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FROM THE PRESIDENT'S OFFICE

Anaesthesia on the national and European scene

Peter Simpson, President

Writing this, as I am, even before Advent Sunday makes me realise how difficult it must be sometimes for newspaper columnists and other professional writers. That flash of inspiration to send one’s thoughts on their way is sometimes not as apparent as it might be at other times and yet deliver I must, because not only is Mandie away on maternity leave but Edwina, our other Bulletin editorial officer, is off for a winter break in Australia! I just sometimes wish that I could do the same and yet the never-ending work of a College President is strangely addictive. It is also a wonderfully privileged position and full of surprises. The other day I received a completely unannounced visit from John Sevringhaus, someone who played a key role in my understanding of clinical chemistry and blood gas analysis. There I was being able to show one of the most influential figures in critical care measurement some of the detailed plans for our new College building over which he was as excited as I.

The President’s Dinner, which I host every year in November, and to which we are able to welcome many of those with whom the College works so closely, is another unique opportunity to foster key relationships with many of our colleagues in the wider aspects of the health service. Some years ago, when the dinner was inaugurated and the decision was taken to hold it in the College, we took the unusual step of inviting guests without their partners, largely due to limitations of space, and it is interesting how popular the dinner has become. Sometimes I feel that what many of us like is a completely unashamed evening of shop talk in a relaxing atmosphere and this time I received a number of requests to continue the dinner in its current format, even when we move to our new larger building.

March, of course, is election time and not only will we be welcoming new Council members but also electing our Officers for the 2005/6 College year. By the time you read this we will have said farewell to Doug Justins, who has served two full terms on Council, including two years as Vice-President. It is hard to do justice to the enormous impact that someone like Doug has had on so many areas of College life, in addition to his work as President of the Pain Society. Always available, ever cheerful and willing to do whatever is necessary, he is a wonderful friend and colleague and our specialty owes him an enormous debt.

Unlike some other Colleges, both the President and Vice-Presidents have to be elected or re-elected each year, which is an excellent way of ensuring that we fulfil the role to which we were elected without becoming too eccentric or autocratic! These will be important elections, particularly for our Staff and Associate Specialist positions on Council and also for our single-term members who are, for at least part of their term, trainees, since they must be within five years of attaining their Fellowship at the time of the election. Over the last few years having representation on Council from both SAS grade and trainee anaesthetists has been of enormous benefit to us, not only because they take a full share of the work of Council, but, importantly, because they provide a unique viewpoint which is essential if we are to make decisions which are relevant to those who will carry anaesthesia forward in the future. At this time, we say farewell to Mark Garfield, Chris Rowlands and Stephanie Glover, all of whom have given freely of their time, enthusiasm and expertise on everyone’s behalf: Mark in intensive and emergency care, Chris in many of the important issues faced by SAS grades, and Stephanie whenever we specifically needed a trainee input. Together with Doug Justins they will all be sorely missed.

Anaesthetists and national roles

The problem for everyone, not least for those elected to Council, is the time commitment which such additional work entails. Now that most consultants have switched to the new contract we are beginning to receive comments from individual anaesthetists about the difficulties they are finding in undertaking national roles. This may, of course, be on behalf of the College as an examiner, College Tutor, Regional Adviser or Council Member. It may also involve sitting on a number of other national bodies for which no official time allowance is recognised. The new consultant contract does contain clear statements about the need to recognise national commitments and make appropriate time available. Nevertheless, while most trusts are supportive and generous about this, realising the long-term benefit of encouraging such activities, some are not so understanding.
While we may be used to, and expect, immediate approval of our obtaining a national role and also expect that we will have time released for doing this, trusts feel understandably aggrieved when they are suddenly faced with a shortfall of consultant sessions. There are, however, a number of important documents which support the statements within the new consultant contract, including a letter from Sir Nigel Crisp, the Chief Executive of the NHS, to all trust chief executives urging them to support those undertaking national roles. Madeleine Wang, the Chair of the College’s Patient Liaison Group, has written to Sir Nigel Crisp and the chief executives of the NHS in each of the devolved countries of the UK and has received very supportive and positive replies to her letters expressing concern at the need for national involvement in examinations and training in order to sustain the quality of patient care. The Academy of Medical Royal Colleges (www.aomrc.org.uk) has produced two documents on its website, one providing guidance on the new contract and its implications for job plans and a second on the roles and responsibilities of College Tutors, both of which clearly state the need for designated sessional allowance for those undertaking official roles.

One problem that trusts have is that consultant contracts were negotiated on a completed job plan and work diary and if these did not contain details of the particular external roles which would allow them to be annualised, then it is hard to expect the trust immediately to acknowledge something without prior warning, given the resultant loss of clinical activity. Furthermore, if one is anticipating applying for a new national role, the question of whether one’s trust should be notified in advance is a difficult one. While we would not wish to encourage trusts to exert a veto over such appointments, nevertheless it would seem courteous and reasonable to discuss the issue with one’s employer and equally with one’s colleagues to ensure that adequate cross-cover will be available to sustain the anaesthetic service.

Clinical Excellence Awards

We were very pleased to hear that in the 2004 Clinical Excellence Awards for England and Wales anaesthesia increased its success rate by 50%, obtaining 45 awards, compared with 31 in 2003. Before you despair that anaesthesia is being reduced to Silver rather than Gold awards, I can reassure you that scanning the Advisory Committee on Clinical Excellence Awards (ACCEA) website shows that this pattern was repeated across all the specialties. It would appear to be the intention of the Advisory Committee to make more awards available at a slightly lower lever and anaesthesia has benefited significantly from this. It will also be very important to sustain the quality of applications in future years and I believe that a number of our colleagues have been sufficiently disillusioned with the system in the past not to submit a CV for consideration. It is hoped that this increased success rate will encourage others to follow suit in future years to ensure that our relatively successful position this year is sustained. Both Mike Harmer and I have written extensively about the awards system and I do believe that successful CVs are not produced rapidly over a winter weekend but rather should be developed gradually and continually edited to ensure that they present our nominees in the best possible light.

Change on the European anaesthetic scene

So who hasn’t got a 0.83 COR large-headed TaylorMade driver then? Golf in the 21st century allows us to hit the ball longer, straighter, higher, lower and with more or less spin, the only constraint being how much we are prepared to spend on the golf club! On seeing a jumbo-headed driver recently, one orthopaedic golfing friend exclaimed that it was so big it had probably got its own postcode! But if it’s big, is it actually any better?

This year has seen the arrival of the new European Society of Anaesthesiology, formed by the amalgamation of the European Society of Anaesthesiologists (ESA), the European Academy of Anaesthesiology (EAA) and the Confederation of European National Societies of Anaesthesiology (CENSA). Although the legal, financial and administrative details of the amalgamation have been very difficult to organise, the end result has potential advantages for all of us, particularly in an ever expanding Europe. For the first time a single Society will embrace all practising anaesthesiologists in Europe to facilitate the provision of training, education, assessment, accreditation, quality assurance and continuous professional development. Each organisation brought with it its own particular responsibilities and everyone involved is determined to ensure that these are not lost within a larger organisation. It is as important to preserve and support areas such as academic anaesthesia, the European Diploma of Anaesthesiology and Intensive Care and the hospital visiting programme as it is to ensure that major meetings such as Euroanaesthesia continue to build on their very successful image. Equally important in our new Europe, with its ten accession countries, is to ensure that everyone is involved with the work of the new Society and that provision is made to run meetings and teaching programmes in Eastern Europe, where resources are not nearly so forthcoming.
Towards a European Board of Anaesthesiology

The ability of doctors to move from one European country to another and to have their professional qualifications recognised is one which affects us all, whether we wish to move or whether we are encouraging others to come and work in our country. Many wonder whether it will ever be possible to ensure that training programmes which allow entry onto an individual country’s Specialist Register can be satisfactorily harmonised in terms of standards and quality assurance – and this is in addition to the inevitable problems of language and culture. To this end, the Anaesthesiology Section of the European Union of Medical Specialties (UEMS) has been developing ideas for a European Board of Anaesthesiology which would essentially be concerned with producing uniformity of qualifications and registration. Proposals have been put forward to produce entry criteria for Membership and Fellowship of the European Board to try and establish a reliable and uniform standard. Board Membership would be open to all practising anaesthesiologists in Europe, but for Board Fellowship clear criteria would apply. After an initial transition period involving strict national limits and qualifications, Board Fellowship clear criteria would apply. After an initial transition period involving strict national limits and qualifications, Board Fellowship would be dependent upon holding the European Diploma of Anaesthesiology together with being on the Specialist Register of an EU country, thus providing an international qualification standard.

While acknowledging that there is considerable anxiety over apparently unrestricted admission of overseas doctors from Europe into the UK, it is vital to emphasise that an entry on the Specialist Register does not guarantee a job. Wherever possible, what needs to be put in place by individual trusts or deaneries is a process by which someone can commence work for a brief period as a ‘locum’ to ensure that both they and the trust are happy with their future prospects for employment on a permanent basis.

Anaesthetists on the cardiac arrest teams

The College has recently issued up-to-date guidance in conjunction with the Resuscitation Council on the composition of cardiac arrest teams in hospital. Although circulated and available on the website, the background to this is that the College appreciates that in a number of hospitals anaesthetists are no longer part of cardiac arrest teams and others with suitable, assessed competence take their place quite satisfactorily. We acknowledge that there is a need for expertise in a number of key areas such as advanced airway management skills but, equally, that these are not peculiar to anaesthetists and, for many trusts, a more practical solution may be for a resuscitation team composed in a different way. The key must be the provision of optimal patient care and provided the trust can assure itself that a complete range of resuscitation skills is provided by the team, then the inclusion of anaesthetists should no longer be considered mandatory. If, however, trusts still consider that an anaesthetic presence is essential, then appropriate arrangements must exist to ensure that an anaesthetist is always available. Furthermore, access to experienced critical care advice is essential when considering and planning optimal post resuscitation care. We hope that by expressing the College view in this way, some constraints on on-call rotas may be alleviated for everybody’s benefit.

Revalidation

Although many of you, I am sure, still feel that revalidation is a long way off, having examined the penultimate digit of your GMC Registration Number, others realise that the actual process is just around the corner, starting in April 2005. Having just calculated, much to my relief, that mine was not due until 2007/8, all College Presidents have had to take part in a pilot revalidation programme, which required our submissions by the end of November. Rest assured, if they can revalidate me, they can revalidate anyone!

Recent discussions with the GMC and particularly the Modernisation Agency suggest that, in the light of a number of high profile cases, including Shipman and Ledward, simply presenting a series of signed-off appraisals will not be sufficient on its own to ensure revalidation. The problem with appraisal is that, quite rightly, it is a private and individual process which for some can be engineered to produce the desired result. Having said that, I do not wish to cause panic and most anaesthetists will already find they have quite sufficient supplementary material to satisfy any revalidation exercise. What is being suggested is still the presentation of successful appraisals plus a continuing personal development plan with evidence that this is being fulfilled, together with a number of other pieces of supporting evidence related to one’s clinical practice. In anaesthesia this is essentially our personal folder, which will contain evidence of clinical activities including, one hopes, participation in audit activities and a critical appraisal of one’s own practice. The inclusion of external assessment by clinical, nursing and managerial colleagues, together with patients, will also provide another important contribution, perhaps as part of a multi-professional 360 degree appraisal. There will also need to be clear assurances about one’s probity and health, though for some the latter will undoubtedly need to retain appropriate confidentiality. The final item which is being considered is a sign-off to verify
that there are no outstanding ‘causes for concern’. Obviously it would be impractical and wrong for this sign-off to be the responsibility of a single individual and the actual process will need to include clinical, managerial and lay representation. Although all this is at the discussion stage at present, even in the three months between my writing and you reading this, I am sure that significant progress will have had to be made if we are to hit the start of the process in April.

Finally, for those who think that retirement will be a convenient way of avoiding revalidation, will this mean that we can forget any need to maintain our skills? Jane and I have recently discovered the world of pub jazz and spent an evening listening to the Muskrats! Watching the dexterity of our children’s former headmaster, playing jazz clarinet at the age of 82, one realises that some inherent skills are never forgotten whether or not they are subject to revalidation, provided one’s joints will still stand the strain!

**Thank You**
The College would like to acknowledge with gratitude the substantial legacies received from the estate of the late Dr Elizabeth Gibbs FRCA, and also from the estate of the late Mrs Lucy Sargent, good friend of Dr Cyril Scurr, Dean of the Faculty of Anaesthetists, 1970–1973.

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**Patient Feedback Appraisal**

**REQUEST FOR VOLUNTEERS**

The College is receiving an increasing number of enquiries from anaesthetists who are concerned about the best way to obtain evidence for revalidation about their communication skills with patients. For some, this will be one of the most challenging area of ‘Good Medical Practice’ to cover. Patient feedback questionnaires are being developed, but few of them are appropriate for evaluating the relatively brief encounters which anaesthetists may have with their patients, especially in day stay surgery.

The College’s Patient Liaison Group has been advising the Joint Committee on Good Practice in Anaesthesia of the College and Association on this matter. They have now agreed to explore the use in anaesthesia of the Consultation and Relational Empathy (CARE) measure, developed by Stewart Mercer in the Universities of Glasgow and Edinburgh. The final version of this measure has recently been piloted in a secondary care setting, though with very few anaesthetists involved.

The proposal is to pilot the CARE questionnaire in anaesthesia in the spring, and possibly in critical care medicine and pain management, recruiting 20 consultant anaesthetists from each of these areas who would like to take part in the pilot study.

Each volunteer will be asked to obtain 50 completed questionnaires from patients for analysis. The method of distribution and collection will ensure patient confidentiality, but individual anaesthetists will be able to obtain copies of the anonymised data relating to themselves if they so wish. Further guidance, both for anaesthetists and patients, will be provided before the start of the pilot study.

Any consultant anaesthetist interested in participating in the study should contact Rici Faber at the Professional Standards Directorate at the Royal College of Anaesthetists (rfaber@rcoa.ac.uk).

Professor David Hatch
Professional Standards Adviser
New systems for pre-operative preparation: challenges and opportunities for anaesthetists
Dr R Kerridge, Director, Perioperative Service, John Hunter Hospital, Newcastle, Australia

Anaesthetists have long understood the importance of adequate assessment and preparation of patients before surgery. This knowledge has been based on evidence from multiple studies of patient morbidity and mortality from around the world. Despite the evidence, adequate patient preparation is difficult to achieve, as the traditional system of patient management prior to elective surgery is unsatisfactory. The commencement of pre-operative patient assessment and preparation after admission is suboptimal. Crucial information that is needed for adequate pre-operative assessment and peri-operative management may include the results of tests (that are difficult to find) as well as the findings of history and physical examination. Explanation of procedures and risks shortly before operation may be harmful, is of dubious benefit, and is of doubtful legal validity. Alterations to the patient’s health state may be difficult unless the operation is postponed.

These problems are systemic, rather than a result of lack of commitment or knowledge on the part of anaesthetists. There have been various attempts to establish pre-anaesthetic clinics to address these problems. These have had limited success and have not become generally accepted as part of routine practice, but rather as a particular service for challenging patients.

The problem of suboptimal pre-operative patient preparation has other untoward effects beyond the direct clinical concern of anaesthetists. These include avoidable cancellations on day of surgery, ‘no-shows’, inefficiency of hospital processes, patient dissatisfaction, and resultant staff frustration or demoralisation. These ‘non-clinical’ adverse outcomes are of increasing concern to the managers of hospitals and health systems. As a result, both anaesthetists and hospital managers have a synergistic interest in improving patient preparation for surgery.

In recent years there has been a concerted drive designed to admit patients to hospital only a short time before their operation, even for major surgery. This change is driven by patient preference and financial pressures, and for patient safety. As a result, the traditional ‘model’ of pre-operative patient preparation, which has always been suboptimal, is now becoming completely unworkable.

In Britain, this has been recognised at a high level in the NHS, and has been a major focus of change by the NHS Modernisation Agency. The most common pattern has been to introduce nurse-based ‘pre-op assessment’, based on the traditional organisation of patient care within surgical ‘firms’. The nurses involved in ‘pre-op’ have a varying degree of training, supervision and resource support. Clinics may be set up in or near established surgical wards, and conducted as part of the activity of the surgical ‘firm’. Involvement of anaesthetists varies greatly between hospitals, and is evolving rapidly. The educational material developed under the auspices of the NHS Modernisation Agency to support this change is a notable innovation.

