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The views and opinions expressed in the Bulletin are solely those of the individual authors, and do not necessarily represent the view of The Royal College of Anaesthetists.
Time to move house

Although I’m writing this at a time when most of us are returning from our summer holidays, it is strange to think that it will be published only a few days before we move into Churchill House, in the middle of November. Although as I have said before, we must not let moving house allow us inadvertently to take our eye of the ball of anaesthesia on the national and local scene, nevertheless this is a very significant step-up for our Royal College and the specialty. It will be both nostalgic and sad to leave Russell Square, which has been a wonderful home for the College, but much has happened in recent years to enhance the significance and recognition of anaesthesia, critical care and pain management. Churchill House will provide the space and facilities to build on this foundation. Furthermore, as a freehold property which we own outright, our new home will provide a valuable asset for our Specialty in the future, rather than a potential liability. And for all our Members and Fellows, we believe that the concept of virtually half of the building being dedicated to flexible use for all aspects of education and training, rather than just for examinations, will make it somewhere with which all of us can identify long after we have passed the final Fellowship!

Although this is a very exciting and exhilarating time for those of us acutely involved with the project, none of this would have been possible without the energy and dedication of many people. Those who established the College within the Royal College of Surgeons in 1988 and those who were instrumental in the obtaining of our Royal Charter, the purchase of the lease and move to Russell Square, all of which occurred in 1992 – the commitment necessary to deliver these major changes and to provide the necessary financial resources was enormous, and we owe our predecessors a great debt of gratitude for providing such a firm foundation. We have been fortunate to be able to continue this progress in the move to Churchill House, and I just hope that others will be able to say the same about this stage in the development of the Royal College of Anaesthetists in future years.

Home thoughts from abroad

Fortunately, I was able to leave for a summer holiday with a relatively empty brain, or at least one free from acute concerns over College activity and Jane and I spent two glorious weeks walking the Tuscan hills, into and out of Siena. There is something about walking through very unspoilt countryside, between medieval towns, many of which were built in the 11th and 12th centuries, which helps to get life into perspective. Although many of the buildings are being developed and restored and the interiors are modern and clean, their shells are still very much original and all unique. Centuries old tree trunks provide major structural beams, juxtapositioned against satellite television aerials. Crumbling masonry, cracks or even gaps in walls are commonplace and everyone still lives there in a relaxed and happy way. Considerations of risk management, health and safety, which, if applied on a UK scale, would undoubtedly inhibit or prevent much of this, are viewed in a realistic and pragmatic way and this is something from which perhaps, we should all be learning a lesson. Whether in healthcare or in other aspects of our lives, do we actually use risk management in the way we should, to manage and balance risk or are we now risk obsessed in the UK and as a result prevent ourselves from actually doing what we would like and enjoy? Many are persuaded to take out expensive and extensive insurance, which they can often ill afford, to mitigate against risk, just because they are too frightened not to do so. Crossing the road and undergoing anaesthesia are both risks, although of a different degree. In theory no-one should ever have an anaesthetic and reducing risk to the minimum would undoubtedly shorten many over-running lists! In healthcare, our job is to minimise risk and to properly inform our patients, allowing them to make a balanced judgement. Equally, in our everyday lives it should be the responsibility of those whose judgement and legislation influences our activity and enjoyment, to ensure that risk is assessed in a sensible and balanced way. Unfortunately and all too often, risk management seems to be becoming bound up in endless bureaucracy surrounding risk avoidance altogether, the easy option being not to do it at all!

The Italian countryside was full of examples of their practical and relaxed approach to life – is the ‘eau’ from the village pump really ‘potable’? The man who demonstrated it to us certainly thought it was! We even saw one man driving his battered Fiat Panda wearing nasal oxygen, travelling reassuringly slowly! Or climbing numerous towers in Siena and San Gimignano and being urged to please not lean out too far at the top. Why – in case you
inadvertently drop something on the people below, but nothing about risk to yourself, which was assumed to be common sense! And no disclaimers either! It is perhaps this lack of being credited with any common sense which one finds so frustrating here in the UK, as exemplified by signs such as ‘Caution, this radiator gets hot’ or, as I saw once ‘no parts of this television set are edible!’ Yet when it was important, we observed risk being minimised far more effectively than we do. You would never see an Italian handling fruit in the supermarket without wearing one of the disposable plastic gloves which are freely available everywhere. We still have a lot to learn. On returning home, we were immediately reminded of our problem, struck by the vast array of negative statements and disclaimers as soon as we set foot on the airport bus. No less than seven were displayed side by side on a single panel behind the driver! By contrast there was no word of welcome to the UK or other similar greeting.

Having been determined to master Sudoku and become very addicted, I was about to ask whether it should carry a health warning, but yesterdays Times convinced me that although it can easily become an obsession, it’s good for preventing cerebral atrophy, so I’ll carry on for now, but only at the gentle and moderate level. Enough of holidays, though anyone wanting to hear more about ‘the Palio’ (the bare-back horse race around the Campo in Siena) only has to ask. Applying risk management to that event, the oldest horse race in history, dating I believe, from the 11th century, would be severely contraindicated!

**Common stem entry programmes**

Now that PMETB has gone live and Foundation programmes are up and running, the Modernising Medical Careers project is rapidly turning its attention to the start of run-through training in August 2007. Having completed their F1, pre-registration year and a further six months or so, graduates will have to apply for the specialty training programme of their choice so that competitive entry can be achieved and trainees allocated to seamless programmes to start in August. Although some may have wanted to become a surgeon or even an anaesthetist ever since they had dismissed the ambition of becoming an engine driver and must be able to pursue this, others will certainly not be ready or equipped to make such a fundamental choice at this stage in their career. However, we believe that many will know into which broad area of medicine they wish to work, for example acute care, primary care or even a system based area such as neurosciences.

For this reason we are exploring a common stem introduction to specialist training in anaesthesia, critical care, acute medicine and emergency medicine, on the basis that many of the competencies will be sufficiently similar to allow the creation of a generic curriculum with transferable skills. Trainees would spend probably the first two years of specialist training in such a post, rotating at regular intervals through these related specialities and achieving common competencies. We believe that this alternative to making an immediate and ultimate career choice at the end of foundation would be very popular with some trainees and prevent them opting for something for which they are subsequently found to be unsuited. It would also be well suited to those training programmes such as intensive care medicine, which require complimentary specialty training.

**So what should we be teaching our trainees?**

While we can be very proud, and grateful to those who designed it, that our competency based training programme is the envy of many other specialities, we must not let it rest there. Extensive discussions are taking place about whether, in every specialty, we are preparing our trainees for the role of consultants in the future NHS. This ‘extended role’ of the Consultant comprises many areas beyond our clinical abilities and for which we all need appropriate training. The basic elements of this could and should be included as generic elements of all training programmes and PMETB will be setting these as principles and standards within the design of curricula. Academic medicine, for all specialities is a good example. On the one hand there is a need for all trainees to understand the basic elements of research and clinical audit, how to critically review an article and the design of clinical trials. Beyond this there will be some who want to undertake research to higher degree level and there must be opportunity to develop this, linked to a clinical training programme, if we are to develop the academic anaesthetists of the future. An understanding of ethics and the issues behind informed consent are also important as key elements of medical professionalism, which is embodied in good medical practice and applying these principles to our anaesthetic curriculum will be important for training in the future. We also need to ensure that provision is made for the key components of hospital and departmental management and organisation, teaching, assessment and medical education to be include in all training programmes which will subsequently allow those with these specific abilities and interests to develop them further during their careers.

