actively involved in the most senior levels of NHS management and some hold influential positions in the Department of Health. A surprisingly large number of the great and good of medical politics are anaesthetists, and successive Presidents of the Royal College have been chosen to represent the medical colleges in discussion with Government and to bring sense back to the recent shambles that characterised the recruitment of medical trainees to the Kafkaesque world of Mangling (sorry – make that Modernising) Medical Careers. On the clinical front, anaesthetists lead acute and chronic pain teams, run Critical Care Units, and are often found heading surgical services.

Superficially at least, the formation of the NHS gave anaesthesia a golden opportunity to achieve equality of status and pay with other specialities which, thanks largely to the efforts of the Association of Anaesthetists and others, was grasped firmly and never relinquished. But might we have developed in the same way without this opportunity? After all, our colleagues in Europe seem to be doing well enough and, while there is some form or other of socialised medicine in most member states of the European Union, none of them experienced the same sort of sea change that Aneurin Bevan ushered in 60 years ago. Our Commonwealth cousins have also fared very well, with anaesthetists in Canada, Australia and New Zealand all enjoying a high level of status and respect. The fate of the anesthesiologist in the United States is not so clear-cut, with anaesthetists in Canada, Australia and New Zealand all enjoying a high level of status and respect. The fate of the anesthesiologist in the United States is not so clear-cut, with surgical domination and the simmering feud with nurse anaesthetists continuing to niggle, but the American Society of Anesthesiologists ensures that not much happens in the world of US medicine without their voice being heard.

But if only one contribution of anaesthesia to the NHS is to be trumpeted, surely it their niche in the health biosphere, and flourished.

What, to ask the question the other way round, have anaesthetists done for the NHS? In simple terms, of course, we have managed NHS patients, and done it very efficiently and cost-effectively. In 1997, we were identified as consuming 3% of NHS Trusts’ expenditure but influencing 60% of income [1]. But we have gone so much further. We have led the development of Critical Care, allowing the service to remain at the cutting edge of the high-tech medicine required by the sickest and most vulnerable patients. We have been instrumental in helping to reduce maternal mortality, which has fallen from 1 in 250 in the late 1920s to 14 per 100,000 maternities in 2003-2005 [2]; this despite a massive increase in surgical delivery, an ageing and increasingly obese obstetric population and a recent influx of mothers from the developing world, many with chronic and acute health problems. By stressing scrupulous attention to postoperative care, we have reduced surgical mortality and morbidity. By developing and utilising novel anaesthetic techniques, we have allowed the growth of efficient day-case and short-stay surgery.

But if only one contribution of anaesthesia to the NHS is to be trumpeted, surely it
must be the culture of safety. For too long, safety has been the NHS management equivalent of awake intubation; everybody talks about it, most people know theoretically how to achieve it, but in practice it hardly ever gets done. A search on the Department of Health website for publications with the word ‘safety’ in the title comes up with a total of 166 items. The National Patient Safety Agency has been formed, league tables of death rates from cardiac and other forms of surgery have been published, poorly-performing doctors have been pilloried, inspections have been made by the Clinical Negligence Scheme for Trusts, the Medicines and Healthcare Products Regulatory Authority have tried to minimise risk from new drugs and devices, and doctors have lost their white coats, shirtsleeves and wrist watches to a ‘bare below the elbow policy’ which, it has been admitted, is more about restoring patient confidence than fighting infection. But, despite all the hand-washing and -wringing, there is precious little to show that patients are any safer than they were, and whenever cost and safety collide, it is rarely safety that comes out on top.

Anaesthetists have long been the leading practitioners of safety, and it is only now, rather belatedly, that this is being recognised by those who run the NHS. After several years of obfuscation, the NPSA is now working directly with the Royal College and the Association on a specialty-specific incident form which will act as a template for other fields of medicine. Automated drug-recognition systems, developed by Alan Merry and his colleagues in New Zealand, are being trialled in several hospitals (along with, it must be said, the rather more prosaic and time-consuming process of manually double-checking all drugs administered by the anaesthetist). The really important enemies of safe practice, such as fatigue, inadequate training, inappropriate delegation, poor team-working and short-cutting to speed turnover, have always been matters of great import to anaesthetists, and we have led the field in dealing with many of them, to the benefit of the wider health community [3-6].

The NHS, flawed, monolithic, ever-expanding, bureaucratic, inefficient and costly though it may be, is a great institution which has been instrumental in improving the health of the nation, and which occupies a unique place in the hearts of the British people, customers and staff alike. In toasting its 60th birthday, we wish it a long and fruitful life, freedom from excessive fuss and interference, and, above all, a safe future rooted in safety. “In Sanitas Securitas”.

David Bogod
Editor-in-chief, Anaesthesia

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The Royal Air Force Medical Reserves at 4626 (Aeromedical Evacuation) Squadron and 612 (County of Aberdeen) Squadron need you to bring your skills to the challenging environment of 21st century combat. You could find yourself practising at 30,000 ft in a Hercules transport plane, working in a busy field hospital or flying in a rescue helicopter over the desert. We can teach and equip you to meet the new challenges you’re looking for.

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