The deployment of nursing staff into the area of pre-operative assessment is a major change, but can be thought of as workforce substitution rather than a fundamental change of process. The challenges of ensuring appropriate patient preparation in modern hospitals are so great that major systemic changes and ‘re-engineering’ solutions are needed. Anaesthetists have a central role in the hospital management of surgical patients, a broad clinical perspective, and wide interspecialty and interdisciplinary interactions. They also tend to have a more ‘team’ style of working relationships than other medical specialists. They are thus ideally placed to develop the systemic solutions needed to improve the peri-operative management of patients having elective surgery.

Developments in Australia
Recent developments in Australia with regard to pre-operative preparation may provide a valuable model for anaesthetists’ response to the challenge of improving pre-operative preparation in the modern hospital setting.

The Australian healthcare system has many similarities with that of Britain. Among these is the system of medical specialist training. Australian anaesthetists share the high standards of those in Britain, including having a broad general medical training. They are also closely involved in post-operative pain services and in intensive care. The sub-specialisation of physicians and surgeons is well advanced in both countries. Individual surgeons are becoming focused on a narrower range of specialised pathology and procedures. As a result, the need for a hospital-based
'generalist', able to deal with a broad range of patient issues both clinical and non-clinical, is becoming more apparent.

There are also important differences between the British and Australian healthcare systems. Australian organisational structures and funding systems are much more fragmented. Patients may attend multiple specialists and have procedures or investigations in a diverse range of settings, both public and private. Primary care practitioners and consulting specialists are less integrated with the health system than those in the British NHS. All these features exacerbate the challenges of global patient care, and particularly that of optimising pre-operative patient preparation.

In this setting, the ‘Peri-operative System’ was developed as a possible systemic solution to the challenge of improving the management of elective surgery patients. The System was developed by a multidisciplinary team of clinicians at Liverpool Hospital (Sydney) in 1992–1993. It has since been disseminated nationally (assisted by a Government-funded change programme) and has now become the standard model of peri-operative care in Australia and New Zealand. Independently, hospitals in Canada and the USA have developed similar systems.

The perioperative system — concept and application

The concept of a peri-operative system is to plan all stages of care of an elective surgery patient as a unified and integrated process. The aim is both to improve the quality and to reduce the costs of care of elective surgery patients. Central to the peri-operative system is the development of a ‘peri-operative service’ as an administrative entity within the hospital. The peri-operative service provides pre-admission assessment and preparation of all elective surgical admissions. There is generally a central office, a clinic, a ward area, clerical support, a medical director and a nurse unit manager for the service.

The global nature of the peri-operative system needs to be emphasised. In the pre-operative phase, the key components include:

- a single entry system for all elective surgery patients (i.e. not a separate system for general surgery, ENT, ophthalmology, gynaecology etc)
- use of a patient-completed pre-operative patient health questionnaire as part of a graded system of patient assessment to replace the traditional admission, and to select patients requiring clinic assessment
- a system for gathering information about the patient from multiple sources (GPs, diagnostic services, consulting specialists, past treating hospitals) before clinic visits
- a multidisciplinary pre-operative clinic, staffed by specialist nurses, anaesthetists and other staff. This is not ‘just’ a pre-anaesthetic clinic. It is a peri-operative clinic, and includes assessment and preparation of all aspects of the patient’s care
- a system to review the patient assessment including results of tests, and then co-ordinate patient preparation before admission. This includes communication with relevant units or services that will be treating the patient
- a specialised pre-operative preparation and holding area (a peri-operative unit) where all patients are admitted from home to hospital shortly before their procedure. Patients do not go to the surgical ward until after their operation
- a medical director to provide readily and immediately available senior medical (anaesthetic) support for the nurses and clerical staff involved in the Peri-operative Service.

Using the peri-operative system, almost all elective surgery patients (including abdominal, joint, vascular, cardiac and thoracic surgery) can be admitted to hospital through the peri-operative unit, 1–2 hours pre-operatively. Patient preparation has improved. Poor preparation, delays, cancellations, length of stay and costs per patient have been reduced, and patient satisfaction is increased. Adverse outcomes, including wound infections, are also reduced.

The development of the peri-operative system has involved a shift in the content and style of work for many of those involved. Nurses have extended their role to become more actively engaged in patient assessment and high-level decision-making about patient preparation. Clerical staff have become closely involved in clinical processes, taking on a ‘para-clinical’ role. Most of the tasks of ‘medical clerking’, traditionally performed by junior medical staff, have been taken over by clerks, nurses and anaesthetists. The clinical role of anaesthetists has expanded to be centrally involved as the medical co-ordinator of pre-operative patient preparation, including a broader involvement in patient safety, quality of care, and efficiency. For anaesthetists, this represents an evolution of a clinical and managerial role out of the operating theatres to a role of ‘peri-operative physician’.

Controversies and special issues

There have been many important aspects, and controversial issues, associated with the development of this new system for the management of elective surgical patients.
The use of patient-completed questionnaires and selective clinics is the most visible feature of the system. Experience has shown that a questionnaire, reviewed by trained clerical or nursing staff, with readily available medical support, can act as an effective and safe screening system to select patients for clinic review. Selectivity of attendance at the peri-operative clinic varies depending on hospital casemix and patient population. In general, approximately 15% of day-only patients and 40% of day of surgery admission patients need clinic-based assessment. Some clinic patients can be adequately prepared by nurses or ‘junior’ medical staff alone, but readily and immediately available anaesthetic (peri-operative physician) consultation is crucial to support this process. Non-clinic patients can be appropriately prepared by questionnaire and telephone consultation. Neither patients nor staff should waste time in unnecessary clinic consultations.

While the clinic is the most visible component of the system, the service activity both before and after the clinic is of equal if not greater importance. The gathering of patient information from a wide variety of sources, such as other hospitals, consulting specialists and general practitioners, is crucial. After the clinic, the challenges of co-ordinating patient preparation, including complex issues such as diabetes, warfarinisation or dialysis, require high-level teamwork and communication. This work is best performed by trained, experienced and energetic nurses, but ongoing senior medical involvement by an anaesthetist (as peri-operative physician) is crucial to support this process. The importance of this office-based role of the peri-operative service tends to be overlooked by hospital administrators and other clinicians. It is crucial to the high-level function of the service to enable safe preparation of difficult patients. It requires adequate support, including staff time, office accommodation and other resources.

The role of ‘peri-operative physician’ represents an expanded role for anaesthetists. Some of this role was previously performed (usually suboptimally) by the surgical houseman. Anaesthetists have the necessary skills and training to take over this role directly or in a supervisory capacity. Some anaesthetists are reluctant to take over the ‘houseman’s job’, or move from their ‘comfort zone’ in the operating theatre. This attitude may be short-sighted. If anaesthetists are perceived as technical staff in theatres (‘bag-squeezers’) rather than broadly skilled doctors, their status and security in the future may be threatened. Taking on the peri-operative role may increase the status of the specialty – this appears to have happened in Australia.

The various functions of the peri-operative service include ‘traditional’ clerical and organisational tasks, and ‘para-clinical’ tasks that can be efficiently performed by clerical staff under clinical supervision. Administrators often overlook the need for clerical support. Clinicians of all disciplines tend to be clerically inefficient and unskilled, and hence the need for clerical staff must not be underestimated.

It is logistically impossible for each anaesthetist personally to assess his or her patients in the clinic. The medico-legal responsibility of the anaesthetist caring for the patient at the time of the operation does not change. Explanation of procedures for consent purposes is probably of dubious legal standing when performed shortly before the operation. This does not prevent the anaesthetist using and relying on others to perform some tasks in the process of pre-operative preparation of the patient. We currently depend on patients to give true answers to questions and follow instructions. We depend on ward nurses to fast the patient, give normal medication, and give premeds. We must develop a system that we can depend on, and trust, to appropriately assess and prepare patients prior to admission. This can be assisted by the development of standardised documentation systems, agreed clinical guidelines and protocols, but most importantly requires teamwork based on mutual professional respect and trust. Anaesthetists are more team orientated than most medical specialists, but for some anaesthetists this is personally challenging.

As noted above, patients are admitted directly from home to an area adjacent to the operating theatres (the peri-operative unit) shortly before their operation. Patients do not enter the surgical ward until after surgery. This has a number of clinical and non-clinical advantages. Surgical ward beds are better utilised, since they are not required until the post-operative phase. The efficiency and quality of patient preparation shortly before surgery are improved, since a small group of specialised nurses are able to focus on these without the clinical distractions seen on a surgical ward. Communication and co-ordination with operating theatres are improved, and delays reduced. The introduction of incremental process improvements and new clinical practices is facilitated by the concentration of patients in one area. To function effectively at a high level, the nurses in the peri-operative unit need to know that they can pick up the phone and rapidly have a response from a senior member of the anaesthetic staff.

The development of a central pre-operative area (which may also hold pre-and post-operative day-only patients) has
been a central aspect of the development of the Perioperative System, and is a component with great advantage for reduction of length of stay and cost savings. It is surprising that the idea appears not to have become more widespread in Britain.

Implementation of a peri-operative system requires a multidisciplinary team approach, with time, energy and goodwill to deal with the multiple ‘minor’ problems encountered. The keys to implementation of the change are: shared enthusiasm, respect and vision amongst all groups involved; tolerance of the many ‘teething troubles’ encountered; frequent meetings of a working party to supervise change; and continuous communication as required. Medical leadership is needed, emphasising the importance of this new role for anaesthetists.

**Peri-operative medicine**

The advent of the peri-operative system has meant that systematic patient preparation one week or more preoperatively is becoming normal. This provides an opportunity to improve patient outcome by a variety of specific interventions, pertaining to the peri-operative period, to improve patient preparation and convalescence. These interventions have previously been not known about, not logistically feasible, or simply not attempted. This represents a developing body of knowledge and interventions that can be described as ‘peri-operative medicine’.

Peri-operative medicine may include the development and evaluation of new techniques and technologies for preoperative assessment. For example, Cardiopulmonary Exercise Testing (CPX) may provide an objective assessment of physiological reserve and predict survival after major surgery.\(^8\)

The use of specific peri-operative pharmacotherapy to improve patient outcome is a broad field for development. The appropriate management of chronic drug therapy, such as antiplatelet agents, needs more research. The current interest in peri-operative beta-blockade\(^9\) provides a template for further research in other pharmacological interventions, including immunonutrition.\(^10\)

Pre-operative interventions to improve patient health, such as psychological preparation, weight loss, smoking cessation and exercise therapy, seem appropriate but must move from ‘enthusiastic amateurism’ to the use of scientifically validated methodology. We have recently completed a randomised controlled trial demonstrating the effectiveness of a multi-component smoking cessation intervention, including extended smoking cessation up to three months post-operatively.\(^11\)

Peri-operative interventions related to blood transfusion, such as autologous or directed donations, and iron or erythropoietin therapy, are appropriately undertaken by the peri-operative service.

Apart from these patient-focused issues, the development of the peri-operative system provides an avenue for involvement in broader health system research and development. Among these are the clinically-focused development and use of better communication systems, such as the electronic patient record.

Ideally, the pre-operative period represents the commencement of a planned and structured multidisciplinary process of care extending into the convalescent phase.\(^12\) There are clearly a wide scope and need for involvement of anaesthetists – as peri-operative physicians – in this exciting field.

**The future for anaesthetists**

Changes in the management of elective surgery are presenting new challenges for anaesthetists. Meeting these challenges will require changes in the way we perform our work. There was a time when anaesthetists worked as individual practitioners, and focused their clinical skills in the operating theatre. We have now developed our specialty so that some patients are looked after by one anaesthetist during induction, another during cardiac bypass, another in the ICU, and another when under the care of the acute pain service. Our involvement is now being extended into the pre-hospital phase, where a structured, teamwork approach is also needed. Some anaesthetists will develop a special interest in the ‘new’ sub-speciality of ‘peri-operative medicine’.

For most anaesthetists, the changes in the system of patient care before elective surgery can result in one of two outcomes. In those hospitals that develop a system with strong anaesthetic involvement, the preparation of patients for surgery will be optimal, use of hospital resources will be efficient, and the anaesthetists shall be respected and (hopefully) satisfied in their work. In other hospitals, patients will continue to be admitted inappropriately prepared, inefficiency will reign, and anaesthetists will be regarded as grumpy, frustrated technical staff who are overpaid and underworked.

The peri-operative system is a patient management system that improves the quality of care, while reducing costs. Anaesthetists have a crucial role in the success of the system. Anaesthetists who take up this challenge are ensuring a better future for themselves, their specialty and, most importantly, their patients.
References


My year in the Netherlands
Dr C E Waters, SpR, Oxford School of Anaesthesia

I spent my Out Of Programme Experience (OOPE) year working in Intensive Care at the Vrije Universiteit Medisch Centrum (VUMC) in Amsterdam. The VU, as it is known colloquially, is one of three main teaching hospitals situated in the south of the city. It is the main trauma centre of the region and has its own aero-medical retrieval service. The hospital has approximately 900 beds and a 35-bed ICU with seven HDU beds.

Organising the year abroad
This was a very lengthy and bureaucratic process but perseverance paid off in the end. Having secured my job as an ICU fellow (SpR equivalent) for the year, I had to register with the Dutch equivalent of the GMC (BIG), organise a sofi or national insurance number, private medical insurance, medical negligence insurance or rechtsbijstandverzekering, legalise documents (by sending them to the Foreign & Commonwealth Office in London) and arrange a bank account and somewhere to live. Once I arrived I was required to register with the local town hall for a residency permit, and with the foreign or alien police (as they call it) for an identity card. I kid you not! Of the entire bureaucratic process, registration of the car was the most difficult part by far in terms of time and effort. It involved vehicle checks, discussions with customs about tax exemptions, and changes to headlights before new Dutch plates could be issued. Retaining English plates was a tempting option but would have risked insurance difficulties in the event of an accident. Last but not least I set about learning the Dutch language or Nederlands. In retrospect, I could have done this more efficiently once I got there by enrolling in a ‘Dutch as a Second Language course’ (in my case at the Free University next door to the hospital). However, the studying that I did before I left the UK was a great help, particularly with the grammar.

Working in intensive care
The ICU had historically been run as separate medical and surgical units plus HDU, and was spread over three floors of the hospital. In more recent times these separate units have been amalgamated under the direction of Professor Girbes. The unit was staffed by arts-assistents (SHO equivalent) and fellows (SpR equivalent) who were predominantly trained in general medicine, but could also be from a surgical or anaesthetic background. Most superviseurs (consultants) were physicians. The set-up of the unit was impressive with the latest Servo Maquet ventilators. All medical and nursing records were accessed on-line using the Metavision-X system,
including patient results, X-rays and CT scans. The beauty of this system was the sheer speed of access and the ability to manipulate the images as required. Each day there were three ward rounds, the first starting at 7.30 am. The main business round occurred just before lunch and was conducted in a room separate from the ICU with access online to all the patients’ observations and results. Except for the first couple of weeks, all the ward rounds and discussions were conducted in Dutch and I had to overcome this obstacle very quickly. Printing out all the patient summaries before each round helped enormously as I found that written Dutch was much easier to follow than spoken Dutch.

I worked an average 50–55 hour week in a full shift pattern, working nights approximately one week in four with a compensatory week off afterwards. On-call rooms did not exist and I was expected to be up and working all night, which I was! When on-call, one fellow would cover two *arts-assistent* so that I would be the most senior intensivist in the hospital at night covering two very junior trainees and all 35 beds. However, this worked very well and they were all, without exception, industrious and helpful, particularly as I relied very heavily on their translating skills! The staffing ratios on the unit were less generous than in the UK, with one nurse to two ventilated patients. The Dutch nursing staff was very competent, hard working and organised. There were typically five to seven routine surgical admissions per day – mainly cardiac and neuro, with thoracic and other major surgical cases being admitted to the HDU. The isolation bays were completely separate from the main ward area and the threshold for admitting patients to these areas was extremely low.

Being such a busy unit, I was not expected to get involved directly with admissions via A&E or *Spoed Eerste Hulp* (SEH), although I was often called upon for an opinion. This was the role of the *anaesthesioloog* or anaesthetist who, following initial stabilisation, transferred the patient to ICU. This certainly took getting used to. I also had the ‘pleasure’ of being able to close the unit to all new admissions when we could no longer admit patients. They were then transferred to outlying ICUs by the anaesthetic team. This didn’t happen very often since Amsterdam is well supplied with intensive care beds, but it did make a very welcome change from having to deal with every admission via A&E, whether there was a bed or not.