**Linking training and workforce issues in anaesthesia**

Irrespective of the reasons, the potential and inevitable changes to the anaesthetic workforce of the future will have a considerable effect on training. At present it takes approximately nine years to train an anaesthetist from
initial qualification and although competency based training should not be strictly time limited, rotating a trainee through all the necessary training modules will inevitably take a similar length of time. We produce approximately 200 CCST holders annually over and above the number necessary to replace retirement vacancies and these all help to expand the consultant anaesthetic workforce (including intensive care and pain management), so that this expands by about 1000 every five years. At present we have about 5,800 consultants and to reach our estimate of the 8,500 required for a wholly consultant delivered service will therefore take 13–14 years, and will be achieved in 2018–2019. Admittedly this is in whole time equivalent terms, but the argument is still valid, in that once the specialty is ‘full’, we will only need to replace consultant vacancies. This means that instead of the 320 or so trainees who get their CCST each year, we will only need half that number, unless we are going to deliberately overproduce. 2018 may seem to be an impossibly long way off, but given the length of training, nine years earlier is actually 2009, or four years from now. With fewer trainees around, although all elective work will be covered by career grade staff, who will help us with the difficult cases, or when we need to take a break from theatre for whatever reason? Perhaps this is one reason why we have been contemplating anaesthetic practitioners as part of the anaesthesia team of the future and is not quite so heretical after all!!

**And finally – Interruptions in the availability of drugs**

Few of us would dispute that the assured supply of intravenous anaesthetic agents and related drugs, which anaesthetists use on a regular basis, is vital to our practice. From time to time, certain drugs have become either temporarily or permanently unavailable, e.g. methoxamine, metaraminol, isoprenaline. More recently, considerable difficulties have been experienced in the supply of diamorphine, which many of us, in particular our obstetric anaesthetic colleagues, regard as a crucial agent in the quality of postoperative intrathecal analgesia. To try and answer many of our questions, several of us met with representatives of the pharmacy division of the Department of Health recently. At the outset, we were reassured that this is certainly not an insidious way of permanently discontinuing the availability of diamorphine, but rather is a result of a serious supply problem of a drug which is only used in small doses and low concentrations in the UK. Large doses, necessitating high concentrations are used in a limited number of countries in Europe in palliative care and those addicted to diamorphine. The detailed reasons for the current shortage and the gradual solution of the problem are outlined in my statement on the College website.

Drug manufacturers do not have ‘an industrial chemistry set’ dedicated to the production of an individual drug, but rather they produce drugs in batches, according to projected demand, both of quantity, concentration and dose. The supply and storage of raw material is crucial, particularly when special conditions of temperature and atmosphere are required to prevent degradation. Outside patent restrictions, profit margins are small and for many drugs, it is just not worth a manufacturer’s while to produce a particular drug. Although the scandal of overpriced generics has recently hit the national press, this is concerned with high volume manufacture and not with the relatively limited market of some anaesthetic drugs. Frustratingly, it seems inevitable that the commercial issues behind drug manufacturing and supply, particularly for those outside patent and therefore where profit margins are limited and competitive, will continue to produce shortages from time to time.
Farewell and hello. A fond farewell to Anna-Maria Rollin, who, as editor of this Bulletin for the past three years, has done such a sterling job in keeping us all informed of the rapidly changing events surrounding anaesthesia. The warm hello to readers is from your new editor, slightly shell-shocked from a combination of jet-lag and a glimpse of the enormous Bulletin email in-tray.

Naturally I was delighted to have been invited to edit the Bulletin. However, when I looked more closely at what the role of editor might involve, I discovered that on a wider front, editors have not always been fully appreciated. Gene Fowler thought that an editor should have a pimp for a brother so that he could have someone to look up to! Samuel Johnson relished the power of the role, and he wrote that ultimate put-down to an aspiring author – ‘Your manuscript is both good and original; but the part that is good is not original, and the part that is original is not good’.

What I might like…

The first job of any incoming editor should be to consider what the purpose of the publication should be, and then to work out how best to achieve his aims. So, if I may take my first few tentative steps, what would I like the College Bulletin to be?

Firstly, I believe it should be relevant to our lives as anaesthetists. Next, it should be informative. As readers, we should be informed about relevant current issues, and we might like to be given some guidance in placing them into perspective. Needless to say, any journal must be interesting. Otherwise readers may be tempted to follow Dorothy Parker’s example: ‘This is not a book to be tossed aside lightly. It should be thrown with great force’. Next, it should be educational. As such, it should encourage debate, and also challenge how we think about things. I would also like the bulletin to be inclusive. We already have sections specifically for trainees and for SAS doctors, but are there other groups out there that we should be catering for? We have a wide readership, both in the UK as well as around the world. Interestingly, the Sun newspaper claims a huge readership beyond its circulation figures, presumably due to people reading copies left lying about. No doubt in the same way, the Bulletin is also more widely read, although hopefully readers will be more willing to admit to having done so!

I also believe it should be entertaining, and hopefully might raise the odd smile. But above all, it should be readable.

…but what you really want

It’s all very well for the editor to pontificate on what he would like to see. But what really matters is what you, the readers, would like the bulletin to be. It cannot achieve any of these aims unless you contribute. So please do write, on any issues which you feel are relevant to our lives as anaesthetists. Controversy is fine. After all, Kingsley-Amis thought that if you can’t annoy somebody, there is little point in writing. But well-written pieces would be particularly appreciated.

So what are these issues? I would not wish to repeat the mistake of trying to predict what future issues might be, but a few of the present ones come to mind:

- Where are we going? What will life be like for the anaesthetist of the future? Change is rapid and standing still is not an option, as I have written previously in this journal.
- What’s in a name? Will ‘anaesthetist’ or ‘anaesthesiologist’ better convey the nature of our future work?
- Technician or clinician? If we view anaesthesia as essentially being a technical process, then we run the risk of being replaced by less highly paid technicians. Surely our strengths are wider than this?
- The challenge of working with new team members like Anaesthetic Practitioners. Do we need to develop our role as team leaders? How can we ensure that a career in anaesthesia remains both interesting and fulfilling, in order to recruit the best trainees?
- What training will be required for this future role? Although Anaesthesia and Intensive Care Medicine were the first specialties to have developed competency based curricula with explicit requirements for training, these documents are not cast in stone. To remain useful, they will require continual updating and revision to match our role as it develops, as it most surely will.
- Can (and should) trainees still be required to provide a service component, or should they become entirely supernumerary?
How can we best adapt our training to match the rapidly changing patterns of healthcare delivery? With Independent Sector Treatment Centres (ISTC’s) providing an increasing proportion of elective surgical services, we will need to use them for anaesthetic training purposes. Other new and innovative ways of providing anaesthetic services will develop, but can we still maintain and improve standards?

Minding the shop after hours – will ‘living in’ for on-call anaesthetic consultants become the norm in the UK? I am writing this on my way home after examining for the Final Fellowship in Hong Kong, where consultants regularly work a 16 hour night shift.

Appraisal – now a part of professional life, and also revalidation, which at the time of writing is still awaiting the decision of the Chief Medical Officer. A necessary requirement for public reassurance, or yet another time-consuming process to impinge even further on our professional time?

**Time to arise?**

There must be many differing views on these and other issues, and the debate must go on. I’d like the bulletin to continue to play an important part in focussing that debate. Although journals may lack the immediacy of the internet, we still need a medium which offers measured and thoughtful analysis and communication. Perhaps the reason that television is known as a medium is that it is neither rare nor well done! For my part, I’ll try and follow the ideals above, so please get in touch if you think you have a burning issue and can write about it.

I’ve avoided any temptation to end this editorial with some suitably stirring metaphor to encourage submissions, such as a new dawn for anaesthesia, and the like. But, as everyone knows, the dawn is just a term for the early morning used by poets and other people who don’t have to get up. So just write, ok?
Roger and I have, over the course of the last two articles, given you an overview of the appraisal process and the optional (discretionary) points system. I thought that now the British Medical Association is in negotiations with NHS Employers over our new contract(s), it would be interesting to give an historical perspective of both the staff grade and the associate specialist grade.

The staff grade

The staff grade was introduced in November 1988 as one of several measures to help resolve problems in the hospital medical staff career structure that were apparent at the time. The staff grade was introduced as a non-training career grade which would meet service requirements (where necessary) and it was envisaged that entry would be direct from the SHO grade. The aim was that it should provide a secure hospital career for those doctors who are unwilling or unable to become a consultant but who wish to remain in hospital medicine. There was initially a ceiling on the total number that could be appointed of 10% of the total consultant numbers – this ceiling was removed in about 1997. Staff grade doctors are appointed under national terms and conditions of service. Trusts are, however, allowed to offer contracts that differ substantially from this and appoint doctors under whatever contract and, terms and conditions of service that they choose to use (the ‘non-standard grades’).