Although intensive care is mostly very similar between the two countries, there were some striking differences. I had to get used to using drugs that are not available in the UK, such as intravenous ketanserin and nicardipine. Patients were ventilated according to the Open Lung or Lachmann approach with emphasis on recruitment manoeuvres to open the lung and high PEEP levels to keep the lung open. They were also prone much earlier than is current UK practice, on Clinitron beds, often on an inspired oxygen concentration (FiO₂) of 0.4. Many patients were converted early to jejunal feeding (*duodenumsonde*) when gastric feeding proved difficult, and this was usually carried out by the gastroenterologists within a couple of hours of making the request! Feeding was often guided by indirect calorimetry to calculate calorie inputs. Most feeding tubes were placed orally to reduce the rate of sinusitis and this continued even when the patient was extubated. Patients did seem to tolerate this surprisingly well. Bronchoscopies were usually performed by *pulmonologists*. All cardiac patients were managed with pulmonary artery catheters for the first 24 hours post-surgery. On this particular unit, there was a low tracheostomy rate. Tracheostomies were carried out using the Grigg’s or forceps technique with an ENT surgeon in attendance.

By UK standards patients tended to stay longer – resulting in a virtually zero readmission rate, helped by the reduced pressure on beds. Most noticeable was the very low MRSA rate (<0.5%) due to very strict infection control measures. These included isolation, absence of hand jewellery at all times, and short sleeved white coats (I was swabbed for MRSA on day one, being from a high risk
country!). I did witness one MRSA admission to the unit and during the patient’s stay all staff had to wear gowns, masks, hats and gloves whether they were in contact with patients or not. Although at first I did find these measures draconian, they have been extremely successful in preventing MRSA becoming a real problem there. Selective decontamination of the digestive tract was also practised. Most patients had daily chest radiographs, which were reviewed at the daily radiology meeting. I have to admit that the information from these was very useful in terms of starting furosemide infusions, performing recruitment manoeuvres or treating infective changes, though it is contrary to current UK practice.

Living and working in the Netherlands

I was very lucky in being able to live in Haarlem, which from a foreigner’s perspective is a very quaint and picturesque miniature version of Amsterdam itself, without much of the big-city madness and bedlam. It was about 20 minutes’ drive away and meant I had the best of both worlds. It was also within easy reach of the bulb fields (e.g. Keukenhof), the beach and a coastal national park. A devoted party animal would probably find the excitement of living in Amsterdam itself difficult to resist, but it is worth knowing that you can live in a quieter family-oriented town such as Haarlem, enjoy Amsterdam’s nightlife and still get a train back home late at night. Furthermore this is true of virtually every town in the Netherlands. Public transport is very clean, reliable and cheap. Although I bought a bike (well, you have to, really) I used it mainly for cycling around Haarlem. Cycling is extremely safe and well organised with separate cycling paths controlled by their own traffic lights. Amsterdam is also a great point from which to travel to neighbouring countries. While Holland is only a stone’s throw across the English Channel, the lifestyle and culture are very different and do take some getting used to. Do not expect to find it easy if you haven’t done anything like this before.

One of the most difficult aspects of the year was being employed as an anaesthetist who was completely separate from the anaesthetic department. However, I did find my anaesthetic colleagues very helpful during handover of patients and I’m sure that, had any major airway crisis arisen, they would have supported me completely. The major problem of course was the language barrier. Never underestimate it. It is surprisingly tiring having to work in an environment where you are continuously having to translate Nederlands, even within Microsoft Word. Every household bill and every automatic answer phone operates in Dutch, so even the very humbling multilingual talents of the Dutch themselves can’t always come to your rescue! However, that said, I also got a tremendous sense of achievement in surviving and passing the Dutch exams. It was strange meeting other Brits who have been living there for years and now find it very difficult to think in English even though they still speak Dutch with a British accent. It was also reassuring to know that they too had spent many months (years even) getting to grips with the language before attaining fluency. While the Dutch are fiercely proud of the uniqueness of their language, from an English speaker’s perspective Dutch has many similarities to German and with a good German foundation you would find it much easier to learn.

While the experience itself was priceless, pay is of course important, and it is worth realising before you hop on the plane that the rate of taxation is high. My personal tax rate was 52% which, along with having to pay for private health insurance and pension, reduced my salary considerably (the cost of living is not dissimilar to London). However, it was a small price to pay for such a unique experience.

Conclusion

I would recommend spending a year abroad in a non-English speaking country but you have to be clear about why you are doing it and what you want to get out of it. Do try to get to grips with the language as soon as possible (admittedly easier said than done). Most Dutch natives do speak English but you will be under a lot of pressure to
function in Dutch and you cannot always rely on getting away with English. Making as much effort as you can with the language certainly makes the entire adventure more rewarding, and will be deeply appreciated and enjoyed by the Dutch, however successful (or not) your efforts!

The responsibility of looking after so many patients on-call and supervising more junior colleagues was extremely good training especially in such a large, well organised and high-tech unit. It also introduced me to different concepts and approaches to management which would have been difficult to attain in the UK. It is very important to learn that there are different ways of doing things. Being an academic unit there were also opportunities for research and audit.

This year is not for everyone but I feel truly fortunate to have gained such a unique and worthwhile experience and despite the difficulties have no regrets whatsoever in doing it.

**THE ANAESTHETIST AS EDUCATOR**

Supervision, teaching, assessment and appraisal are becoming increasingly important parts of every anaesthetist’s work load.

Following a review of its Education Strategy the College will shortly be introducing the Anaesthetist as Educator project with the aim of developing a programme at four complementary levels to support anaesthetists who have to teach, supervise, assess and appraise other people. The project includes:

- **SpRs** – Achieving the competencies in the CCST programme
- **Career grades** – Training in educational supervision
- **College Tutors** – Specific training required by College Tutors
- **The University of Dundee Certificate in Medical Education for Anaesthetists**

To implement this ambitious project the College needs to expand the pool of dedicated faculty who currently run the programme of ‘How to Teach’ courses and workshops.

If you have an interest or expertise in this area and would like to help the College achieve its aim please email your details, including your experience, to educ@rcoa.ac.uk.
The purpose of revalidation is to create public confidence that all licensed doctors are up to date and fit to practise. The scheme, previously proposed by the General Medical Council to begin in April 2005, has been delayed for all 200,000 registered doctors as a result of the recommendations of the fifth and final Shipman Enquiry Report. Findings include the view that, although there have been significant changes in clinical governance in the NHS in recent years, there has not yet been the change in culture within the GMC that will ensure that patient protection is given sufficient priority over the interests of the medical profession. Amongst its key recommendations, the report suggested that there should be an increase in the number of GMC members appointed against ‘public interest’ criteria, lay people who are independent from the health services and the medical profession. Perhaps this will reassure the public that doctors will, in future, be regulated and called to account by the public’s ‘representatives’ rather than those within their own profession. There should be no doubt that lay representatives will have some valuable and (as yet unknown) role to play in revalidation. Being competent is more than being ‘up to date’ however; keeping a record of such things as continuing professional development for example, will be insufficient markers to prove a doctor’s fitness to practise. The GMC will be expected to ensure that the new scheme is fit for purpose and appropriately quality assured.

…and double standards

But there are many who work in the NHS who will not be subject to the same standards of scrutiny as those proposed for doctors. The NHS is increasingly using other health professionals to do the jobs previously confined to medical practitioners; the introduction of Anaesthesia Practitioners (AP) is but one example. Patient representatives and anaesthetists alike have fought hard to ensure that their education and training is nationally driven, co-ordinated, approved and supervised for the foreseeable future. It has been proposed that this College will oversee the AP’s development of professional standards. It would make sense, therefore, that the College should be involved in any on-going assessment of ‘fitness to practise’ for these professionals, but presently there is no regulation or guidance requiring this.

The regulation of many other health professionals and assistants does not appear to require any form of revalidation or equivalent. For example, it would appear that the Government requires from the GMC and of registered individual practitioners much more than it does of nurses who appear to have no obligations in this regard. At the time of writing there is only one reference to revalidation on the Nurses and Midwives Council (NMC) website (March 2003) that states: ‘The General Medical Council (GMC) has changed its proposals for the revalidation of doctors’ practice. According to a report in Hospital Doctor magazine, the procedure will be simpler than previously anticipated.’ This demonstrates a straightforward example of double standards: clearly not in the interests of patients or doctors who surely have the right to expect that equal levels of protection be applied regardless of the health professional responsible.

…and more!

Anaesthetists may be reassured that AP’s roles and responsibilities are presently overseen by a national Modernisation Agency stakeholder board. The education and training of these health professionals is set within a new curriculum, nationally set against common core competencies and the new role will have a national job description. But those NHS trusts that have chosen to ‘go it alone’ (some trusts have already introduced fast track in-house training of theatre staff) and create their own APs and anaesthesia assistants whilst ignoring the fact that properly approved courses have been developed, risk the understandable objections of anaesthetists with whom they will expect these people to work. They create a different but equally unjust set of double standards. Why? Because it seems that nowadays, so long as the waiting lists are driven down and patients receive a ‘choice’ of care, little else matters. I wonder what patients are told when making their decision about where to receive their care? Are they properly informed that the team responsible for anaesthesia and pain management may have received different training and therefore have different competencies, as a result of which the choice they make will not be an equal one? Will they be informed that different standards will inevitably mean that one place of care will be better and safer than the other? I think not. As doctors, patients will be thankful that your competence will be revalidated. Your patients’ safety is in your hands; keep it there.

References
1 Nurses and Midwives Council website (www.nmc.org)
Accessed 19.12.04
The College’s journal

Professor G Smith, Past Vice-President, BJA Editor 1987–1997

The College’s journal, the British Journal of Anaesthesia known universally as the BJA, is the second oldest anaesthetic journal in the world. It was founded in 1923, the year after the launch of Anesthesia & Analgesia Current Researches. The first editor was H M Cohen, an American who served for a time in the US army but settled eventually in Manchester. Past distinguished editors of the BJA include Joseph Blomfield, E Faulkner-Hill, T Cecil Gray (a past Dean of the Faculty of Anaesthetists), J Edmund Riding (also a past Dean of the Faculty), Alastair A Spence (a past President of the Royal College), William Fitch, and Jennifer M Hunter. The current Editor is Charles Reilly who commenced his term of office in June 2004.

The Royal College of Anaesthetists (RCoA) originated in 1948 as the Faculty of Anaesthetists of the Royal College of Surgeons. Although there were some discussions about a union between the Faculty and the BJA it was not until an independent College metamorphosed from the Faculty in 1988 that such a union occurred in 1990. Although the RCoA and BJA are still legally independent charities, all the business activities of the journal are governed by a BJA Management Board which consists of equal numbers of representatives of the RCoA and the BJA Editorial Board. Editorial control of the journal resides in a fully independent BJA Editorial Board. In recent years, the membership of the Editorial Board has widened considerably; currently members of the Board are drawn from around the UK and also from Belgium, Denmark, France, Germany, Sweden and Switzerland together with Corresponding Board Members from Australia, Canada, Japan and the USA. The President and Vice-Presidents of the RCoA are ex officio members of the Editorial Board.

The success of a journal is often determined by the combination of its circulation size and its impact factor. Of all the journals of anaesthesia published in Europe, the BJA has the largest circulation size, currently in excess of 15,000 (including subscribers with internet only access). The first impact factors produced by the Institute of Scientific Information in the USA were published in its Journal Citation Reports of 1975 and since that date, with the exception of two aberrant years, the BJA has always been the European anaesthetic journal with the highest rating. Currently, it is second to Anesthesiology for journals which are described traditionally as anaesthetic journals (Table 1).

Table 1 Latest impact factors (2003) for journals ranked under Anesthesiology

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<thead>
<tr>
<th>Ranking</th>
<th>Journal</th>
<th>Impact factor</th>
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<tbody>
<tr>
<td>1</td>
<td>Pain</td>
<td>4.556</td>
</tr>
<tr>
<td>2</td>
<td>Anesthesiology</td>
<td>3.503</td>
</tr>
<tr>
<td>3</td>
<td>BJA</td>
<td>2.365</td>
</tr>
<tr>
<td>4</td>
<td>Anesth Analg</td>
<td>2.210</td>
</tr>
<tr>
<td>5</td>
<td>Clin J Pain</td>
<td>2.080</td>
</tr>
<tr>
<td>6</td>
<td>Anaesthesia</td>
<td>2.041</td>
</tr>
<tr>
<td>7</td>
<td>Eur J Pain</td>
<td>1.770</td>
</tr>
<tr>
<td>8</td>
<td>Region Anesth Pain M</td>
<td>1.766</td>
</tr>
<tr>
<td>9</td>
<td>Acta Anaesth Scand</td>
<td>1.680</td>
</tr>
<tr>
<td>10</td>
<td>Eur J Anaesth</td>
<td>1.217</td>
</tr>
</tbody>
</table>

It should be noted that, whilst publishers, advertisers, university promotion committees (especially in Europe) and grant awarding bodies may be enamoured of the impact factor, caution should be exercised in interpreting this measure and the writer has already drawn attention to its inherent problems.1 Irrespective of impact factors, however, it is acknowledged universally that the BJA remains the pre-eminent European anaesthetic journal.

The purpose of this short article is to draw the attention of the reader to activities which are not part of the BJA’s core function of producing a scientific journal.

Supporting research

Until the early 1970s, the BJA was barely viable financially but, following a change of publishers, the improved financial state of the journal allowed the Board to allocate funds for supporting research. The total amount allocated for funding research gradually increased from the 1980s up to a peak of almost £220,000 pa. Following the union of the BJA with the RCoA, this activity is now part of the RCoA’s overall commitment to supporting academic activities. Research Fellowships, project grants, and grants in aid of research are administered by a RCoA/BJA Grants Committee which is currently chaired by Dr David Lambert. In the last year of full accounting, the total

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amount of research funding allocated by the RCoA/BJA exceeded £420,000 and thus it is the UK charitable body distributing the largest amount of funding for research in anaesthesia, critical care and pain management.

Writing workshops

In order to assist inexperienced writers to create manuscripts suitable for publication, in the late 1970s the BJA developed its famous annual ‘writing workshops’. These workshops, the first of their type in anaesthesia, were held for many years at various centres around the UK and, in addition to formal lectures, participants were given the opportunity of discussing a draft scientific manuscript on a one-to-one basis with a Board Member or senior academic. These workshops and all the expenses of the participants were funded entirely by the BJA. They became so popular that the Board proposed the concept of hosting a session at each World Congress of Anesthesiology (WCA) on a variety of issues related to publication. The first of these BJA sessions was held at the WCA in Washington DC in 1988 and it proved so successful that it spawned many imitators; sessions on publication/conduct of research are now to be seen frequently at many national and international meetings. The BJA has continued to appear at every WCA since 1988 and the sessions seem to remain extremely popular. The original writing workshop has now been incorporated into the College’s annual programme of CEPD and it comprises a day devoted not only to the construction of a scientific manuscript but also to many aspects of conducting research. The current organiser of this event is Professor Philip Hopkins.

The Electronic Anesthesia Library (TEAL)

Following informal discussions in 1992 at the WCA in Holland between the writer and Professor R Miller, then editors of the BJA and Anesthesia & Analgesia respectively, agreement was reached on an exciting collaborative arrangement between the two journals. This was joined by Anesthesiology and the Canadian Journal of Anaesthesia resulting in TEAL, a CD-ROM containing all the peer-reviewed material published by the four journals within a five-year period. Professor Miller has observed that the speed at which this project moved from initial discussions to production was amazing in view of the fact that this required the agreement of four different editors, four different Societies, and four different publishers. As a result of advances in technology, the latest version of this project has been released in the form of a DVD-ROM which incorporates all the original peer-reviewed material published by these four journals during the period 1991–2003. All the surplus CD-ROMs have been donated to WFSA for distribution to departments of anaesthesia in underdeveloped countries.

Continuing Education in Anaesthesia, Critical Care & Pain Management (CEACCP)

After almost a decade of discussion within the BJA Editorial Board on the merits of producing a review journal devoted to continuing medical education, action was eventually taken in 2001 with the advent of an enthusiastic Editor-in-Chief in the shape of Professor David Rowbotham. Originally termed BJA:CEPD Reviews in its first two years, CEACCP (as it has been known since 2004) is designed to contain material suitable for continuing education in anaesthesia, critical care and pain management and in particular it aims to cover all the core topics described by European Union of Medical Specialties (UEMS). It represents one of the important methods by which the RCoA provides CEPD material for all its Fellows, Members and Associates. The production of CEACCP is overseen by a Board of Editors which is effectively a sub-committee of the main BJA Editorial Board. Articles in CEACCP should not be confused with review articles appearing in the general or annual Postgraduate Educational issues of the BJA; these latter articles are designed specifically to review latest advances and the cutting edge of research in areas relevant to both clinical aspects and basic science pertaining to anaesthesia. All the costs associated with the production and distribution of CEACCP are borne by the BJA.

Distribution of the RCoA Bulletin

Using desktop publishing software, the College Bulletin is produced on a disk every two months by the College’s Editorial Officer. The disk is transmitted to the BJA’s publishers, Oxford University Press (OUP), who arrange to have the disk converted to printed format and distribute the Bulletin with the BJA bi-monthly. Since 2001, the costs of printing and distribution have been included within BJA financial accounts.

On-line archives

In July 2000, the BJA was put on-line to provide Internet access to its contents in full text, HTML (Hypertext Markup Language), and also PDF formats. Recently, at a cost of £30,000, back-issues of the BJA were converted into appropriate SGML (Standard Generalised Markup Language) format to provide an on-line archive in PDF files for the years 1995–2000. On-line access to all these files is provided to any individual but only subscribers to the BJA may access the most recent two-year archive.
Recently, OUP has put forward proposals to the Board for creating an on-line archive extending back to the date of publication of the first issue of the journal in 1923. When this has been accomplished, it will provide an extremely valuable reference source particularly for those involved in research or interested in the history of anaesthesia.

**On-line access for underdeveloped countries**

The Board of the *BJA* has made the journal available within a collection of on-line journals from OUP offered to developing countries in conjunction with the International Network for the Availability of Scientific Publications (INASP). The collection is offered free to institutions in the 67 poorest countries in the world and at greatly reduced rates to qualifying organisations from countries with an income of $736–$293 GNI per capita identified through reference to the World Bank reports.

**Teaching Aids at Low Cost (TALC)**

One of the exciting charitable activities undertaken recently by the *BJA* has been the allocation of funds to provide 2000 copies of a CD-ROM containing the first three years’ issues of *CEACCP* for distribution to anaesthetists in underdeveloped countries. The material is written onto CD-ROM by TALC, a UK-based educational charity which supplies material and teaching aids to doctors and other health workers in developing countries.

**Publication of abstracts of the Anaesthetic Research Society and the Intensive Care Society**

The Anaesthetic Research Society is the oldest specialist anaesthetic society in the UK and was founded in 1958. It has been closely associated with the *BJA* since its origin although it is a totally separate organisation. The link is manifest by the fact that the *BJA* publishes those abstracts of ARS meetings which have been approved by both the Society and also the *BJA* Editor. The *BJA* provides this service, at no cost to the Society, in order both to encourage research within the UK and also to disseminate knowledge of work in progress. In recent years, a similar arrangement has been reached with the Intensive Care Society.

**South African and Indian Excerpt editions of the *BJA***

For almost a decade, the *BJA* has allowed reproduction of original research, review articles and editorials to be published in the *South African Excerpt* edition. This journal contains six or seven articles selected by its South African Editor, Professor M F James of Cape Town, and with revenue generated entirely from advertising is distributed free of charge to anaesthetists, anaesthetic nurses, and anaesthetic technicians throughout South Africa and neighbouring countries.

In 2004, the *Indian Excerpt* edition of the *BJA* was launched with Professor Deepak Tempe from New Delhi acting as the local Editor. The *BJA* receives only nominal revenue from these editions as they are regarded primarily as an educational service for anaesthetists in developing countries, who might not otherwise be able to access the journal.

**The new College building**

The most exciting activity which has occupied the *BJA* Board recently has been assisting the RCoA to acquire Churchill House in Red Lion Square, Holborn, for the sum of £8.45 million. The *BJA* invested the sum of £2 million with the College in order to allow this project to go forward. This development, when completed, will provide the largest and best-equipped educational centre for anaesthesia in the UK. It will contain a *BJA* boardroom/library which will represent the first permanent home for the journal and the enhanced space, secretarial and editorial assistance, and increased IT capacity will enable the *BJA*/RCoA to intensify and widen the type of activity described above.

**Summary**

It will be seen from the foregoing that the revenue which the College’s journal generates is used not only to produce a journal but also to provide a wide range of educational and other charitable activities for the benefit of individuals practising anaesthesia, intensive care and pain management – not only in developed countries but also in less fortunate locations throughout the world.

**Reference**

Early every day Charlie McLaughlan, Director of Professional Standards, and his team receive questions from anaesthetists, other healthcare workers, managers, government and other officials and, most frequently, patients. The questions cover a fascinating range of medical and non-medical topics, and we do our best to answer them fully and promptly. Many can be dealt with by reference to our own or the Association’s published guidelines, or by referral to our respective websites. Some questions require reference to other publications and websites such as the joint GMC/NHS appraisal and revalidation website (www.revalidationuk.info). Those needing medical knowledge are usually referred in the first instance to the Professional Standards Advisor, Professor David Hatch, who may seek help from Council members, including the President, with special areas of expertise, or from experts outside the College. We do not give advice to patients on individual healthcare matters for which they should consult their GP or other medical adviser.

Contentious issues may be discussed at the weekly President’s meeting in the College, attended by the President and Vice-Presidents together with the Senior Management Team. Interesting or commonly asked questions may appear as ‘Frequently Asked Questions’ in the Professional Standards section of the RCoA website and some even find their way onto the agenda of a full Council meeting. A couple of the topics about which we have been asked recently are outlined below, as examples of the subjects on which we are asked to advise.

**Anaesthesia Practitioners**

We are receiving an increasing number of enquiries about this proposed new grade of non-medical anaesthetic assistant, not only from anaesthetists but also from theatre nurses and ODPs, some of whom erroneously see the grade merely as an opportunity for them to extend their role. We have made it clear that the Anaesthesia Practitioner grade will only be open to those who have satisfactorily completed the defined course and obtained the necessary qualification. Details of this course and qualification are currently being developed by the College in association with the Modernisation Agency and the NHS University (NHSU), and it has just been announced that it will be delivered by the University of Birmingham in conjunction with the NHSU.

The situation has been complicated by the fact that following the demise of the nursing ENB qualification there is now no course for national ‘anaesthetic nurse’ recognition. Some trusts take NVQ Level 2 for anaesthesia assistance qualifications for ODPs, but other than this, no DH/NHS recognised qualification exists. Other trusts, together with local education facilities, have developed and initiated courses and qualifications which they recognise and indemnify locally.

Further information can be found in the Association’s 1998 booklet on *The Anaesthesia Team*, in the President’s statement in the ‘News’ area of the RCoA website and in Professional Standards FAQ 3.

**Equipment for tonsillectomy**

Some anaesthetists are still unclear as to why our recommendation – that disposable anaesthetic equipment such as LMAs should be used whenever possible for tonsillectomy – differs from that given to surgeons (which incidentally differs in the various parts of the UK). Our answer is that surgical guidance is influenced by the debate as to whether the use of disposable instruments may lead to an increased incidence of complications. We are not aware of such an issue arising in relation to anaesthetic equipment (apart, possibly, from laryngoscopes).

**Guidelines**

Some of the College’s existing guidelines, such as those on paediatric services, are currently being updated. Enquirers regularly suggest topics for new ones, some of which are more within our remit than others, and some more appropriate for the Association than the College. Suggestions include such varied things as the use of cycle helmets by cyclists, suggested reading lists for anaesthetists, how to become a College Tutor, pre-operative assessment clinics and post-operative assessment. The College is happy to consider any sensible suggestions, so keep them coming!
Please note that unless indicated otherwise, lunch is included in the registration fee.

### Airway Workshop
2 March 2005 (code: C96)  
Cardiff Marriott Hotel  
For further details see page 1506.  
Registration fee: £285.

### How to Teach

#### Teaching Methods Workshop
3–4 March 2005 (code: C80)  
The Royal College of Anaesthetists, London  
For further details see page 1506.  
Registration fee: £370.

### Anniversary Meeting

#### Regional Anaesthesia and Analgesia
16–17 March 2005 (code: A03)  
Institution of Electrical Engineers, London  
In addition to the two-day programme, there is an opportunity to meet with colleagues and friends at an informal reception on the evening of 16 March.  
Registration fee: £340 or £270 for trainees registered with the College.  
For further details see page 1507.

### Primary FRCA: Basic Sciences

#### Phase A
11–13 July 2005 (code: A78)  
The Royal College of Anaesthetists, London  
For further details and a registration fee, please see page 1510.

### Core Topic Day, Belfast
September 2005 (code: C37)  
Venue in Belfast to be advised  
A joint meeting with the College of Anaesthetists RCSI. Further details to follow.

### Final FRCA Course
September 2005 (code: A79)  
Clore Management Centre, London  
For further details see page 1511.  
Registration fee: £600.

### Primary FRCA: Basic Sciences

#### Phase B
26–28 September 2005 (code: A71)  
The Royal College of Anaesthetists, London  
For further details and a registration fee, please see page 1510.

### Current Concepts

#### Anaesthesia and the Extremes
3–4 November 2005 (code: B05)  
Institution of Electrical Engineers, London  
Further details to follow.

### Developing Paramedic Practice
13 June 2005 (code: A74)  
The Royal College of Anaesthetists, London  
For further details see page 1510.  
Registration fee £165.

### Core Topic Day

#### Paediatric Anaesthesia
22 June 2005 (code: D08)  
The Royal College of Anaesthetists, London  
For further details please see the website.  
Registration fee: £185 or £115 for trainees registered with the College.

### College Tutors Meeting
7–8 July 2005  
University of Wales Institute, Cardiff  
By invitation only.
AIRWAY WORKSHOP
2 March 2005 (code: C96)
Cardiff Marriott, Mill Lane, Cardiff

10.00 Welcome and aims of the workshop

Split into four groups rotating through each station:
10.15 Station 1: Failed ventilation including cricothyrotomy
    Station 2: Failed intubation and use of ILMA and Proseal
11.45 Station 3: Failed intubation and low skill FOI via airway and LM
    Station 4: FOI setting up, handling skills, decontamination
13.00 Lunch
14.00 Group 1: Awake intubation
    Group 2: Retrograde techniques blind and fibreoptic assisted
    Group 3: Difficult airway trolley and new airway equipment
    Group 4: Extubation and follow-up
16.30 Finish

The focus will be on case scenario, hands-on practice and group discussion.

Please note that there are limited places on this workshop. Priority will be
given to those who have attended a College Airway Day.

It would be ideal to know beforehand (on your application forms) the level of
experience that you have with the familiarisation and or use of core clinical airway
equipment.

Registration fee: £285
Approved for CEPD purposes

HOW TO TEACH
TEACHING METHODS WORKSHOP
3–4 March 2005 (code:C80)
The Royal College of Anaesthetists, London

An intensive two day workshop for all career grades and post-fellowship SpRs, about the teaching techniques that are
useful for anaesthetists who plan and participate in education programmes for medical students, anaesthetic trainees and
career grades.

Delegates will learn how to extend their repertoire of teaching techniques both in theatre and in the classroom. There will
be an emphasis on the skills of planning, teaching and giving feedback. The workshop will include lectures and discussion
groups, and there will also be an opportunity for participants to be videoed making a presentation they prepared before
arrival and to discuss their style with a professional actor.

Lunch and refreshments are included in the registration fee.

Registration fee: £370
Approved for CEPD purposes

Please note that there are limited places for this Workshop.
REGIONAL ANAESTHESIA AND ANALGESIA
16–17 March 2005 (code: A03)
Institution of Electrical Engineers, Savoy Place, London

WEDNESDAY 16 MARCH

09.00 Registration and coffee
09.55 Introduction,
  Dr Peter Simpson, President, Royal College of Anaesthetists

Session 1
10.00 Regional anaesthesia – the last 40 years
  Dr Tony Rubin
10.25 Local anaesthetic drugs and adjuncts
  Dr John Picard
10.50 Regional anaesthesia and analgesia: does it affect outcome?
  Dr Martin Herrick
11.15 Panel Discussion
11.30 Coffee

Session 2
11.55 The Patrick Wall Lecture – ‘Through the gate: new concepts in pain mechanisms’
  Professor A H Dickenson
12.40 Research Presentations (BJA Award Holders)
13.00 Lunch

Session 3
14.00 The Frederick Hewitt Lecture – ‘Leap before you look’
  Professor Sir Graeme Catto, President, General Medical Council
14.45 Annual General Meeting

Session 4
15.00 Peripheral nerve blocks: do we need new approaches?
  Dr William Harrop-Griffiths
15.25 Location, location, location: finding peripheral nerves
  Speaker to be confirmed
15.50 Tea
16.15 Continuous regional anaesthesia and analgesia
  Dr Nicholas Denny
16.40 Teaching and learning in regional anaesthesia
  Dr Tim Johnson
17.05 Panel Discussion
17.30 Reception

Registration fee: £340 (£270 for trainees registered with the College)
Wednesday only £200, Thursday only £190

THURSDAY 17 MARCH

Session 5
09.15 Obstetric regional anaesthesia and analgesia: what is new?
  Dr Ian Russell
09.40 Regional anaesthesia in children
  Dr Jane Peutrell
10.05 Regional anaesthesia/analgesia for day-case surgery
  Dr Ian Jackson
10.30 Panel Discussion
10.45 Coffee

Session 6
11.15 Continuous spinal anaesthesia
  Dr Mark Blunt
11.40 Epidural analgesia: how to get it to work
  Dr Graeme McLeod
12.05 Paravertebral block
  Dr Jonathan Richardson
12.30 Panel Discussion
12.45 Lunch

Session 7
13.45 Coagulopathy, anticoagulation and regional anaesthesia
  Professor Tony Wildsmith
14.10 Nerve damage: causation, investigation and management
  Dr Michael Hudspith
14.35 Consent for regional anaesthesia
  Dr Andrew Hartle
15.00 Mini debate – ‘Routine use of regional anaesthetic techniques on the anaesthetised adult patient should no longer be considered acceptable practice’
  For: Dr David Bagod
  Against: Dr Barrie Fischer
15.30 Panel Discussion

Close and Tea

Approved for CEPD purposes
CARDIAC DISEASE AND ANAESTHESIA
14–15 April 2005 (code: C55)
The Royal Northern College of Music, Manchester

THURSDAY 14 APRIL
09.00 Registration and coffee
09.45 Introduction

Session I – Hypertension
09.55 Is there a strong rationale for deferring elective surgery in patients with poorly controlled hypertension?
Dr B Casadei, John Radcliffe Hospital, Oxford
10.20 Current treatment of hypertension
Professor D G Beevers, City Hospital, Birmingham
10.45 Treatment: do anaesthesia interactions affect outcome?
Professor J Sear, John Radcliffe Hospital, Oxford
11.10 The Hypertensive patient: Cancel or not?
Professor G MacGregor, St George’s Hospital, London
11.35 Discussion
11.55 Coffee

Session II – Valvular heart disease
12.20 Pathophysiology and haemodynamics
Dr L Cotter, Manchester Royal Infirmary
12.45 Anaesthetic management for non-cardiac surgery
Dr M Patrick, Whythenshawe Hospital Manchester
13.10 Discussion
13.20 Lunch
14.20 Macintosh Eponymous Lecture
‘Identifying high-risk hospital patients’
Dr D Goldhill, Royal National Orthopaedic Hospital, London

Session III – The adult with congenital heart disease
15.10 Overview of grown-up congenital heart disease
Professor J Deanfield, Great Ormond Street Hospital London
15.35 Anaesthesia for non-cardiac surgery in the grown-up congenital heart disease patient
Dr M Barnard, University College Hospital London
16.00 The failing right ventricle
Dr A Redington, The Hospital for Sick Children, Toronto, Canada
16.25 Discussion
16.40 Tea

Session IV – Drugs for cardiac patients
17.00 Angiotensin antagonists: implications for anaesthesia
Speaker to be confirmed
17.25 Beta-blockers for all?
Professor P Foëx, Radcliffe Infirmary Oxford
17.50 Discussion
18.05 Reception for all participants

FRIDAY 15 APRIL

Session V – Coronary heart disease
09.00 Pathophysiology of coronary heart disease
Professor S Cobbe, Royal Infirmary, Glasgow
09.25 Screening for coronary artery disease
Dr A Kelion, Harefield Hospital, London
09.50 Myocardial preconditioning and the Anaesthetist
Dr M Zaugg, University Hospital, Zürich
10.15 Adrenergic mechanisms: heart and brain
Professor M Maze, Chelsea & Westminster Hospital, London
10.40 Discussion
11.00 Coffee

Session VI – The patient with heart failure
11.25 Pathophysiology and treatment of heart failure
Professor A Struthers, Dundee
11.50 Advances in inotropic support
Dr R O Feneck, St Thomas’ Hospital, London
12.15 Anaesthetic management of the patient with heart failure
Dr D Royston, Harefield Hospital
12.40 Discussion
13.00 Lunch

Session VII – Pace-makers and temporary pacing
14.05 Anaesthesia and conduction disorders
Dr J P van Besouw, St George’s Hospital London
14.30 The patient with a pace-maker
Dr D Zideman, Hammersmith Hospital London
14.55 Discussion
15.10 Guest Lecture – Reducing the cardiac risk in CAD patients undergoing non cardiac surgery
Professor P Coriat, Hôpital Pitie-Salpetrière, Paris
16.00 Close and tea

Registration fee: £340 (£270 for trainees registered with the College)
Thursday only £200, Friday only £190
Approved for CEPD purposes
AIRWAY DAY
RECENT ADVANCES
19 May 2005 (code: C19)

The Royal College of Anaesthetists, London

This recent advances day will concentrate on areas within airway management that have undergone considerable change in the last few years. The day is designed for trainees, SAS and consultants in anaesthesia or critical care with particular emphasis on those engaged in airway management training.