There are several things to remember about the staff grade.

- It was set up as a non-training career grade and the majority of those practitioners who enter the grade will remain in it until they retire. The opportunity to progress to another grade is limited.
- A staff grade doctor is responsible to a named consultant. Within the boundaries agreed with their named consultant and accepted professional standards, staff grade doctors need to be free to take clinical decisions. The named consultant and the staff grade doctor are responsible for agreeing the staff grade doctor’s duties. A job plan – and its integral work programme – should be part of every such contract.
- It does provide a secure career. Most staff doctor contracts are subject to a probationary year but, after this, may be extended without term and held until retirement.

- Practitioners are paid an equal amount for each session worked, regardless of what time of day or which day of the week. This means that individual practitioners’ working weeks may be very flexible and not necessarily adhere to a standard working week.
- Staff grade practitioners who are permanent members of staff are, like consultants and associate specialists, subject to the European Working Time Directive unless they sign the ‘opt out’ clause.

The associate specialist grade

This grade arose from the old medical assistant grade and was created in 1964 as a permanent career grade of limited responsibility. The actual term ‘associate specialist’ was introduced in 1981 along with the ability to work on maximum part-time contracts. In 1991, new terms and conditions of contract were agreed by all parties and this was introduced as the ‘new inclusive professional contract’. The 1991 terms also allowed for maximum part-time contracts for associate specialists. However, as with the staff grade, trusts are not bound to employ doctors on national terms and conditions but can offer their own contract as well as terms and conditions.

The associate specialist is a senior grade of hospital doctor who is responsible to a named consultant. It is a career grade post and, if a doctor is employed under national terms and conditions, the contract is without a fixed term of appointment. Subject to a probationary year the post can be held until retirement. Associate specialist posts are often personal appointments that are established for those doctors committed to a career in the hospital service but who are unable to complete higher professional training or who, having completed it, are unable or do not wish to accept the full responsibility of a consultant appointment and make a personal application for regrading. Trusts in England and Wales can, under certain circumstances, advertise ‘new’ associate specialist posts.

Whole-time associate specialists can undertake private practice subject to certain contractual restrictions that include a strict limitation on private practice income. An associate specialist who is on a whole-time (NHS) contract cannot, in any one financial year, gross more than 10% of their gross NHS salary from private practice. In addition to
A Kiwi returns
An opportunity not to be missed
Dr R Smith, Clinical Fellow in Cardiothoracic Anaesthesia, Glasgow Royal Infirmary

As a Kiwi who had come to the United Kingdom for a year and never quite managed to leave, the chance to complete some of my specialist registrar training in New Zealand was not to be missed. Eight years of British summers had given me a rose tinted view of life in New Zealand, and I relished the prospect of golden beaches and turquoise seas. I was eager, of course, to complement my British training with some antipodean experience.

Before you go…

The question I am most frequently asked by other prospective travellers is: ‘I’m going to New Zealand, where should I go?’ The answer is always the same: ‘What do you want from your work experience, and what do you like to do for leisure?’ The North is warmer, with fabulous beaches but more people. The South is a mountainous playground where, without much effort, you can enjoy true remoteness. Auckland is the largest city, with Wellington, Christchurch and Dunedin having city amenities with easy proximity to the outdoor life. I wouldn’t exclude some of the more provincial towns if planning to go to New Zealand for a year. They are often staffed by ex-pat Brits, giving a ready made social life, and a truly down to earth Kiwi feel. I chose to work in Auckland City Hospital.

I’d spent all my pre-UK training in the South Island, and thought I should try living somewhere new. I wanted a cardiac job and the city’s cardiac unit – Greenlane Hospital – had recently moved into a newly built city centre hospital. This unit pioneered some of the early work in valve surgery with Barratt-Boyes developing the homograft aortic valve replacement in 1964. Rheumatic fever remains endemic in some parts of New Zealand with poor uptake of antibiotic treatment for streptococcal throat infection by some portions of the rural Maori population. As a result, valve surgery continues to be a large portion of their work. Coming from the West of Scotland, the rate of ischaemic heart disease was less than I was used to seeing, but the pattern of risk factors differed. The Pacific Island population has a high incidence of morbid obesity, and consequently of Type II diabetes.

The cardiac intensive care unit is recognised for training in intensive care, and nearly all of the consultants are accredited in

private practice income, earnings from ‘Category 3’ work count towards the 10% limit. This is work performed on NHS patients by separate arrangement outside the practitioner’s principal contract of employment, e.g. waiting list initiative work.

The vast majority of private patients are covered by health insurance. All the major health insurers have strict rules as to who should supervise treatment in order for the patient to qualify for reimbursement of treatment costs. Most insist on either the holding of a substantive NHS consultant post or inclusion on the Specialist Register of the GMC.

This is by no means a complete accounting, but I hope that it helps to clarify where we have come from. With the BMA in negotiations with NHS Employers over our new contracts and the PMETB now in existence and accepting applications for admission to the Specialist Register via Article 14, where we as a group are going and what we can become are in a state of flux. I would, however, remind all of you that both bodies are asking for grass roots opinions to help them in their deliberations. I am writing this article in August but you will not be reading it till much later in the year. However, I would still urge you all to send your input to one of the following email addresses: info.sasc@bma.org.uk or sascviews@nhsemployers.org.
Some things were different

I was delighted when I was emailed the first three months of my rota two months before leaving for New Zealand. New Zealand medics are heavily unionised, and have negotiated their contract so that health boards are fined if rotas aren’t produced six weeks in advance. My first three months were spent working in the cardiac intensive care unit. We worked 13 hour shifts in blocks of three to five days. The work was busy and more varied than I expected. The unit took both elective patients and emergency admissions. The emergencies covered medical and trauma patients. I had frequent blocks of three to five days off and organised my time to sail, sea kayak and catch up with family and friends. The second three months I spent in cardiac theatres. It truly was a shock to have an 8.00 am cutting time. This meant I was in at 7.15 am to draw up drugs, check machines and put in lines. The days didn’t necessarily finish any earlier. We worked hard.

The hospital I worked in was brand new. The New Zealand health system is going through a similar rationalisation of services to that happening here. It does, however remain centrally funded. I was struck by the resources and apparent wealth of the system. On the cardiac floor there were two registrar rooms, with five computers between them. Each theatre had at least three computer terminals – one of which doubled as a monitor and produced an automated anaesthetic record. I was never sure that Internet access on the anaesthetic monitor was such a good idea! Anaesthetic Registrars are paid a comparable salary to UK SHOs. Their training was financially supported to a much greater extent than here. All textbooks, training courses and exam fees were paid for by their employer. Trainee doctors also had their meals subsidised by the hospital in which they worked. The financial flipside for New Zealand graduates is that they have all paid substantial fees during their medical degrees and so start their working life with a mortgage-sized debt. The consequence for the NZ health system is that many leave the country to earn foreign currency to pay their debts off more quickly.

I think that the biggest difference between myself, being largely British trained, and my New Zealand peers was in our exposure to patients and duration of training. To become a consultant anaesthetist in New Zealand can take a minimum of five years from first year SHO to fully trained consultant. Most of that will be spent working full shift rotas – with all that that implies for exposure to daytime teaching lists. With two years to go in my training, I had anaesthetised more than twice as many patients as the final year trainees I was working with in New Zealand. New

Medical registration can be initiated through the NZ Medical Council website (www.mcnz.org.nz) and should be straightforward for British graduates. You will require a certificate of good standing from the GMC and two references. Allow time for a face-to-face interview (informal chat) and verification of original degrees before starting work. This interview only takes about half an hour but it needs to be arranged in advance. This can be organised before you leave the United Kingdom. Medical indemnity can be covered locally in New Zealand. Check with your UK provider before you leave. Mine was happy to cover me for my time in NZ at no extra cost. New Zealand has a unique ‘no fault’ compensation scheme, which makes legal action against doctors a rarity. The Accident Compensation Scheme was conceived to ensure workers would always have an income if they couldn’t work following an accident. It is funded from employers’ compulsory contributions and is centrally administered. It legislates the definitions of an accident and negligence, and provides for the cost of medical care as well as providing an income while a worker is unable to work. As a result, the right to sue following injury is removed. Medical ‘accidents’ are covered by the legislation. From this end there is some paperwork involved to ensure your time abroad is recognised towards your training. This must be prospective. The RCoA syllabus for Year 3, 4 and 5 SpRs is explicit about the requirements.