10.00 Introduction and welcome
An overview of recent advances
Dr Adrian Pearce (London)

10.15 Physiological perspectives on oxygenation and apnoea
Dr Jonathan Hardman (Nottingham)

10.45 Recent advances in management of the lost airway
Dr Chris Frerk (Northampton)

11.15 The rise and rise of supraglottic airways
Dr Tim Cook (Bath)

11.45 Discussion on previous 3 talks

11.55 Are national airway guidelines beneficial? – a debate with the audience
Dr John Henderson (Glasgow)

12.25 Three interactive case histories – to be discussed after lunch
Dr Tony Turley (Llandough)

12.30 Lunch

13.30 Panel discussion

13.50 The educational value of the previously presented case histories
Dr Tony Turley (Llandough)

14.25 Extubation strategies

15.05 Single use airway equipment
Dr Mark Blunt (Kings Lynn)

15.35 Good practice and medicolegal considerations
Dr Ian Calder (London)

16.00 Close of meeting

Registration fee: £185
Approved for CEPD purposes

Please note that there are limited places on this meeting.

HOW TO TEACH
AN INTRODUCTION
24 May 2005 (code: C18)

Venue in London to be advised

Topics will include:

- An introduction to teaching adults
- How to give a lecture
- Teaching for small groups and tutorials
- Using PowerPoint effectively
- Teaching in theatre

Registration fee: £185 or £115 for trainees registered with the College
Approved for CEPD purposes

Please note that there are limited places for this meeting.

SLEEP DISORDERS
AND ANAESTHESIA
25 May 2005 (Code: C77)

The Royal College of Anaesthetists, London

Subjects to include:

- Definition of obstructive sleep apnoea
- Medical disorders commonly affecting patients with sleep apnoea and relevant to anaesthesia
- Recognising and diagnosing the patient with sleep apnoea
- Practical management of the patient with sleep apnoea undergoing surgery for unrelated disorders
- Management of post-operative problems in patients with sleep apnoea
- Palatal surgery, sleep apnoea and anaesthesia
- Safe anaesthetic management of the child with obstructed breathing during sleep
- Is pre-eclampsia really a breathing related sleep disorder?
- Narcolepsy, restless legs syndrome and anaesthesia
- Sleep problems in patients on the intensive care unit

Registration Fee £185
Approved for CEPD purposes
CURRENT TOPICS IN ANAESTHESIA
6–8 June 2005 (code: A32)

Holiday Inn, St Nicholas Circle, Leicester

This course consists of three days of lectures, each of which is followed by ample time for discussion. It is intended for doctors engaged in clinical anaesthesia (ie Consultant, Specialist grade or their overseas equivalent) who feel that they may benefit from a refresher course in the latest techniques. Places will not be allocated to anaesthetists in training. The programme will cover topics under the following headings:
- Scientific foundations of anaesthesia and their clinical implications.
- Advances in anaesthesia, intensive care and pain.
- Local and regional anaesthetic techniques.
- Anaesthetic equipment and monitoring.
- Postoperative care.

Places are limited on this popular course and you are strongly advised to apply as soon possible.

Registration fee: £390
Approved for CEPD purposes

DEVELOPING PARAMEDIC PRACTICE 2005
13 June 2005 (code: A74)

The Royal College of Anaesthetists, London

A comprehensive annual one day seminar for anyone associated with the ambulance service and the provision of prehospital care be they paramedics, doctors, nurses or RTOs. Speakers cover a wide variety of topical subjects relevant to current practice and there is plenty of opportunity for open discussion, the day’s proceedings being reported each year in Ambulance UK.

Registration fee: £165.00
Approved for CEPD purposes

PRIMARY FRCA: BASIC SCIENCES COURSES

The three phases of the Primary FRCA course can be attended in any order and trainees will be able to come to one, two or all three to suit their individual needs. The cost of each phase will be £200. All three phases booked at the same time will cost £550. Each phase will include one evening of tutorials.

Phase A 11–13 July 2005 (code: A78)
Phase B 26–28 September 2005 (code: A71)
Phase C 21–23 March 2005 (code: C73) and 21–23 November 2005 (code: A89)

If you are interested in attending, please check the Courses and Meetings pages of the College website for further details and an application form.

PHASE A
Cardiovascular
- Cardiovascular drugs
- Ventilators and artificial ventilation
- Anaesthesia and the heart
- Respiration
- Cardiovascular physiology

Physiology of special systems
- Renal physiology
- Nutrition and metabolism
- Metabolic response to injury
- Acid base balance
- Liver

PHASE B

Physics
- Breathing systems and low flow
- Statistics and research methodology
- Physics
- Electrical safety
- Measurement and monitoring
- Anatomy

Pharmacology
- Pharmacokinetics
- Intravenous induction agents
- Adverse drug reactions
- Neuromuscular blocking drugs
- Pharmacology of local anaesthetists

PHASE C

Physiology of special systems (I)
- Endocrinology and anaesthesia
- Neurophysiology of pain
- Autonomic nervous system
- Cerebral physiology
- Paediatrics
- Neurophysiology
- Pregnancy, placenta and foetus

Pharmacology
- Applied pharmacology of pain
- Inhalation agents
- Mode of action of drugs

Physiology of special systems (II)
- Anatomy
- Gastric physiology and pharmacology
**SASGs as Teachers**  
9 June 2005 (code: D10)  
*Holiday Inn, St Nicholas Circle, Leicester*  

Please note there are limited places for this meeting. Topics will include:  
- Teaching small groups.  
- Teaching practical procedures.  
- Teaching in theatre.  
- Using PowerPoint.  
- Developing your portfolio.  

*Registration fee: £185*  
*Approved for CEPD purposes*

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**Final FRCA Course**  
September 2005 (code: A79)  
*Clore Management Centre, 25–27 Torrington Square, London*  

This course is intended for those studying for the Final FRCA Exam and consists of lectures on anaesthesia, intensive care and pain relief. The lectures run throughout the day – Monday to Friday. Each participant will be entitled to attend four tutorials during the course. Those wishing to apply for admission to the course are strongly advised to do so as soon as possible as places are strictly limited.

Please do not use the generic registration form. Forms for this course are available from the Courses and Meetings Department at the College, or can be downloaded from the College website at: www.rcoa.ac.uk.

*Registration fee: £600 (excludes lunch)*  
*Approved for CEPD purposes*

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**Preliminary Notice**  
**Core Topic Day, Belfast**  
September 2005 (Code: C97)  
*Venue in Belfast to be advised*  

A joint meeting with the College of Anaesthetists, RCSI. Further details to follow.  
*Approved for CEPD purposes*

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**Courses and Meetings**  
**Booking Procedures**

A generic application form for all events, except FRCA courses, is contained in every edition of the *Bulletin*. This is also available to download from the College website (www.rcoa.ac.uk/courses).

Application forms for the Final FRCA course and Basic Sciences course for the Primary FRCA are available separately from the Courses and Meetings Department.

Once a course or meeting and the relevant fee have been publicised, bookings on the generic application form will be accepted at any time. The appropriate fee must be paid at the time that the booking is made (bookings will not be accepted for events that do not show a fee). If your Hospital/Trust is paying your registration fee, please pass the completed application form to the relevant person for forwarding with payment.

To ensure that bookings are processed correctly, it is essential that the booking form shows the code number, title and date of the event being booked, e.g. C19 – Airway Day, 19 May 2005.

All courses and meetings are open to all grades of anaesthetist (unless specifically stated otherwise). Bookings will be accepted on a first come first served basis. When a course or meeting is full this will be publicised on the College website. For several weeks before major meetings, details of vacancies will be available on the Courses and Meetings Department ansaphone.

**Fees and Cancellations**

Payment for all College courses and meetings can be made by Sterling cheque, payable to ‘The Royal College of Anaesthetists’, Switch, or Credit Card (Mastercard/Visa/Delta).

Notice of cancellations must be given in writing to the Courses and Meetings Department at the Royal College of Anaesthetists at least ten working days before the course or meeting commences in order to qualify for a refund. All refunds are made at the discretion of The Royal College of Anaesthetists and are subject to a £25 administration fee. Delegates cancelling after this date will NOT be entitled to a refund unless the Royal College of Anaesthetists considers there to be exceptional circumstances that would warrant a refund.

**Accommodation**

Local hotel information will be sent to you on receipt of your application.

**Application Forms**

Completed generic application forms should be returned to the: Courses and Meetings Department, Training and Examinations Directorate, The Royal College of Anaesthetists, 48/49 Russell Square, London WC1B 4JY  
switchboard 020 7813 1900  
ansaphone 020 7813 1888  
fax 020 7636 8280  
email educ@rcoa.ac.uk
# Delegate Details (Please Use Block Capitals)

- **Full name:**
- **College Reference Number (CRN):**
- **Full mailing address:**

This address is (tick ✓ one only):  
- Temporary  
- Permanent  

**Date of birth:**  
- Day:  
- Month:  
- Year:  

**Tel:**

**Fax:**

**Email:**

**Present appointment and hospital:**

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# Meeting/Course Details (Please Use Block Capitals)

**Title:**

**Date:**  
- Day:  
- Month:  
- Year:  

**Code:**  

**Registration fee:** £  

**Members of the Senior Fellows Club are entitled to attend College Meetings at Half Price.**

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# Payment Information (Please Use Block Capitals)

Sterling cheques should be made payable to “The Royal College of Anaesthetists”

Please charge my credit card (tick ✓ whichever is appropriate):  

**Total remittance:** £  

**Card number:**

**Expiry date:**  
- Month:  
- Year:  

**Issue number (Switch only):**

**Start date (Switch only):**  
- Month:  
- Year:  

**Cardholder’s name:**

**Signature:**

**Date:**  
- Day:  
- Month:  
- Year:  

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THE ROYAL COLLEGE OF ANAESTHETISTS  
48–49 Russell Square, London WC1B 4JY  
**Switchboard** 020 7813 1900  
**24 hr ansaphone** 020 7813 1888  
**fax** 020 7636 8280  
**email** educ@rcoa.ac.uk
Since stepping down as College President in June 2003, my everyday life has changed out of all recognition. Initially feeling as if I was sailing off romantically into the sunset, I was quickly brought down to earth by the necessity to have a new job plan, local throughput targets, medical school expansion and car parking. My old office had become a storeroom and, to add insult to injury, on one occasion I was asked when I had started work in Birmingham! Since then, I’ve had plenty of time for reflection and my perspective has once more become that of a worker on the so-called ‘front line’ who experiences the consequences of centralised NHS, University and College decision-making at the amoebic end of the food chain.

My first observation was the anxiety that people had (and continue to have) over their job plans. Outside activities again seem to be coming under disproportionate pressure: doctors still feel ‘got-at’ and some undoubtedly feel that the illusory class war exemplified by the fox hunting debate is alive and well in the NHS. It is, however, greatly to the public’s benefit that College Members and Fellows are allowed to represent patients’ interests as set out in our Charter. I would therefore ask that whenever a colleague stands for Council of the College or the Association or some other professional body, rather than resenting them, take the trouble to back them. If turbulence occurs with the management, get into negotiation mode as a group to sort things out. Most managers are decent people whose lives are ruled by diktats and targets and they need our advice and flexibility to make sure that by being generous to individuals they are not putting themselves or the organisation at risk.

**Progress in medical care in the last 25 years**

Over the last 25 years, for me, in the treatment of human disease there are three major areas that stand out:

- the increased accuracy of diagnosis
- the increased predictability of the progress of a disease once diagnosed
- the increased use of protocols in the management of disease.

The combined effect of these has been the growth of non-medically qualified personnel in clinical management across all subject areas. By reducing uncertainty, progress has, in effect, de-mystified our profession. Anaesthesia, intensive care and pain management have all played their part in this process. Most of the drugs I use regularly in clinical practice have been introduced since I qualified in medicine; nurses run pre-operative clinics and provide post-operative pain services; monitoring equipment is easy to use and reliable. The list goes on and on. How should we respond in this environment of progress and greater predictability? For those of us of more mature years, it is surely simply illogical to continue practising in the way we did during our training.

**Demographic change, funding and health economics**

People know about demographic change: it gets plenty of publicity because of worries over the future funding of pension plans. It is my belief that its impact on health services is not really appreciated. In 2002 Oeppen and Vaupel demonstrated that, for the last 150 years, life expectancy has increased at the rate of 2.5 years per decade and that this trend shows no signs of stopping. The consequence is that a large percentage of children born today will live to be over 100 years old. Currently in the UK, the life expectancy of 65-year-olds is 23 years for women and 20 years for men. Data from the Department of Health (DH) indicate that 80% of NHS resources are consumed by 15% of the population and that demands increase rapidly over the age of 65 years. Compounding this is the falling birth rate and the future relative reduction of people in work to fund healthcare through taxation. Whatever happens, as time passes, the gap between resource and demand will widen: some sort of rationing is inevitable. The current policy developed in Oregon of setting a budget and then deciding by professional and public consultation what is possible may well become a model adopted by others.

The objective of health economists is to deliver the agreed health provision in the most cost-effective way and to anticipate and plan for future trends. As the economic clamp tightens, their power over events will increase. It is essential that the College works with them so that the correct decisions are taken, rather than have solutions imposed that are in the best interests of neither patients nor clinicians. This means looking at the way we provide services and maintain quality from the point of view of the patient and the paymaster rather than ourselves. There is, to date, little evidence that we are, as a profession, doing this: it is an area that needs urgent attention.
The Government and Foundation Trusts

The Government has the unenviable role of being blamed for any failure in the NHS. Furthermore, as services improve, norms will be reset and complaints will continue. The Government is continuously in a no-win situation that is compounded by its current enthusiasm for the choice agenda.

Part of the Government’s problem is the size of the NHS and the media perception that Whitehall is somehow responsible for every problem that arises. The Government has undoubtedly done the right thing in breaking up the service into more manageable blocks but could usefully have worked up in more detail the consequences of foundation hospitals (which I, in fact, support), before putting them on the statute books.

The ramifications of foundation status for anaesthetists warrant speculation. Reading some of the articles in management journals and listening to some DH spokespersons, one gets the impression that well run hospitals will find themselves bursting at the seams with patients exercising ‘choice’ and so generating continuous financial surpluses. This is simply garbage. At the moment we are in a honeymoon period and my advice to any CEO who is successful over the next few years would be to move on (possibly to become an inspector of foundation trusts) before the bubble breaks.

The exact powers and limitations of foundation hospitals will probably only be decided by the courts. By creating them the government has, either deliberately or inadvertently, transferred the future management of rationing from the centre to the periphery. When rationing bites, as it inevitably will, reality will dawn. Since many foundation trusts are the recipients of Private Finance Initiative (PFI) funding and other forms of private finance that adversely affect the profit and loss account, this day may come sooner than we think. Only cash, not paper profit, matters to the men in grey suits some of whom are, after all, looking after our pension funds.

What will happen if a hospital goes bust? Will it be like the United States and simply close down with the staff left to find other jobs? Being Britain, probably not, but it could be put into the hands of a receiver. In UK law, a receiver has huge powers and the current philosophy in industry is that the receiver should try to maintain the profitable parts of the business as a going concern rather than simply disposing of the assets to compensate the creditors. This might mean that certain services would be preserved, others would be closed and others might be outsourced. Compulsory redundancies would occur with re-employment at a later date on the hospital’s terms so as to keep it competitive. To those with a mortgage and a growing family, some employment is better than none. Units within a hospital would be compared with external provider teams, the on-costs of training would come under scrutiny and medical staff would be appointed to deliver service without the flexibility enjoyed by current consultants.

The evolution of the specialty, consultant status and other countries

When the Faculty was created in 1948 it was unambiguously directed towards the administration of anaesthesia. At that time, intensive care and pain management had not been invented but now, together with A&E and acute medicine, they form the future. It is to the credit of our specialty that it has, over time, embraced new directions to improve the peri-operative care of patients. At the same time, surgeons have become more operative in their focus and physicians have become more orientated to sub-specialty and long-term management. It is this wider spectrum of activity that we now need to capture and to which we should direct the College. With this as an objective, closer links with A&E Medicine are vital. Perhaps thought should also be given to creating subdivisions within the College looking after anaesthesia, intensive care and pain management, the College acting as the statutory umbrella organisation with its own operational units working closely with the Faculty of A&E Medicine. Clearly, we also need to recognise the value of non-medically qualified personnel and welcome them into the fold.

Although the data are soft, it is my understanding that at least half the anaesthetics administered are on ASA 1 and 2 grade patients, they last for no longer than 45 minutes and the surgeon stays within a few centimetres of the skin. Do these cases really need to be done by a consultant, or can they be delegated to others without loss of safety or quality? The evidence from around the world (and the lack of contrary evidence from the UK) is that delegation to doctors with a shorter training than UK consultants or to appropriately trained non-medical staff can achieve the same outcomes provided that they are in consultant-led teams. Consequently, we do need to re-define what we mean by a consultant: it cannot be somebody who only does easy lists and has minimal responsibilities outside the clinical area. I do have some sympathy with those associate specialists who say the only difference between them and some consultants is that they represent better value for money.

One comparison that will continually be made is that of the UK with other developed countries. What will be found in the latter is that over 75% of hospitals have few or no trainees, that in all hospitals doctors qualified to specialist level provide 24-hour cover and that there is a pyramidal medical career structure. Training in the UK is now no longer the best available in the world. In the UK as working
hours were reduced consultants failed to grasp the nettle and concentrated more on maintaining trainee on-call rotas than on looking radically at methods of service delivery. My impression from overseas visits is that senior staff members in other countries are now doing more service delivery than UK consultants and are providing 24-hour cover. In short, we risk becoming bad value for money. Perhaps the threat of in-hospital on-call returning to satisfy demands for service delivery by ‘trained clinical staff’ will stimulate a more sensible approach to specialist registration. Should we, for instance, lower the level of the CCST to produce a specialist and only allow the privileges of consultant status to those who re-apply later having shown their worth or having had further training?

Conclusions

The future of healthcare provision is likely to become more, rather than less, of a battleground, with the causes of war being economic. Foundation status will make these into local rather than national conflicts and medical staff may find themselves being made redundant if hospitals go into receivership. The wisdom of having trainees in almost every hospital will be brought into question. To represent patients in all hospitals the College will therefore need to be linked not only through the traditional training axes in the form of the Postgraduate Medical Education and Training Board (PMEFTB) and the Council of Postgraduate Medical Deans (COPMeD) but also within other statutory bodies such as the Healthcare Commission and the Health Professions Council.

Because of the success of medical endeavour in increasing the understanding and management of disease, there will be a paradoxical reduction in the status of doctors unless doctors’ roles shift to those which cannot be fulfilled by other healthcare workers. Maintenance of the present ‘flat’ career structure is uneconomic and consultants (as opposed to specialists) may become re-defined as those (few) members of staff who deliver care beyond established protocols and/or who manage the service or training.

The responsibility of the College to the public must be to anticipate such events and to protect the public from the adverse consequences of decisions being made on poor evidence by those who have to balance the books. This can only be achieved by the College maintaining its hegemony so that it is able to influence decisions as they are made rather than merely responding to events. Simply reacting to events as they occur risks becoming irrelevant. To maintain its hegemonic position the College requires a ruthlessly realistic view of the future, a drive towards giving value for money, the acceptance of a plurality of providers and a realignment of our College’s professional portfolio to encompass the whole of acute provision. It also requires elected representatives to put the time and effort into making sure that our influence is felt from the highest level downwards, and the support of others to enable them to do so.

With the political landscape being populated more and more by career politicians with no alternative professional fall-back position, Robert Louis Stevenson’s view that ‘Politics is perhaps the only profession for which no preparation is thought necessary’ is becoming ever more relevant. It is very important that politicians have the proper information to make the best decisions: if we do not supply it, somebody else or some other group will. The Government has been elected by the public to run the country and it has committed huge resources to the NHS. This should be recognised and we need to make sure that the money is spent to its best effect.

Of course, when you aren’t responsible for implementation, it’s easy to be free with advice as I have been in this article, and, after all, as Bismarck said ‘Politics is the art of the possible’. Thank goodness it’s now other people’s responsibility to worry about such things.

References

2. www.dhs.state.or.us/healthplan/overview.html.
Introduction

The report on The Confidential Enquiry into Maternal and Child Health (CEMACH) into maternal deaths in the United Kingdom for the triennium 2000–2002 has just been published. The first triennial report of the Confidential Enquiry into Maternal Deaths (CEMD) was published in 1952. CEMACH was moved recently to be under the umbrella of the National Institute for Clinical Excellence (NICE), but is shortly to move again to the National Patient Safety Agency (NPSA). This is the first of the Maternal Death reports to be published under CEMACH. The aim of the Enquiry is to help ensure that all pregnant and recently delivered women receive safe, high quality care delivered in appropriate settings based on their individual needs.

The report is important to a wide range of healthcare professionals including public health specialists, general practitioners, midwives, obstetricians, staff in accident and emergency departments, psychiatrists, anaesthetists and pathologists. It is important to recognise that the report is relevant to all anaesthetists, not just obstetric anaesthetists.

This report does not contain any surprises but discourages us from becoming complacent as many of the problems and recommendations for improvements have been highlighted in previous reports. In this article I shall comment on the key findings and their relevance to anaesthesia.

Key findings

The enquiry considers deaths in the following categories:

- **direct**: deaths directly related to pregnancy
- **indirect**: those due to pre-existing maternal disease aggravated by pregnancy
- **coincidental**: those due to a cause unrelated to pregnancy
- **late**: those occurring between six weeks and one year following delivery

There were 391 maternal deaths reported to the Enquiry in this triennium and they fall into the following groups:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct</td>
<td>106</td>
<td>27%</td>
</tr>
<tr>
<td>Indirect</td>
<td>155</td>
<td>40%</td>
</tr>
<tr>
<td>Coincidental</td>
<td>36</td>
<td>9%</td>
</tr>
<tr>
<td>Late</td>
<td>94</td>
<td>24%</td>
</tr>
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</table>

There were 261 deaths due to direct and indirect causes this triennium (compared with 242 in the last triennium), giving a rate of 13.1 maternal deaths per 100,000 maternities. This is not a statistically significant increase on the previous triennium. The main direct causes and rates of maternal death remain unchanged, with thromboembolic disease, haemorrhage and hypertensive disease of pregnancy leading the field. There has been an increase in deaths due to haemorrhage and anaesthesia though this may not be of statistical significance.

The numbers of deaths in the indirect category exceed those due to direct causes and this reflects the increasing number of women who become pregnant with significant intercurrent medical problems, and the need for good communication between medical disciplines. Within the indirect deaths, the most common cause is psychiatric disease though not all these deaths were reported to the Enquiry but were identified through the Office for National Statistics.

The report identified the following risk factors for maternal deaths:

- social disadvantage
- poor communities
- minority ethnic groups
- black African women
- late booking or poor attendance
- obesity
- domestic violence
- substance abuse.

This is no surprise to those of us in clinical medicine, particularly those who work in large cities, as we have been well aware of a rise in the refugee population as well as an increased incidence of obesity, substance abuse and social deprivation.
Obesity

The particular problems of obesity have been highlighted recently as a national problem and within maternity units. Body mass index (BMI) is regularly charted where some years agoweighing the woman was thought to be insulting. The obese pregnant population is an excellent group to target for health education and this is an area in which midwives and other healthcare professionals should be actively involved. We as anaesthetists and in particular obstetric anaesthetists need to be proactive about discussing the increased risk factors surrounding analgesia and anaesthesia and obesity, preferably in the antenatal period. It is much easier to place an epidural catheter early in labour rather than hope that the woman will not need us, and then be forced to try to put in a spinal anaesthetic or give a general anaesthetic in a hurry. Obese pregnant women are becoming more prevalent and I have recently started to see some of them in my obstetric anaesthetic assessment clinic where the indication for a consultation is a BMI ≥40 unless the woman has other medical problems.

Social disadvantage and ethnic minorities

The report highlights the need for a service that is approachable and flexible enough to meet the needs of all women from all walks of life and in particular the need for professional interpreters. It is essential to take a good medical history with the assistance of a professional interpreter in the antenatal period to enable planning for intrapartum care; intrapartum care should also be arranged with an interpreter where appropriate. Consent for regional analgesia and anaesthesia is often forgotten and relying on relatives in an emergency is far from ideal when good explanation could have been given in the antenatal period. The Obstetric Anaesthetists Association (OAA) has recognised this need and the Information to Mothers leaflets are now translated into many languages. Without good communication an anaesthetist may well be put in a situation where he or she needs to administer general anaesthesia as the only option in a situation that is out of control. This may have been the case in one of the women who died as a result of general anaesthesia discussed in the report’s anaesthesia chapter.

History taking and care planning

The antenatal history is an essential part of planning high quality care in appropriate settings for each woman. The report discusses the problems of information about the pregnant woman not being passed to the midwife from the general practitioner. The midwife taking the history must take responsibility for a clear and comprehensive history and the maternity record usually uses a series of tick boxes as a guide. I am not sure how accomplished midwives are at taking a good medical history and, though it is an integral part of medical training, it may be an area that should receive a higher profile in midwifery training. As healthcare professionals we need to be aware that a woman with a serious medical problem may conceal the severity of the condition as she may have been told not to become pregnant and is thus fearful of the reaction of the professionals. Women with significant medical problems should seek antenatal counselling and early antenatal care with input from relevant specialists so that care can be planned. This may include termination of pregnancy, an area where delays were highlighted in the report. This is all part of making the system accessible to everyone.

Once a history has been taken, plans for an appropriate ‘bundle of care’ can be considered and this should include the place of delivery. The woman should be given a clear account of the services that are available at each place so that she can make a fully informed choice. It is particularly important that those women who choose low risk care understand the limitations of the service, as there is usually no access to epidural analgesia, emergency medical care of the neonate, or blood transfusion. In stand-alone units there need to be clear protocols for patient transfer in an emergency. Women with medical problems should be delivered where there can be suitable support for their medical condition, as well as specialist care, during the antenatal period. Many of these women will need to be delivered in a tertiary referral unit and all specialists need to communicate well to ensure that each woman is delivered in the most appropriate place, which may be, for example, a cardiac unit for women with severe cardiac problems. Co-ordinated multidisciplinary care is recommended many times in the report and this does mean that we all have to speak to each other and formulate plans with the woman and her family. Perhaps the word multidisciplinary is incorrect and interdisciplinary would be better as it would suggest we talk together – rather than just involving many personnel in many disciplines in isolation who may not be talking to each other or to the woman. The creation of a team to care for high risk women – for example women with cardiac disease – may need to be considered.

Medical Disease

During the antenatal period the report highlights the failure or late diagnosis of common medical conditions, in particular the failure to recognise common signs of critical illness such as pyrexia and rapid pulse. This failure may be due to an increase in the numbers of direct entry midwives who have not had the experience of looking after sick non-pregnant patients, and to the relative inexperience of our trainees in medicine.
All of the above demonstrate the importance of good antenatal care and planning and, with this, the intrapartum care should be delivered in the appropriate setting. Consultant obstetric units should have ‘dedicated’ anaesthesia services. The revised guidelines for the provision of anaesthesia services and an updated joint document on obstetric anaesthetic services produced by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the OAA (soon to be published) will help purchasers and anaesthetists achieve an appropriate standard of service for their unit. This guidance encompasses the epidural service, anaesthesia, recovery and high dependency.

The assessors for the report felt that much of the clinical care was excellent though it was still suboptimal in over half the women who died. There were problems in recognising signs of illness and incorrect diagnoses were made, leading to ineffective or incorrect treatment and this was coupled with a failure to seek advice from senior colleagues, a problem that has been highlighted in successive reports. The failure to seek senior help was particularly evident in the women who died from hypertensive disease of pregnancy and haemorrhage. All professionals, including anaesthetists, failed to call for help either from a more senior colleague or colleague in another discipline. As there may be a shortage of ITU beds, the report stressed the need for intensive care to commence on the maternity unit perhaps with the support of outreach teams.

**Anaesthesia**

There were six direct deaths due to anaesthesia in this triennium and one late death and, though this rise may not be statistically significant as the numbers are small, it ensures that we as anaesthetists do not become complacent. There were also 20 deaths where anaesthesia contributed. All the direct deaths were due to general anaesthesia. An estimate of one death due to general anaesthesia in 20,000 is made in the report extrapolated from the 2000 figures showing that 91% of elective and 77% of emergency Caesarean sections were performed under regional block. The relatively small number of general anaesthetics given for Caesarean section has led to a lack of experience. There are few general anaesthetics administered for planned Caesarean sections, therefore relatively few teaching opportunities may arise for an individual trainee. Training in obstetric anaesthesia has improved and the development of competency-based assessment should avoid anaesthetists working inappropriately without direct supervision. As anaesthetists we have to recognise the increased complexity of many of the cases we look after. Therefore, anaesthetic consultation must be part of the antenatal assessment to ensure there is an appropriate level of anaesthetic care available. The rationalisation of maternity services has reduced the number of areas where anaesthetists are isolated, though maternity units on the same site as a general hospital often isolate themselves with security codes and may be physically difficult to reach via long corridors.

The discussion within the anaesthetic chapter brought out the following:

- failure to recognise oesophageal intubation
- lack of a capnograph
- failure to check the anaesthetic machine
- failure to follow a failed intubation drill
- anaphylaxis
- inhalation of gastric contents
- delay in treating cardiac arrest.

All of these are problems we encounter in our everyday practice and they are not specific to maternity. Maternity patients are more vulnerable to problems associated with general anaesthesia and the presence of the baby sometimes leads us to forget the basic principles of maintaining oxygenation, or prompt treatment in the event of a cardiac arrest or anaphylaxis. There is no excuse for failing to check the anaesthetic machine: checks must occur at each shift change.

The report found that the general problems of language, obesity and failure to call for help all contributed to the mortality. This was shown to be particularly so in the indirect deaths where anaesthesia contributed. The failure to ask for help was seen particularly in the indirect deaths and is not confined to trainees but includes consultant anaesthetists who may fail to ask for help from their anaesthetic colleagues. We often need another pair of hands, or advice from our intensive care colleagues or colleagues in other disciplines, for example, haematology or cardiology.

**Conclusion**

We have come a long way in improving maternity care but will need to continue to respond to the challenges of the future. I will leave you with the words of one of our recent trainees. At the end of the obstetric module I was asking whether he had enjoyed the module and what he had learnt. He said that two of the things he had learnt were that consultants often themselves needed help for difficult cases and above all it was really important to be nosey.
New developments in postgraduate training for anaesthesia and intensive care medicine (ICM) have been unfolding during the last three years. As Lead Dean for both specialties I have been part of this process, aiming to support the College and the Intercollegiate Board in advancing the needs of those they represent. This has required effective networking with the College and between the College, the Department of Health, the Postgraduate Deans, Regional Advisers and trainees across the UK. This role has required me to act as a manager, adviser, honest broker and representative. I have also used my roles as Chair of the Modernising Medical Careers Delivery Board and as a member of the Postgraduate Medical Education and Training Board (PMETB) to advance the needs of the specialties.