The Royal College of Anaesthetists November 2005
Zealand reduced trainee doctor’s working hours 15 years ago – long enough ago to mean that the current consultant body had a relatively reduced training time. There has been no sudden decrease in the quality of medical care delivered in New Zealand as a consequence. I was, however, surprised to be asked by the cardiology registrar on more than one occasion for assistance in inserting a central line – something they had not done sufficiently often to be confident to do unsupervised. Those NZ trainees who want to sub-specialise will travel overseas to the US, the UK or Australia to do at least one Fellowship year. The Australasian College has recently shifted to a similar modular system of training to that being introduced here.

But many things were the same

It is reassuring to travel to the other side of the world and realise that many of our practices are the same. The language, the drugs, the equipment are so similar. The structure, the culture and the feel are near identical. It was certainly no problem, having completed all of my anaesthetic training to date in the UK, to walk through the doors of a New Zealand theatre suite and start working on the first day.

There is no doubt that any experience working in anaesthesia in another country is intrinsically worthwhile. The similarities in clinical practice while working in another system are reassuring. The differences are often thought provoking. It can be challenging to be taken outside your comfort zone, but ultimately rewarding.

Contact web addresses

The Australian and New Zealand College of Anaesthetists:
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To email the New Zealand branch:
nz@anzca.edu.au

New Zealand Medical Council website:
www.mcnz.org.nz
How long does an anaesthetist’s duty of care to a patient last? At our September meeting, our attention was drawn to this item which originally arose at the Joint Committee for Good Practice. A brief discussion ensued on the duration of an anaesthetist’s duty of care to a patient; its brevity tempered only because it quickly became apparent that this was a highly complex issue, encompassing levels of institutional, departmental, team and individual responsibility.

It may be reasonably clear when an individual becomes your patient and your duty of care begins: when they have been directly referred to you by letter or telephone, or indirectly either by being allocated to a routine list, or by attending a clinic to which you have been allocated. You are bound to act on the information you are given, and must see the patient yourself or delegate care to another health care worker. However, the situation is much less clear when your duty of care ends or how it might transfer from you to a colleague.

Does this matter for patients?

Patients need to know who is responsible for their care and whom they might consult should any additional information, advice and reassurance be needed. They need to know who to turn to for information when things don’t go according to plan. However, multi-professional teams increasingly provide care for patients using anaesthesia services. This often results in increasingly fragmented care, contributing to the likelihood that patients will be unaware of which health professionals are responsible for their care.

Patients seldom understand the value and importance of your role and responsibilities, your professional status and your specialty. Patients should not only know who is responsible for their anaesthetic, they should also be reassured that you remain accountable for your professional conduct and the care you provide, even when care is delegated.

Nowadays, delegation within a team is likely to be to a non-medical health professional that is trained specifically to administer one or more aspects of care. The duties of such personnel are usually carefully defined, and described within a protocol. Delegation involves being sure that the person to whom you delegate is competent in that procedure, because your duty of care to your patient remains. Although this may seem obvious within the immediate pre- and post-operative phases of care, matters become more complicated once the patient returns to the ward or is discharged home. Clearly, some patients might have a bad event as a result of their treatment. But would answering a query or concern from such a patient be part of your duty of care to them? If you are no longer responsible for continuing care, does this negate responsibility for the care you provided and the outcomes possibly attributed to that care?

Greater patient understanding of the risks associated with anaesthesia and pain management, alongside an increased awareness of your duties and responsibilities, may be better facilitated with the availability of more detailed information. The forthcoming publication of information on risks associated with anaesthesia (published by the College and available on the website from late 2005) may go some way towards helping patients to become better informed about the important role that you, the anaesthetist, play in their care. The information may help to address or clarify risks that are specifically associated with anaesthesia rather than with their surgery or surgeon.

Your duty to care underpins the trust relationship between you and your patient, and it is this trust which ensures the existence of a duty of care for which you are accountable. However, it is unlikely that you could be accountable for something out-with your control. You may fulfil your duty by doing your utmost to the best of your ability and competence, despite unfavourable circumstances. Conversely, you may have failed in your duty of care as a result of adverse working conditions or working long hours with little sleep. Comments and solutions by email please!

Farewell

It was with great sadness that the PLG said goodbye and thank you to Christine Peddle, our administrator, who retired at the end of August. She was excellent at her job, and we were fortunate in having the benefit of her considerable experience of College matters, arising from over sixteen years at the RCoA. She was an invaluable source of sound advice, support and guidance to members throughout the past four years, when she acted as secretary to the Patient Liaison Group. We shall miss her, and I have no doubt that the College will miss her too. We are grateful for the support of Ebony Riddell who is temporarily filling this vacancy.
Introduction

Automated record keeping is now attracting increasing attention from anaesthetic authorities. In America, one such authority is the Anesthesia Patient Safety Foundation (APSF) with a mission to ensure that no patient is harmed by anaesthesia. In 2001, the APSF Board of Directors approved the following statement: ‘The APSF endorses and advocates the use of automated record keeping in the perioperative period and the subsequent retrieval and analysis of the data to improve patient safety.’ In the UK the forthcoming Association of Anaesthetists publication Information for Anaesthetists states: ‘2.3 Every anaesthetic machine should be equipped with a computerised anaesthetic record keeping system connected to the patient monitors. This should be linked with the main hospital and administrative and clinical systems.’ Although standards as to the content of paper-based anaesthesia records have previously been published, relevant standards for AIMS have not yet been developed.

As will be explained in this article, there is a considerable amount of development work required in order to be able to fully implement these recommendations.

One of the first attempts to create a national database of anaesthesia outcomes in the USA occurred in the late 1990s. The National Centre for Clinical Outcomes Research (NCCOR) was to develop a data warehouse to which participants would send peri-operative records. In return, NCCOR would provide comparative derivatives of the submitted data. This effort failed for a variety of reasons. One of the principal obstacles to success was the lack of standardised medical terminology. Even if participating institutions had an AIMS, they faced a major task in reformatting data into a standard data file for submission. In addition, the lack of a standard data dictionary for anaesthesia meant that participating institutions could not be sure that their data were comparable with other hospitals collecting data using different terms and semantic meanings.

Some difficulties with AIMS

Although the Anesthesia Patient Safety Foundation is a recognised leader in patient safety in the USA, as yet only about 5% of US hospitals have implemented automated anaesthesia record systems. The current situation in the UK is similar, but the National Programme for Information Technology offers an unparalleled opportunity to effect change in England.

One of the most significant barriers to adoption of information systems is the complexity and length of the product installation. The installation of AIMS generally includes the development of a customised set of terms and phrases to be created specific to each individual institution. There are few guidelines available and minimal standardisation of terms. Product installation times in excess of one year and significant additional cost are not uncommon. This results in a barrier to adoption of technology that at least solves problems of legibility and accessibility of the anaesthesia record.

The lack of standardisation of terminology in AIMS inhibits the sharing of data between systems from the same vendor, let alone across institutions with different vendor systems. This data comparability issue does not arise only with the advent of automated systems. It exists for paper-based anaesthesia records and hinders comparative research in the specialty. There have been a few attempts to standardise some terms relevant to anaesthesia, such as the American Association of Clinical Directors’ (AACD) Procedural Times Glossary. Such lexicons have not been widely adopted. The Clinical Terms Project resulted in a considerable lexicon of terms for anaesthesia, pain management and intensive care, which were incorporated into Clinical Terms Version 3 (CTV3, Read Codes) but were not widely adopted into clinical systems for these specialties.