High quality training programmes

I am impressed by the selfless commitment of all of those I have met in the anaesthesia and ICM meetings in improving training programmes and the quality of patient care. I believe that training programmes in both specialties are of exceptional quality and are leading the way for other specialties to follow in the new era of Modernising Medical Careers. It is impressive how the Royal College of Anaesthetists has raised the standards of training and led the way in competency-based assessment and curriculum design. It will be easy for the College to develop the curricula further to meet the needs of Modernising Medical Careers and the PMETB.

I have been very pleased to become involved in the steering committee of CoBaTrICE (competency-based training in intensive care medicine in Europe). This project is led by the inspirational Dr Julian Bion from Birmingham and involves partnership work with universities across Europe and the Picker Institute. The aim of CoBaTrICE is to use consensus methods to develop an internationally acceptable set of common ‘competencies’ for specialists in ICM across Europe. The underlying principle of the project is that an intensive care doctor trained in one European country should possess the same core skills and abilities as one trained in another, thereby guaranteeing a common basic standard of clinical competence. It is about establishing an international consensus on the basic minimum skills expected of doctors completing their training in intensive care. By focusing on competencies, the project makes it easier to ensure a common international standard, independent of the duration of national training programmes. This is groundbreaking work that is years ahead of other specialties.

Workforce planning

One of the key roles as Lead Dean is to contribute to workforce planning for the specialties of anaesthesia and ICM, including recommendations on the distribution of National Training Numbers (NTNs) for specialist registrars in England. By working closely with the College and the Intercollegiate Board I aim to promote the needs of the specialties through representation at the Conference of Postgraduate Medical Deans (COPMeD) and through the Department of Health’s central mechanisms in liaison with the Workforce Review Team which works on behalf of the Workforce Numbers Advisory Board (WoNAB).

It is my responsibility to manage NTNs for specialties that are increasing or decreasing, in accordance with the Department of Health’s national policy in England. I am delighted that anaesthesia and ICM have seen large increases in NTNs over the last few years. This has been a tremendous opportunity but there have also been problems with balancing the pressures of increasing the numbers while maintaining the quality of the training programmes. I hold the national stock of NTNs and distribute these to Postgraduate Deans who wish to obtain extra numbers. This has been quite onerous because of the dramatic increase that has resulted from trusts investing in new training numbers to help address their need to comply with the European Working Time Directive. It has been a very challenging time for Regional Advisers who, while being delighted at the increase in NTNs, have needed to ensure that the trusts and Postgraduate Deans do not exceed the appropriate numbers of trainees in a particular trust and that there are appropriate numbers of tertiary placements on the programmes. This has been particularly difficult when many of the teaching trusts have not had the means to fund new placements. I have also tried to support the needs of those seeking research placements and particularly the
increasing number of flexible trainees who are appointed to specialist registrar (SpR) posts. On top of all of that we have all worked hard to increase the number of SHO posts in the specialties in order to feed the increasing SpR numbers!

**Specialty specific advice**

An important role that I have developed, through gaining particularly deep insights and keeping abreast of specialty specific issues, is to act as a focal point for responding to queries, questions and requests for advice; these come from a range of sources including colleague Postgraduate Deans and their teams and also from workforce development confederations and strategic health authorities.

What I don’t do is provide advice for individual trainees or for trainees with difficulties who are normally the responsibility of local Postgraduate Deans and their staff. There are, however, rare occasions when Lead Deans are asked for advice in confidence outside their local deanery. Most of these issues are sorted out by Regional Advisers but occasionally I do get involved in a supportive role. I never get involved in acting on behalf of individual trainees in appeals against the appointments process or discussion about the management of a training programme, unless this is part of a Training Committee or Board discussion following a visit.

Over the last three years I have immersed myself in anaesthetic and ICM training issues and have travelled the length and breadth of the UK to meetings and conferences. CoBaTrICE has also led me to European meetings that have allowed me to compare our programmes with those across Europe. We are in very good shape and leading the way – I look forward to the future with great optimism and with enthusiasm for my continuing work as Lead Dean.

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**AS WE WERE ...**

**The Great Divide ...**

‘The desirability of frequent blood pressure observations during the procedures of general surgery is receiving increasing recognition, and in our opinion such observations should be made during all prolonged and serious operations.

‘In spinal anesthesia there is a fall of blood pressure greater than that found in any other form of anesthesia, and the evidence given by repeated blood pressure readings often enables the surgeon to anticipate and prevent collapse and death from the intradural injection. There are few, if any, recorded deaths under spinal anesthesia where the anesthetist or surgeon has followed the guide of frequent blood pressure readings and has adopted proper restorative treatment.’

(W Wayne Babcock, Blood Pressure in Relation to Spinal Anesthesia, *Anesthesia and Analgesia* 1925, 222.)

‘It is a mistake to take frequent blood pressure readings as this disturbs a patient greatly, and sufficient information can be obtained by the observation of his colour and the characteristics of his pulse.’


‘During the operation a constant watch must be kept on the pulse and respiration for the first signs of impending failure. It is usually unnecessary to take repeated blood pressure readings …’


‘Sphygmomanometer readings are of little use in estimating the efficiency of the cardio-vascular system during spinal anaesthesia.’

(T A B Harris, *The Mode of Action of Anaesthetics*, Livingstone, Edinburgh 1951, 348.)

David Zuck

History of Anaesthesia Society
The background

The College completed the purchase of Churchill House in January 2004. Since then we have obtained full approval from Camden Council for the planning permission application that we submitted to develop it into 34,000 square feet of education centre and offices, including a 150–160 seat tiered lecture theatre, examination floors, and flexible workshop / breakout spaces. When completed there will be four floors of education centre and four floors of office space. Considerable time was spent in selecting the correct team of advisors at the beginning of the project and this has proved to be incredibly valuable. The design has progressed very well and a tendering exercise was undertaken to select a main contractor for the project. A clear winner emerged, references were taken up and on Friday 5th November contractual details were finalised and the President signed contracts to enable the contractor to commence work on Monday 8th November. The site was handed over to the contractor and is now their responsibility.

Progress

The construction work is split into two phases, enabling works and main contract. The first phase removes things that we do not want and allows the design to be finalised by testing the structure of the building. The second phase actually builds what we want. The enabling works contract is nearly complete and we have accelerated some works into this first phase in order to reduce delay later (e.g. removal of the main lift to leave an empty shaft, clearance of old redundant plants and the creation of some apertures in the concrete structure). Scaffolding is nearly all the way up the building and we are negotiating with large poster companies who wish to place adverts on the scaffolding. Income from this venture may be considerable and, if secured, will be reinvested in the project to deliver additional benefits.

The initial survey at purchase showed a small amount of asbestos was present in the building, so a total search and complete strip out of this was included in the enabling work using a specialist licensed contractor. The comprehensive report by that contractor shows that the search revealed no additional asbestos or other hazardous materials and, by 13th December, none at all will be present in the building. In January we will be negotiating the main contract and a Guaranteed Maximum Price.

The architects gave a presentation to Council in November on the colours and designs for the interior spaces to ensure that their designs remained in line with Council’s wishes. All was very well received and I am pleased to report that we are still all travelling in the same direction. The architects utilise computer generated graphics to demonstrate how their designs will actually look and these images are stunning. One image of the lecture theatre is shown above.

Other related organisations such as the Intensive Care Society and the British Pain Society have pronounced that they wish to benefit from Churchill House and will be joining us there, retaining their own autonomy but allowing all organisations to benefit from economies of scale and the efficient use of resources.
On 1 October 2004, the Royal College of Anaesthetists had 12,940 Fellows, Members and trainees who have a current association on the database. This map identifies the countries around the world where these Fellows, Members and trainees reside. In total the College is represented in 77 countries around the world. Countires where there is only on representative of the College have not been marked on the map.
Distribution of Fellows, Members and trainees of the Royal College of Anaesthetists around the world

<table>
<thead>
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<th>Country</th>
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<th>Fellows</th>
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<td>Vietnam</td>
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<tr>
<td>Cayman Islands</td>
<td>3</td>
<td>TOTAL</td>
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ELECTION TO 
THE SCOTTISH BOARD 2004

The election of three Fellows to consultant vacancies and one Fellow to NCCG vacancy on The Scottish Board took place on Monday, 6 December 2004. The votes were counted by Electoral Reform Services (ERS).

Consultant vacancies
Consultant members of the Board are elected by Fellows and Associate Fellows resident in Scotland. The first term of service for the candidate elected to this vacancy is three years and the second term is three years. Three consultant vacancies on the Board occurred in December 2004. These were caused by the retirement of Dr Cameron Howie, who completed his full term of office, and the completion of one term of office by Dr John McClure and Dr Paul Wilson. Dr McClure and Dr Wilson were eligible for re-election for a second term of three years. Those eligible to stand were Fellows by Election, Fellows ad eundem, and Fellows by examination of the College of four or more years’ standing, resident in Scotland and complying with the conditions of the Ordinances and Regulations.

The results of the consultant candidates are as follows:

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<th>Elected (in order of seniority)</th>
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<td>Wilson Paul</td>
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<th>Not elected (in order of seniority)</th>
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<tbody>
<tr>
<td>Webster Nigel Roger</td>
<td>93</td>
</tr>
<tr>
<td>Kinsella John</td>
<td>178</td>
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</table>

- The total number eligible to vote was 630.
- The total number actually to vote was 378.
- There were no invalid votes.

NCCG vacancy
NCCG members of the Board are elected by Fellows, Associate Fellows, Members and Associate Members resident in Scotland. The first term of service for the candidate elected to this vacancy is three years and the second term is three years. There was one vacancy for an elected Board member following the resignation of Dr Christine Robison. Those eligible to stand were Fellows and Members of the College complying with the conditions of the Ordinances and Regulations and who were neither a consultant nor a trainee.

Dr Kate Wilson, being the only candidate for this vacancy by the closing date, has therefore been duly elected without ballot, effective Monday, 6 December 2004.
At a meeting of Council on **Wednesday, 17 November 2004**, the following was admitted as **Regional Adviser**:

**Triservices**
Dr D A Hett, Southampton General Hospital  
(in succession to Surgeon Captain C G Johnston)

The following were admitted/re-admitted as **College Tutors**:
(re-appointments are marked with an asterisk):

**Anglia**
Dr M T Memon, Hinchingbrooke Hospital, Huntingdon  
(in succession to Dr A S Majeed)

**Northern**
*Dr F M E McMenemie, Wansbeck General Hospital, Ashington

**South Thames (East)**
Dr H M Hartley, St Thomas’ Hospital, London  
(in succession to Dr C Mallinson)  
*Dr E A Wheatley, King’s College Hospital

**West Midlands (South)**
*Dr J M Budd, Worcester Royal Hospital  
Dr R J Elton, University Hospitals Coventry and Warwickshire NHS Trust  
(Acting College Tutor for six months in Dr A J Thacker’s absence)

At a meeting of Council on **Wednesday, 15 December 2004**, the following were admitted/re-admitted as **College Tutors**:
(re-appointments are marked with an asterisk):

**Oxford**
Dr C P Leng, Northampton General Hospital  
(in succession to Dr M B Wilkinson)

**Northern**
Dr S Stein, South Tyneside Hospital, South Shields  
(in succession to Dr J H Carter)

**Yorkshire**
*Dr M D J Donaldson, Hull Royal Infirmary

**North Thames (West)**
Dr S I Jaggar, Royal Brompton Hospital  
(in succession to Dr A A Kelleher)  
Dr M B Hacking, Royal Marsden Hospital  
(in succession to Dr G P R Browne)

**West of Scotland**
*Dr I T Davidson, Southern General Hospital, Glasgow  
*Dr G J Wardall, Falkirk and District Royal Infirmary

**South Thames (East)**
Dr M R J Parsloe, Conquest Hospital, St Leonards-on-Sea  
(in succession to Dr A P Stoddart)

**Nottingham and East Midlands**
*Dr L A Woods City Hospital, Nottingham

**Leicester and South Trent**
Dr V B Tore, Grantham and District Hospital  
(in succession to Dr N D Platt)  
*Dr A S Wolverson, Lincoln County Hospital

**West Midlands (South)**
Dr D R Derbyshire, Warwick Hospital  
(Acting Tutor to cover the absence of the College Tutor on maternity leave)
Correspondence

Please make your views known to us via email (preferred option) to: bulletin@rcoa.ac.uk, or by post accompanied by an electronic version on floppy PC disk, preferably written in Microsoft Word (any version), to: The Editor, c/o Mrs Mandie Kelly, Editorial Officer, The Royal College of Anaesthetists, 48/49 Russell Square, London WC1B 4JY. Please include your full name, grade and address. All contributions will receive an acknowledgement. The Editor reserves the right to edit letters for reasons of space or clarity.

Study leave – can the NHS afford it?

Madam, – Like many Board areas in Scotland, my Board has a serious financial deficit. One casualty of this economic crisis is the study leave budget for career grade staff. In my hospital, the budget for course fees has been set at £280 per person per year. Afficionados of College courses will realise that this sum will barely pay the registration fee for one two-day College meeting. There has been much wailing and gnashing of teeth but three points come to mind.

Firstly, it is stipulated in both old and new consultant contracts, and in the SAS contract, that study leave which is approved should be funded. Without study leave, appraisal and revalidation are threatened and our credibility as teachers for a variety of students and postgraduates (think Foundation Years) is jeopardised. If not us, the consultants, who is going to pick up all the teaching/training responsibilities that lie ahead?

Secondly, it is not all really need to go to London for educational meetings. Members and Fellows of UK Colleges, which are always based in London, have continuously suffered in this respect, but to their credit both the RCoA and the Association have in recent years organised more regional meetings. That needs to continue and indeed be expanded. I won’t name the College administrator who several years ago defended the lack of local meetings by saying that few would attend and it would be difficult to attract speakers of international calibre. Not so – the Scottish meetings I have attended have been excellent. There will of course be some specialties or sub-specialties where only national or international meetings can provide the appropriate level of peer interaction but for the majority perhaps one national meeting per year can be supplemented with regional meetings.

Lastly, our universe has shrunk thanks to expertise in communications. Perhaps we don’t need to travel at all now to ‘attend’ meetings – video-conferencing has arrived, albeit patchily. A radiologist colleague recently attended such a meeting in Glasgow’s Royal College of Physicians and Surgeons, video-conferenced from London. Travel was cheap and easy, subsistence was zero, the registration fee was considerably reduced and the meeting was excellent. This must surely be the way forward and the College and the Association should pursue it as a matter of urgency.

In the ideal world funding would be unlimited, as it once seemed to be. However, this is the real world, and for so long as patients suffer from NHS underfunding it will become increasingly difficult to defend unnecessary study leave expenses, contractual right or not. Alternatives are both available and adequate – we should develop and use them.

V T Reid, Consultant, Lanarkshire, Scotland

Research competencies

Madam, – I recently had an opportunity to attend the course on ‘Research Competencies in Anaesthesia’ organised by the Anaesthetic Research Society in Leeds. My first impression was that it is mainly intended for specialist registrars, but an encouraging and uplifting statement made by Professor Harmer and Dr Hall laid my fears to rest. ‘It is important to understand that the ability to attain a level of research education is not dependent on the point a trainee is in the rota, or their seniority; all levels can be attained by SHOs and specialist registrars.’

The BMA Medical Academic Staff Committee (MASC) has proposed injecting research awareness into Foundation Year 2 trainees at an early stage. This would provide a positive opportunity to stimulate academic careers in all areas, including those disciplines that have been under-represented in the past. An approach proposed is to make the career pathway for aspiring young academics flexible enough to allow interdisciplinary training. This is especially true of surgery, anaesthesia and applied physiology. It is
appropriate that all trainees should have a knowledge of research methodologies and show some involvement in audit or a research project.

The ‘Research Competencies in Anaesthesia’ course included an interesting combination of the ABCDE of research, presentation and publication (A – approval from R&D, B – BJA Editor’s tips for publication, C – critique of paper, D – design of study, E – ethics). Obviously, the ABCDE indicated here is not a step-by-step approach, but the course provided clear insight starting from finding a question to getting your research published. First hand information about practical problems faced by trainees and their solution made the overall scenario clearer.

The trainees need to be aware of any opportunities that can be created.

J Kaur, Clinical Observer, Nottingham

References
2 Proposal for an academic component of the foundation years programme under Modernising Medical Careers. BMA Medical Academic Staff Committee, 4 March 2004 (revised 26 March 2004).