The Data Dictionary Task Force (DDTF) and International Organisation for Terminology in Anaesthesia (IOTA)

APSF recognised that the primary problem preventing meaningful outcomes research in anaesthesia was a standardised terminology. In 2001, the APSF executive committee commissioned a DDTF to:

a. create a data dictionary of standardised terms for the collection of peri-operative information, and

b. identify specific peri-operative outcomes to be investigated.

Dr Terri Monk, then at the University of Florida was appointed chairperson and Dr Iain Sanderson, Duke University Medical Center, Durham, North Carolina, became technical director for the project. The DDTF was
tasked to recruit contributors from academic medicine, private practice and industry. The aims of the project were to deliver a set of anaesthesia terms that could be included in an AIMS during the installation and to provide a service to the system vendors and to the institution installing a system. The baseline set of terms would not preclude customisation, but could reduce the need or desire for it.

In 2003, the DDTF joined forces with members of SCATA who had previously authored the anaesthesia content of CTV3. In 2002, this content had been incorporated into SNOMED CT (Systemized Nomenclature of Medicine/Clinical Terms) as part of the merger of CTV3 and SNOMED CT undertaken by the NHS Information Authority and the College of American Pathologists. The collaboration of the DDTF, members of SCATA and members of the Canadian Anesthesiologists Society and American Society of Anesthesiologists resulted in the formation of IOTA.

The current leadership of IOTA is:

**Chairperson**
Dr Terri Monk, Duke University, USA

**Content Director**
Dr Andrew Norton, Pilgrim Hospital, Boston, UK

**USA Content Director**
Dr David Reich, Mount Sinai Medical Center, USA

**Technical Director**
Dr Martin Hurrell, Informatics Clinical Information Systems, Glasgow, UK

**SNOMED CT and anaesthesia**

SNOMED CT was adopted as the terminology standard for the NHS National Programme for Information Technology (NPfIT) in 2002 and is licensed to be used throughout the NHS. It is extensively mapped to other lexicons such as ICD-10 and OPCS-4. In July 2003, the US National Library of Medicine purchased a national licence for SNOMED CT, making its use free of licensing charges to all US medical entities. In September 2003, IOTA was formally adopted as an official SNOMED extension group that would develop and have editorial control of the anaesthesia content of SNOMED CT.

To date, IOTA has reviewed, corrected and developed over 2,500 SNOMED CT terms, including the addition of over 600 new terms. Initial work has concentrated on the core of terms needed for anaesthesia records for common specialties. Work is currently underway to define and add the terminology necessary for pre-operative assessment. Additional areas of work will include adverse events and terms necessary for anaesthetic sub-specialties such as cardiothoracic and paediatric anaesthesia. Terminology for equipment will be aligned to relevant international standards (IEEE 1073/ISO 11073) and device nomenclature being adopted for NPfIT (dm+d – Dictionary of Medicines and Devices).

**Beyond clinical terminologies**

The IOTA anaesthesia subset of SNOMED CT has been registered with the NHS Connecting for Health Subset Register as the terminology supported by The Royal College of Anaesthetists for electronic anaesthesia records. IOTA uses a web-based submission process to the College of American Pathologists/SNOMED for terminology changes and additions. These terms are incorporated into the next SNOMED CT release, currently occurring at six-monthly intervals.

Use case testing of the core terminology for intra-operative records has been undertaken against both paper and computer generated anaesthesia records from the UK and the USA.

IOTA has recognised that the AIMS of the future will need more than just a terminology to enable outcomes research and artificial intelligence applications for reasoning and decision support. The next generation of the systems will need a schema in order to define a structure for well formed anaesthesia XML documents (Extensible Markup Language) and a common model or ontology to develop anaesthesia specific vocabulary. XML is an international standard for data exchange in web-based applications. Use of XML schemata is one of the key specifications for the National Care Records Service (NCRS, electronic patient records for the NHS) and for the e-Government Interoperability Framework.

An XML schema for anaesthesia records has been developed by Gardner and Peachey. In the time since its publication, technical standards for messaging and data structures in clinical information systems have evolved. The standard adopted internationally and by NPfIT is HL7 CDA (Health Level 7 Clinical Document Architecture). The anaesthesia XML schema requires further work to be compliant with HL7 CDA and HL7 Clinical Statements.

Thus, the IOTA project now embraces three main areas of development.

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*An ontology defines the terms used to describe and represent an area of knowledge. Ontologies are used by people, databases and applications that need to share subject specific domain information. Examples include areas as wide as medicine, tool manufacturing and financial management. Ontologies include computer usable definitions of basic domain concepts and the relationships amongst them. Rules are defined that specify the type of logical relationships that can exist in a domain ontology. Ontologies are used to encode knowledge in a domain and also knowledge that spans different domains. IOTA is using open source software tools to develop an ontology for anaesthesia information.*
Ontology.

Schema definition (consistent with the HL7 Clinical Statement initiative).

Terminology for SNOMED CT.

Together these aim to deliver an international standard for the communication and understanding of anaesthesia information, which will facilitate progress in consistent and comparable record keeping across institutions and enable a new era of research and clinical audit.

Help needed!

IOTA is keen to seek input from interested clinicians in this area. The potential for input includes the following:

- Volunteers from the anaesthesia community to review and constructively criticise sections of SNOMED CT terms authored by IOTA and the SNOMED International authority. Volunteers would be asked to review specific areas of terminology in which they have an interest or which have not previously been reviewed. User guides, term browser tools and feedback templates will be supplied.
- Suggestions for new terms.
- Use case testing against anaesthesia records and clinical scenarios.

The Anaesthesia SNOMED CT terms are available for download from www.apsf.org/datams. Anyone interested is welcome to contact the Content Director of IOTA, Dr Andrew Norton at andrew.norton@tiscali.co.uk who will supply access instructions and relevant documentation.

Acknowledgement

The contribution of Dr Terri Monk and Dr Martin Hurrell to the preparation of this article is gratefully acknowledged.

References

5. www.connectingforhealth.nhs.uk/.
11. (www.ieee1073.org/).
17. HL7 Clinical Statement model (www.hl7.org/).
The National Programme for Information Technology (NPfIT), now renamed NHS Connecting for Health (NCFH), was established in 2002, aiming to improve services and delivery of care in England, Scotland, Wales and Northern Ireland. All have their own, different programmes.

Before NCFH, all systems were procured locally, or by consortia of organisations within a geographical area. NCFH has shifted this towards a national approach, with procurement and implementation conforming to national standards. Richard Granger, the Director General of the National Programme uses the term ‘ruthless standardisation’.

England has been divided into five ‘clusters’ for this purpose, shown in Figure 1, and commercial consortia have been contracted as Local Service Providers (LSPs) to each cluster. These are as follows.

- North East – Accenture.
- Eastern – Accenture.
- NorthWest & West Midlands – Computer Sciences Corporation.
- London – Capital Care Alliance (BT).
- Southern – Fujitsu Alliance.

The projects

The work of NCFH consists of a number of separate but interdependent projects, including the following.

- N3 – A New National Network with sufficient connectivity and broadband capacity to meet current and future NHS needs (2005).
- ETP – Electronic transfer of prescriptions between GPs and pharmacists.
- NCRS – An electronic NHS Care Records Service, computerising the health records of all patients.
- Contact – A centrally managed email and directory service for NHS staff.
- PACS – Picture Archiving and Communication Systems to capture, store, distribute and display digital medical images, especially X rays.

The NCRS will deliver the patient’s health record to any point of care, including acute, primary, mental health or social care. A summary of the patient’s lifetime health record will be held on the Information Spine, which should be accessible at any point. The national programme is supported by substantial central funding, but this still leaves much to be funded locally.

Anaesthetic involvement

Why is it important that anaesthetists are involved now?

Firstly, we need to prepare ourselves for what will be an enormous change in the way we work. For instance, all investigations and laboratory orders will be made with these systems, as will the results and reports. Clinical letters will no longer be on paper, and theatre lists and audits will be online, as will pre-operative and other assessments. Soon after that ALL drugs and fluids will be prescribed and their administration recorded on a computer system and later anaesthetic records will be automated. Of course, some hospitals have some of these systems already, but the intention is to make all this functionality available everywhere.

Secondly, we should influence the local implementation of the systems (ISOFT in the NW, NE and Eastern clusters, IDX in London and Cerner in the South). For example, how fast does the response time need to be for it to be practical to use a computer instead of paper? How many terminals or
wireless linked laptops will be needed locally? What should be available in theatre, and at the anaesthetic workstation?

Thirdly, we must influence the development of the clinical content of the systems. The ‘national approach’ will try to enforce standard screens on ALL hospitals. So, for example, preassessment will ask the same questions in Leeds as in Torquay, and all intensive care units will have the same lists of procedures from which to choose. Does this make sense? What local tailoring capability is essential?

Find out more

If your department hasn’t been kept up to date with local plans for NCFH ask now for a presentation from your local Director of Informatics Services.

There is also a great deal of information on NHS websites.1 NCFH has recognised that there need to be more clinicians involved in this process and Richard Jeavons has taken over this role from Alan Burns who took it from Aidan Halligan! There are many ways to contribute to this programme,2 and most of them are remunerated!

SCATA meetings have been keeping members informed of the progress with NCFH and they provide a forum to discuss many of these issues. SCATA working groups have helped produce clinical standards which will underpin the new NHS Care Record but these are still evolving and a wider interest group is very welcome.

References

1 NHS Connecting for Health Programme for Information Technology (www.connectingforhealth.nhs.uk).
2 NHS Information Authority (www.nhsia.nhs.uk).
3 Clinical engagement strategies for NPfIT (www.npfit.nhs.uk/clinical_engage).

Resuscitation Council (UK)

CHANGES IN RESUSCITATION GUIDELINES AND TRAINING COURSES

The Resuscitation Council (UK) will be introducing new training courses in 2006

Over the last few years, researchers from the member councils of the International Liaison Committee on Resuscitation (ILCOR) have been evaluating the science of resuscitation. This work culminated in a large international conference in Dallas, Texas in January 2005, at which several members of the Resuscitation Council (UK) were present. In November this year, the conclusions of the conference will be published simultaneously in the journals *Circulation* and *Resuscitation*, under the title Consensus on Cardiopulmonary (CPR) and Emergency Cardiovascular Care (ECC) Science and Treatment Recommendations. This will provide a summary of the science on which current resuscitation practice should be based, and will lead to new, evidence-based guidelines.

The Resuscitation Council (UK) and the European Resuscitation Council (ERC) will be publishing their new guidelines on 13 December 2005. These will be displayed on our website (www.resus.org.uk) and will be available in printed form from the Council.

The relevant subcommittees will be able to agree the final content of the new courses only once the ERC and Resuscitation Council (UK) guidelines have been finalised. Because of the vast amount of material that will require changing, the Guidelines Project Group has decided to stage the introduction of these new courses as follows.

- Immediate Life Support (ILS) and Advanced Life Support (ALS) – Spring 2006.

The Resuscitation Council (UK) will be encouraging course centres to continue to run the current courses until the new ones are available. NHS trusts should, therefore, be aware that several different courses may be in use during the interim period.

It is important to emphasise that the publication of new and revised treatment recommendations does not necessarily imply that current clinical care is either unsafe or ineffective.
There have been a lot of changes in anaesthetic practice for ophthalmic surgery in the last decade. The use of local anaesthetic blocks has risen from about 20% 14 years ago to over 86% by 1997. Sub-Tenon’s local anaesthetic has been proven to be as effective in cataract surgery as the more traditional peribulbar block and is increasing in popularity potentially being safer as a blunt cannula rather than sharp needle is employed. There is greater patient acceptance and less intraocular pressure elevation with sub-Tenon’s anaesthesia than with peribulbar block.

A literature search was performed to establish whether there is a recommended position for the anaesthetist to stand whilst performing right- and left-sided blocks. None of the articles found commented on an essential position for the anaesthetist.

It is normal practice for a right-handed anaesthetist to carry out a block for the right eye standing behind the patient’s head with the forceps in the left hand and the scissors then the sub-Tenon’s cannula in the right. The left eye approach is not so straightforward and results in the new practitioner finding this block more tricky.

The reason for this becomes clear if one examines the alignment of the instruments. To perform the block the forceps and scissors oppose each other to form a straight line which usually comes in over the bridge of the nose. The right side alignment makes this easiest to perform from the top of the patient’s head, forceps in left hand and scissors then cannula in the right. The alignment of the instruments for the left side is a mirror image of the right and the forceps again come over the bridge of the nose at a right angle to the orientation of the right side. In order to hold the instruments in a similar fashion on the left side the practitioner should move through 90°. Hence it is natural when doing a left-sided block to stand to the left side of the patient: the right and left hands and their instruments are now naturally in the same alignment as for the right side.

For the left handed anaesthetist the opposite orientation would be true standing at the top for a left block and at the right side for a right sided one. It is hoped that this information may be of benefit to those new to this valuable technique who have had initial difficulty with left eye blocks.

References
Increase your chances of getting a car, not a goat
Dr J Carlisle, Consultant Anaesthetist, Torbay Chairman, Preoperative Association

You’re in a game show. You can choose one of three doors. Behind one door there is a car that you want. Behind two doors there are goats that you don’t want. The host knows what is behind each door. You choose the middle door. He opens the left hand door, revealing a goat. He says ‘Do you want to choose the right hand door instead of the middle?’ Do you stick or switch?

Dr Ross Kerridge has already outlined the ‘challenges and opportunities for anaesthetists’ posed by preoperative preparation in his excellent editorial (www.rcoa.ac.uk/docs/Bulletin30.pdf). I’m going to write about a few developments particular to the UK and a few items of personal interest.

www.pre-op.org
The Preoperative Association celebrates its anniversary at the second national conference in Brighton on 23–24 November (details at www.pre-op.org). This association continues the work of the Modernisation Agency and previously the National Patient Access Team by supporting the senior nurses who are managing the centralisation of hospital preoperative assessment clinics. Unlike its predecessors the Preoperative Association has an expanded role and benefits from a close working relationship with the Royal Colleges of Nursing, Anaesthetists, Surgeons and General Practitioners, the Association of Anaesthetists, the British Association of Day Surgery and the UK Clinical Pharmacists Association.

Associations generally fill the gaps that exist between national policies and local implementation. They provide a conduit for the bi-directional flow of information and with Royal Colleges they develop standards of training and service that link quality to quantity.

www.preop.soton.ac.uk
The University of Southampton continues to develop curricula and learning resources for preoperative practitioners: initially as a book and CD-ROM and this year as e-learning courses at diploma, degree or master’s levels. This is an exciting national development promising a standard of knowledge. It will be interesting to see how usable e-learning is and how trusts support their staff who want to learn outside of the classroom. It will also be interesting to see how the knowledge provided by these courses can be complemented by similar standards for physical examination and its assessment.

These courses are not just for nursing staff. They may be of interest to anaesthetic practitioners and I hope that the courses will be flexible enough to link with other learning courses to avoid unnecessary repetition. Healthcare assistants and other auxiliary staff may be interested in learning at diploma level whilst some anaesthetists may be interested in the master’s course.

www.nhslists.net
The bridging role of the Preoperative Association, between local and national agendas, is facilitated by a shared communication system accessible by all healthcare staff. I have just set up (July 2005) a list at this site called ‘PACE’, standing for ‘preoperative assessment and clinical evaluation’. Once you have registered (http://listserver.nhslists.net/LMS/subrequest/pace) you can post questions, answers, links, documents, guidelines and so on. These are shared with every other subscriber to the list. This is a potentially really useful device to help identify and disseminate best practice, organise local and regional service groups, as well as gauging opinion and helping to answer niggling questions.