Organ donation and transplantation

Madam, – Mr Rudge pleads for more organs for donation (Bulletin, November 2004, pg 1386–1387), noting especially the increased refusal rate by relatives from 30% reported in 1992 to 44% now. Until there is more openness about the condition of donors, whose bodies are clearly alive when organs are harvested, I believe that the refusal rate will continue to increase. The donors are not actually dead any more than a boxer is actually knocked out when the referee stops the bout, declaring a technical knock-out. In America the September Kennedy Institute of Ethics Journal is devoted to reconsidering the ‘dead donor rule’, as it becomes increasingly apparent that there are many signs of life in the donor. Attention is moving from the brainstem to the thalamus as a source of some sort of consciousness. The suggestion is that we should abandon the pretence that donors are dead and begin to consider how to treat them more humanely as dying persons, but not yet dead. This will bring its own difficulties and may not increase the number of donors, but will have the virtue of honesty.

D J Hill, Emeritus Consultant Anaesthetist, Cambridgeshire
Haemolytic jaundice can be associated with

A  An increase in urobilinogen in the urine  T / F
B  Increased blood alkaline phosphatase  T / F

May be used in the treatment of organophosphorus poisoning

B  Propranolol  T / F
C  Atropine  T / F

Infective endocarditis

C  Associated with low complement levels  T / F
D  Pyelonephritis is a common complication  T / F

Dystrophia myotonica

D  The NMJ is affected  T / F
E  Is found in males only  T / F

Monday 28th March – Friday 1st April

University Hospital Aintree
£300
(Includes Breakfast & Lunch)

For details and an application form please visit our website: www.msoa.org.uk

E  Life expectancy is increased by success in examinations  T / F
Anonymised Comments of Earlier Courses:

‘Practice at physical/mental stress of writing for 3 hours’

‘Excellent course’

‘A very useful technique’

‘Very practical approach to the SAQ exam’

‘Very good technique’

‘Allows structured construction of answer’

‘Very well organised and structured course’

‘Very good on 12 questions at a stretch training’

‘Bit exhausting, but well worth it’

‘Mersey way of SAQ seemed a bit frightening until you actually try it’

‘Unique course’

‘It has delivered exactly what I expected’

‘I am self-funded and feel it has been money well spent’

‘An Eye Opener: would have failed otherwise!’

‘Well convinced’

‘The course provides excellent practice for the exams’

‘Very well run, it shows how strict discipline is extremely valuable for this exam’

I wasn’t convinced at the start of the course – but I am now’

‘Money well spent!’

‘I would highly recommend it’

‘Excellent value!’

‘I was suspicious of the technique at first – now I am utterly converted’

‘I was dubious about stylised technique at the start of the course, but once practised, it seems a good idea’

I will be recommending this course to colleagues’

‘Excellent technique taught’

‘The course being of a weekend is perfect’

‘2 days is good for the objective of the course’

‘A very useful course to learn a technique of answering SAQs’

‘I am satisfied with this course, it is worth spending the money’

‘At the end of the course I really felt that I had learnt the art of answering the SAQ’

2 pm Friday April 1st – 4 pm Sunday April 3rd

University Hospital Aintree

Registration fee: £250 – includes Breakfast & Lunch on the Saturday & Sunday. For details and an application form please visit our website: www.msoa.org.uk.

(Study Leave Funding is NOT available to Mersey Deanery trainees to attend this course)
The European Society of Regional Anaesthesia and Pain Therapy
Great Britain and Ireland Section

22nd Annual Scientific Meeting
12–13 May 2005
Beardmore Conference Hotel, Clydebank, Glasgow

The meeting will occur principally on Friday 13th May, with additional workshops on upper limb, lower limb blocks and ultrasound on Thursday 12th. The programme will include:

- Regional Analgesia for Lower Limb Arthroplasty
- Peripheral Infusion Techniques
- Accelerated Recovery Programmes in Practice
- Advances in Sedation
- Free paper presentations
- The Bruce Scott Guest Lecture

The faculty includes local and visiting speakers from Europe and North America

Approved for CEPD purposes

For further information visit the ESRA website at: www.ragbi.org or contact Ms Lorna Macdonald, Department of Perioperative Medicine, Golden Jubilee Hospital, Beardmore Street, Clydebank, G81 4HX or email lorna.macdonald@gjnh.scot.nhs.uk tel ++44 (0)141 951 5600

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BRISTOL MEDICAL SIMULATION CENTRE
Forthcoming courses for 2005

17–18 March – Transport for the critically ill course, for anaesthetists and EM staff (£275)
7 April – Low-flow anaesthesia course for anaesthetists (£150)
22 April – OSCEs, for Primary FRCA SHOs (£100)
5 May – Paediatric anaesthesia course (SJM), for occasional paediatric anaesthetists (£150)
19–21 May – Society for Europe for Simulation in Applied Medicine (SESAM) for simulation enthusiasts and users
25–26 May – Team training for core critical incidents, for nurses and clinician (£270)
9 June – Senior consultant refresher course, for consultant anaesthetists (£150)

Fees include coffee, tea, biscuits and lunch. All courses approved for 5 CEPD points (1 day) and 8–10 points (2 days)

For bookings please contact Alan Jones, Centre Manager, The Bristol Medical Simulation Centre, UBHT Education Centre, Level 5, Upper Maudlin Street, Bristol BS2 8AE tel 0117 3420108 email alan@simulationuk.com; and/or visit the website at www.simulationuk.com (this contains course details)

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The Association of Anaesthetists of Great Britain and Ireland

22–24 June 2005

20–23 September 2005
Annual Congress 2005
Manchester

19–22 September 2006
Annual Congress 2006
Aberdeen

More detailed information can be obtained from the Association of Anaesthetists of Great Britain and Ireland, 21 Portland Place, London WC1B 1PY tel 020 7631 1650 fax 020 7631 4352 email meetings@aagbi.org website www.aagbi.org
APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

The College would like to congratulate the following who have been admitted:

**Associate Fellow**
November 2004
Dr Henry Koranteng Gyasi
Dr Vesna Colovic
Dr Mohammad Tayyab
Memon
Dr Arka Genähr

**Member**
November 2004
Dr Steven Charles Benford

December 2004
Mujeebur Rehman
Dr Alison Jane Keay
Dr Kim Hong Lim

**Associate Member - November 2004**
Dr Thomas Oommen

December 2004
Dr Ludovicus Petrus Johannes Van Der Heijden

DEATHS

The College regretfully records the deaths of the following Fellows:

Dr W K Jones, Macclesfield
Dr D W J Cullingford, London
Professor H Ruben, Denmark

The following obituaries are available on the website at: www.rcoa.ac.uk/index.asp?PageID=79

Professor Sir D Campbell, Glasgow
Dr J M Imray, Aberdeen

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College would like to congratulate the following Fellows on their consultant appointments:

Dr Gareth P Sellors, Worcestershire Royal Hospital
Dr Kaushlendra P Karn, Queen Elizabeth Hospital, Gateshead
Dr Rahul Basu, Nottingham City Hospital
Dr Morag Renton, Freeman Hospital, Newcastle-upon-Tyne

Deaths

The College regretfully records the deaths of the following Fellows:

Dr W K Jones, Macclesfield
Dr D W J Cullingford, London
Professor H Ruben, Denmark

The following obituaries are available on the website at: www.rcoa.ac.uk/index.asp?PageID=79

Professor Sir D Campbell, Glasgow
Dr J M Imray, Aberdeen
Chirocaine Solution for Infusion (Levobupivacaine Hydrochloride) Prescribing Information. Presentation: Two presentations are available; Chirocaine Solution for Infusion (Levobupivacaine Hydrochloride) in polypropylene bags in packs of 10. Indications: Adults: Chirocaine: Pain management – Continuous epidural infusion, for the management of post operative pain and labour analgesia.

Indications: Children: Pain management – Continuous epidural infusion, single or multiple bolus epidural administration for the management of pain especially post-operative pain in labour analgesia.

Dose and Administration: Chirocaine bags: Chirocaine solution for infusion is for epidural use only. It must not be used for intravenous administration. Careful aspiration before and during injection is recommended to prevent intravascular injection. If toxic symptoms occur, the injection should be stopped immediately. The maximum dose must be determined by evaluating the site and physical state of the patient. The maximum recommended dose during a 24 hour period is 40ml. For posterior pain management, the dose should not exceed 10 35mg/hour. For intrathecal use, the dose should not exceed 5 10mg/hour. Chirocaine ampoules: The precise potency will depend upon the procedure and individual patient concerned. Careful aspiration before and during injection is recommended to prevent intravascular injection. If a large dose is to be injected, e.g. ampoule bagged, a short-dose of 5 75mg/hour (Propacaine) with attention is recommended. If inadvertent intravascular injection may then be recognised by a temporary increase in heart rate and accidental distal injection by signs of a slow block. Aspiration should be repeated before and during administration of a bolus dose, which should be injected slowly and at a maximum dosage, of a rate of 3.5 5.0mg/min, while slowly observing the patient’s vital functions and maintaining an end-tidal carbon dioxide level recommended single dose is 10mg. The maximum recommended double dose is 20mg. For posterior pain management, the dose should not exceed 10mg/hour. For intrathecal use, the dose should not exceed 5mg/hour. In labour, the maximum recommended dose of levobupivacaine hydrochloride is 1.25mg/kg/hour.

Indications: Chirocaine bags and ampoules: General contra-indications related to regional anaesthesia/analgesia, regardless of the local anaesthetic used should be taken into account. Intravenous regional anaesthesia (Bier’s block): Patients with severe hypotension: e.g. cirrhosis, shock, use of pressor drugs in haemodynamic and known hypertensives in adrenal local anaesthetic agents on vital contra-indications. Chirocaine impure: Local anaesthetic 7.5mg/ml is contraindicated for obstetric use due to an excitatory risk for cardiac events based on experience with bupivacaine. There is no experience of levobupivacaine 7.5mg/ml in obstetrics.

Precautions: Chirocaine bags: General warnings related to regional anaesthesia, regardless of the local anaesthetic used, should be taken into account. Epidural anaesthesia with any local anaesthetic may cause hypotension and bradycardia. All patients must have intravenous access established. The availability of appropriate fluid, vasopressor, resuscitation equipment and expert must be ensured. Levobupivacaine should be used with caution for epidural anaesthesia in patients with, impaired cardiovascular function e.g. severe cardiac disease; or in patients with chronic renal disease with normal renal blood flow e.g. diabetics or diabetics. Intravenous: Chirocaine bags and ampoules: Administration of levobupivacaine may be affected by CYP3A4 inhibitors e.g.: ketoconazole, and CYP1A2 inhibitors e.g.: methylxanthines. Levobupivacaine should be used with caution in patients receiving anti-arrhythmic agents e.g. quinidine, as it may affect the cardiac conduction system and cause ventricular arrhythmias. Levobupivacaine may increase the risk of cardiac arrhythmias and in patients with liver disease or with reduced liver blood flow e.g. diabetics or cirrotics. Interactions: Chirocaine bags and ampoules: Administration of levobupivacaine may be affected by CYP3A4 inhibitors e.g.: ketoconazole, and CYP1A2 inhibitors e.g.: methylxanthines. Levobupivacaine should be used with caution in patients receiving anti-arrhythmic agents with local anaesthetic activity, e.g. quinidine, as it may affect the cardiac conduction system and cause ventricular arrhythmias. In patients with liver disease or with reduced liver blood flow e.g. diabetics or cirrotics.

Interactions: Chirocaine bags and ampoules: Administration of levobupivacaine may be affected by CYP3A4 inhibitors e.g.: ketoconazole, and CYP1A2 inhibitors e.g.: methylxanthines. Levobupivacaine should be used with caution in patients receiving anti-arrhythmic agents with local anaesthetic activity, e.g. quinidine, as it may affect the cardiac conduction system and cause ventricular arrhythmias. In patients with liver disease or with reduced liver blood flow e.g. diabetics or cirrotics.

Side Effects: Chirocaine bags and ampoules: Adverse reactions with local anaesthetics of the amide type are rare, but they may occur as a result of overdosage or inadvertent intravascular injection and may be serious. Accidental intravascular injection of local anaesthetics can lead to very high plasma anaesthetic levels of bupivacaine, severe hypotension and cardiac arrest. The most frequent adverse effects are local tissue reactions and local reactions by the drug or its metabolites, e.g. urticaria, edema, transient skin discolorations. Rarely, these may be permanent. Use in Pregnancy and Lactation: Chirocaine bags and ampoules: Levobupivacaine should not be used during early pregnancy unless clearly necessary. The maternal experience of local anaesthetics of the amide type including bupivacaine for obstetric surgery is extensive. The safety profile of such a substance is considerably unknown. There are no data available on the effects of levobupivacaine on human reproduction. However, local anaesthetics are likely to be transferred in the mother’s milk, but the risk of affecting the child of therapeutic doses is minimal. Overdose: Chirocaine bags and ampoules: Accidental intravascular injection of local anaesthetics may cause irreversible toxic effects. In the event of overdose, peak plasma concentrations may not be reached until the patient is stable. Treatment of overdose usually consists of supportive therapy and, in severe cases, treatment with a specific postoperative anaesthetic agent may be required.

Storage Conditions: Chirocaine bags and ampoules: No special storage precautions. Use immediately after opening. Legal Category: POM. Marketing Authorisation Numbers: PL 0037/0404 – Chirocaine Solution for Infusion 0.625mg/ml. PL 0037/0405 – Chirocaine Solution for Infusion 1.25mg/ml. PL 0037/0300 – Chirocaine Solution for Infusion 2.5mg/ml. PL 0037/0301 – Chirocaine Solution for Infusion 5.0mg/ml. PL 0037/0302 – Chirocaine Solution for Infusion 7.5mg/ml.

Sevoflurane Prescribing Information. Presentation: Amber bottle containing 250ml sevoflurane. Indications: For induction and maintenance of general anaesthesia in adult and paediatric patients for inpatient and outpatient surgery. Dosage: MAC values decrease with age and the addition of nitrous oxide (see Summary of Product Characteristics). Induction in adults up to 5% sevoflurane usually produces surgical anaesthesia in less than 2 minutes; in children up to 7% sevoflurane usually produces surgical anaesthesia in less than 2 minutes. Up to 8% sevoflurane can be used for induction in unanaesthetised patients. Maintenance concentrations range from 0.5% to 3%. Elderly: lower concentrations normally required. Administration: Deliver via a vaporiser specifically authorized for use with sevoflurane. Induction can be achieved and maintenance sustained in oxygen or oxygen-nitrous oxide mixtures. Contra-indications: Sensitivity to sevoflurane. Known or suspected genetic susceptibility to malignant hyperthermia. Precautions: For use only by trained anaesthetists. Hypertension and respiratory depression increase as anaesthesia is deepened. Malignant hyperthermia: Experience with repeat exposure is very limited. Until further data are obtained, sevoflurane should be used with caution in patients with renal insufficiency. Levels of Compound A (produced by direct contact with CO2 absorbents) increase with: increase in ambient temperature; increase in anaesthetic concentration; decrease in gas flow rate and increase more with the use of Boyleme rather than sod lime. Interactions: Potentiation of non-depolarising muscle relaxants. Similar to isoflurane in the sensitisation of the myocardium to the arrhythmogenic effect of adrenaline. Lower concentrations may be required following use of an IV anaesthetic. Sevoflurane metabolism may be induced by CYP2E1 inducers, but not by barbiturates. Side-effects: Drug-dependent cardio-respiratory depression. The type, severity and frequency of adverse events are comparable to those seen with other inhalation anaesthetics. Most adverse events are mild to moderate and transient: nausea, vomiting, increased cough, hypertension, agitation and bradycardia. Hepatitis has been reported rarely. Convulsions may occur extremely rarely, particularly in children. There have been very rare reports of pulmonary oedema. As with other anaesthetics, twitching and jerking movements, with spontaneous respiration have been reported in children during induction. Patients should not be allowed to drive for a suitable period after sevoflurane anaesthesia. Use in Pregnancy and Lactation: Use during pregnancy only if clearly needed. It is not known whether sevoflurane is excreted in human milk. — caution in nursing women. Overdosage: Stop sevoflurane administration, establish a clear airway and institute assisted or controlled ventilation with pure oxygen and maintain adequate ventilation function. Special Storage Conditions: Do not store above 25°C. Do not refrigerate. Keep cap tightly closed. Legal Category: POH Marketing Authorisation Number: PL 037/02538. Basic NHS Price: £250 bottle £123.00. Further Information is available on request from Abbott Laboratories Ltd., Abbott House, Burdon Road, Maidenhead, Berkshire SL6 4DE. Ref: P/12/009. Date of preparation: October 2007. Mmc number: 09432/2007/1.0.