NHS treatment code 190
‘Anaesthetists exist but don’t do anything’. Treatment function 190 is the code for anaesthetic care that is distinct and not ‘on behalf’ of another, usually surgical, specialty. And the NHS information authority dropped this code because no one could think of treatment by an anaesthetist, other than chronic pain management, that was not part of the service provided by another specialty. Amongst other places that anaesthetists are considered not to be providing a distinct and separate service is the pre-operative assessment clinic.

‘An indistinct service’ may be a reasonable if rather parsimonious interpretation of a pre-operative clinic if it only determines whether it is possible to anaesthetise someone for the proposed surgery. But that is not what we do, particularly in clinics that assess unfit patients for major operations. For instance, I assess and inform patients facing colorectal resections, repair of abdominal aortic aneurysms, major joint surgery and so on. My assessment, including cardiopulmonary exercise testing, provides information that changes the balance of anticipated risk and benefit, changes the understanding of the patient, changes behaviour (exercise), changes medications (aspirin, statins, β-blocker, ACE inhibitor, NSAIDs) and hopefully reduces
the peri-operative and long-term chances of patients dying or being critically ill. I think that as a consequence of pre-operative anaesthetic clinics patients are better informed, they are ‘empowered’, and sometimes we – patient, anaesthetist, and surgeon together – decide against a planned operation or decide for an operation that before assessment and preparation would not have happened.

And what do accountants, managers and politicians see? The see surgeons running clinics that save lives because that is how they are coded. And in response to what they see what will they do? Invest millions of pounds in surgical directorates, plan for the expansion of the surgical workforce and wonder what the hell the anaesthetists are doing. I hope that by the time you read my plea ‘bring back 190!’ this treatment function will have been reinstanted. If so it will have been because of the work of my colleague Dr Roger Tackley.

**Knowing risk**

It is not just the ‘high risk’ patient who wants information before surgery. Fear of death, awareness, pain, sickness, delirium and so on is not dependent upon the grade of surgery. The Royal College of Anaesthetists is, at the time of writing, drafting 14 updated patient information leaflets that address common areas of concern. I look forward to providing these to patients early in their journey, perhaps with the help of my local general practitioners.

However, there are other questions that people have (but don’t seem to ask much) that I think are not adequately addressed by anyone. ‘How likely am I to be better or worse after my operation?’ ‘Are my chances of having a good outcome “average” or something else?’ In order to answer these fundamental questions we need to combine two national databases that don’t exist: pre-operative variables and long-term post-operative outcomes. We routinely record simple variables such as age, sex, height, weight, ASA grade, medications and so on. But if a 68-year-old woman asks me tomorrow what the likelihood is that she will be better or worse in one year with or without an elective cholecystectomy I have nothing to say. Well, I do because I’ve gone and ferreted out information locally. But my answer is limited by the amount of collected information that has been electronically coded and by the number of laparoscopic cholecystectomies done in my hospital. And should I have to go to extraordinary lengths every time I want to answer an ordinary question?

I have been amazed by the volume of data that has been generated by the uncontrolled screening programme known as ‘routine’ pre-operative testing, and I have been even more amazed that we haven’t done anything useful with it, other than for the individual patient with the occasional fortuitous discovery. I expect to continue to be amazed well into the era of ‘Connections for Health’ before we work out whether this is an untapped goldmine of information or a waste of resources with the potential for damaging consequences that all screening programmes have.

**Communicating risk**

It is important that we know the incidences of good and bad outcomes. It is also important that patients understand the risks of potential harm versus benefit. If you think you have a difficult time understanding percentages, fractions, relative risks, odds ratios and hazards imagine how difficult it is for most of your patients. Read the following paragraph and tell me, what is the probability that a 50-year-old woman who has a positive mammogram actually has breast cancer?

The probability that a 50-year-old woman has breast cancer is 0.8%. If a woman has breast cancer, the probability is 90% that she will have a positive mammogram. If a woman does not have breast cancer the probability is 7% that she will still have a positive mammogram.

Now try the next paragraph.

Eight out of every 1,000 50-year-old women have breast cancer. Of these eight women with breast cancer, seven will have a positive mammogram. Of the remaining 992 women who don’t have breast cancer 70 will have a positive mammogram.

Natural frequencies are much easier to understand than conditional frequencies and convey the uncertainty of what a positive mammogram means much more clearly.

**Confidence and the illusion of certainty**

The confidence that you and your pre-operative patients have about the future is not dependent upon certainty. It is dependent upon the intelligible communication of what is and is not known (data from the past) coupled with a clear explanation of the uncertainty that accompanies any attempt at predicting the future from this past knowledge. To provide a good pre-operative service we need a national database coupling peri-operative variables with post-operative outcomes and a workforce capable of communicating the outputs of any information system. However, the most profound change will be moving from a medical culture that has rewarded the illusion of certainty, with its by-products of polarised opinions and didactic teaching, to one that rewards acceptance of uncertainty, options and choice.

So should you change your mind and choose the right hand door? Yes, without a doubt. Switching increases your chances of getting a car from one-third to two-thirds.

(If you don’t believe me try the experiment with a toy car under one of three cups. You’ll need a ‘host’ who knows where the car is, a ‘contestant’ who does not, and you’ll need to repeat the experiment say 200 times, sticking 100 times and switching 100 times.)

**Further reading**

Sub-specialty Networking in anaesthesia
Development of the Thames Paediatric Anaesthetists Group
Dr R F Howard & Dr I Walker, Consultant Anaesthetists, Great Ormond Street Hospital, London
email: r.howard@ich.ucl.ac.uk

Introduction
The Thames PAG, a group of paediatric and children's anaesthetists formed in 1997, is an informal network of clinicians who meet regularly with the aim of maintaining and improving local standards of practice, education and training in paediatric anaesthesia. These rather lofty sounding ideals are in fact rather easily achieved through information and resource sharing, discussion and the implementation of co-ordinated policies and management guidance in all the participating hospitals. The original idea for the group was conceived during the implementation of 'Calmanisation' in 1996/1997 with the intention of improving the training environment, but since that time it has become clear that, as training and service are inextricably linked, the group has developed a wider role in sub-specialty professional practice.

Group meetings are held twice a year in Central London, at Great Ormond Street Hospital (GOSH), and are attended by anaesthetists who anaesthetise children from 42 hospitals in London and the South East. Membership is open to all anaesthetists with an interest in paediatrics, meetings are approved for CME and there is no registration or other fee. Since its inception the group has grown in membership, and a number of notable objectives have been identified and met. The success of the group has demonstrated that informal networks of sub-specialists are a viable, effective, economic and enjoyable way of sharing resources and helping to meet many of the professional and educational objectives confronting consultants in the modern NHS.

Background and origins of the group
In 1996/1997, the prospect of a radical change in professional medical education to be brought about by Calmanisation led to a reconsideration of how sub-specialty training in anaesthesia might take place. In the North Thames (London) Region it rapidly became clear that if trainees were no longer to be apprentices but students in a modular, structured training programme, significant local reorganisation of training would be needed. As implementation of this new programme was to be ‘cost neutral’ it appeared that much of the work involved would inevitably devolve upon those individuals who were providing the paediatric anaesthesia clinical services in the region. Clearly, for larger centres with more manpower and greater resources this would be a much easier task than in smaller hospitals with possibly only one or two children’s anaesthetists. Although there are several large paediatric centres in the London area, a lot of surgery for children also takes place in other hospitals, but at the time exact figures were not available, nor was it known whether this work was accessible for training. In order to understand the situation better, a survey of paediatric practice in the hospitals of the region was conducted, and subsequently a meeting of the anaesthetists responsible for paediatric anaesthesia in each hospital was held at GOSH.

One of the many striking things to emerge at this meeting was that although there was plenty of training ‘material’ available in terms of the number of operations taking place, there were potential problems of access and wider learning opportunities for trainees. These were largely related to the fact that there were enormous differences in practice between the hospitals. For example, some hospitals had dedicated paediatric ‘lists’ whereas in others children could appear almost anywhere in the schedule. Some hospitals had extensively implemented policies and protocols governing routine practice, such as pre-operative starvation, management of perioperative fluids, postoperative pain and for emergency situations, whereas at the other end of the spectrum, some hospitals had none of these. In addition, where protocols existed, they frequently differed between hospitals, subtly and often unnecessarily. The larger centres held regular paediatric themed teaching sessions, morbidity and audit meetings whereas many of the smaller hospitals were unable easily to support this kind of activity on a regular basis. At that time many of the smaller hospitals had no clear ‘lead clinician’ for paediatric anaesthesia. Another important issue was that the paediatric surgery centres and particularly GOSH, an exclusively paediatric hospital, had infrastructure, resources and expertise which allowed them rapidly to assimilate changes in practice and formulate new policies and protocols accordingly; however, there was no mechanism for dissemination of this knowledge outside the institution. On the other hand, there was enormous potential for ‘re-inventing the wheel’, and so it was obvious that harmonisation of practice would be beneficial. When the group was established, it originally consisted of...
representatives from hospitals in the North Thames region. Since that time hospitals from throughout the London region have been included, mirroring changes in Deanery boundaries.

Objectives and achievements
The group is active in three important areas of NHS professional practice: clinical management, teaching and training, and CME and quality assurance (QA). Initially, we set out to achieve a consensus governing some general areas of practice, to produce protocols which could be implemented in all participating hospitals, and to provide a resource of general information which would be of use to trainees and consultants. The result of this endeavour is the Thames PAG Resource and Information Pack, a document which now runs to some 40 pages and is the basic handbook of the group. Since 2002 the handbook, which is updated regularly, has been available for download on our website: www.gosh.nhs.uk/thamespag, along with details of upcoming and previous meetings and other information about the group. At the time this document was first produced, evidence-based clinical guidelines for paediatric anaesthesia were a thing of the future (as they largely remain) and we decided that it would not be feasible to attempt to produce such guidelines but instead to agree ‘recommended management protocols’ based on accepted best practice. The Resource and Information pack also provides an excellent route for dissemination of guidelines and recommendations from professional and educational bodies as they appear.

Our CME/QA activities include regular updates from expert guest lecturers, on key topics such as pain control, resuscitation of the critically ill child and management of uncommon conditions. In 2001 we ran an introductory course in Evidence Based Medicine (EBM) in conjunction with the Department of EBM at the Institute of Child Health, and since that time we have held an evidence-based journal club during the final part of each meeting. Regular audits of local practice have been presented and we have recognised the value to members of visiting each other in order to observe practice; members’ contact details are published in the handbook to encourage this. More recently, the group has acted as a useful forum to inform outside organisations – for instance, it was consulted by the London Specialised Commissioning Group to identify some of the problems in providing comprehensive services for children in London. The group was also recently able to be involved in discussions with the North Central London Diabetic Network regarding protocols for peri-operative management of children with diabetes.

Funding, organisation and future plans
The Thames PAG survives on minimal resources. The venue for meetings and light refreshments have been provided by the Departments of PGME and Anaesthesia at GOSH since 2001. The Department of Anaesthesia also provides secretarial and administrative services and web space for our website and email accounts. Funding for the Evidence Based Medicine course (£800) was obtained from the Deanery. All the members of the group actively participate in meetings by lecturing, presenting audits, reviewing important topics and organising the journal club; there is no charge to attend.

Future developments emerge from group meetings, often after an examination of local practice. For example, following an audit conducted in response to a group discussion, we are currently developing guidance to improve post-operative pain management after day surgery, including procedure-specific analgesia information for parents, which will be available to all the participating hospitals in the region.

Conclusion
The Thames PAG has now been in existence for more than eight years; meetings are very well attended and have a congenial and informal atmosphere. The concept of shared resources, discussion and common purpose has allowed considerable progress towards unified practice in paediatric anaesthesia among hospitals with diverse populations and services situated geographically in the same region. Such groups can make an important contribution to professional life and the quality of services in the NHS.
THE ROYAL COLLEGE OF ANAESTHETISTS
EDUCATION PROGRAMME

Please note that unless indicated otherwise, lunch is included in the registration fee.

CURRENT CONCEPTS
AT THE EXTREMES OF PHYSIOLOGY AND PRACTICE
3–4 November 2005 (code: B05)
Institution of Electrical Engineers, London
Registration fee: £360 or £275 for trainees registered with the College.

CONTINUING MEDICAL EDUCATION DAY
5 November 2005
Institution of Electrical Engineers, London
A joint meeting with the Association of Anaesthetists of Great Britain and Ireland.

RESEARCH METHODOLOGY MEETING
8 November 2005 (code: C43)
Holiday Inn, Bloomsbury, London
A joint meeting with the British Journal of Anaesthesia. Introduce participants to the way in which good research should be conducted and presented. Registration fee £115.

INTRODUCTION TO TEACHING
9 November 2005 (code: A12)
School of Oriental and African Studies, London
A one day meeting for Consultants, SAS Grades and SpRs which is designed to introduce doctors to the skills that are required to facilitate effective teaching and training. For further details see page 1714.
Registration fee: £190 (£120 for trainees registered with the College).

CURRENT TOPICS IN ANAESTHESIA
9–11 November 2005 (code: C11)
Radisson Edwardian Manchester Hotel
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 (i.e. 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. Registration fee: £410.

SAS JOINT REVIEW DAY
17 November 2005 (code: C12)
Association of Anaesthetist of Great Britain and Ireland, London
A joint meeting with the Association of Anaesthetists of Great Britain and Ireland. For further details see page 1714.
Registration fee: £200.

PRIMARY FRCA: BASIC SCIENCES PHASE C
21–23 November 2005 (code: A89)
The Royal College of Anaesthetists, London
For further details see page 1714.
Registration fee £200.

CHRISTMAS LECTURE
5 December 2005
The Royal College of Anaesthetists, London
The Royal College of Anaesthetists will be holding its Christmas Lecture for fifth year students considering a career in medicine or associated subjects. As well as a lecture, the attendees will also have an opportunity to view and interact with much of the technology used by anaesthetists. Please contact the Courses and Meetings Department for further details.

HOW TO TEACH – TEACHING METHODS WORKSHOP, LONDON
7–8 December 2005 (code: C80)
The Royal College of Anaesthetists, London
An intensive two day workshop for Consultants, SAS 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 consultants. For further details see page 1716.
Registration fee: £390.

FINAL FRCA COURSE
20 February – 3 March 2006 (code: A82)
The Royal College of Anaesthetists, London
For further details see page 1715.
Registration fee: £600.

AIRWAY WORKSHOP – CARDIFF
1 March 2006 (code: C96)
Cardiff Marriott
With a focus on clinical scenarios, group discussion and hands-on skills practice. The Airway workshop will cover a number of topics using experienced small group teachers. Please note the places are limited for this Workshop. For further details please see page 1716.
Registration fee: £300

ANAESTHETIC EMERGENCIES – GLASGOW
10 March 2006 (code: C49)
Institution of Electrical Engineers, Glasgow
A one-day meeting covering the core topics of anaesthetic emergencies.
Registration fee: £200.

CURRENT TOPICS IN ANAESTHESIA
30 January – 1 February 2006 (code: C68)
The Royal College of Anaesthetists, London
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 (i.e. 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. For further details please see page 1714.
Registration fee: £410.

PRIMARY FRCA: BASIC SCIENCES PHASE B
6–8 February 2006 (code: B63)
The Royal College of Anaesthetists, London
For further details see page 1715.
Registration fee: £200.
ANNIVERSARY MEETING
CLINICAL MONITORING
15–16 March 2006 (code: A03)
Institution of Electrical Engineers, London.
A joint meeting with the British Journal of Anaesthesia. Clinical monitoring is at the centre of our daily practice. National and international speakers will be talking on a range of topics of direct relevance to clinicians today, identifying what is new, what is coming soon and how monitoring choices may impact on patient outcomes. The programme will allow time for discussion. For further details see page 1715. Registration fee: £360 (£275 for trainees registered with the College).

PRIMARY FRCA: BASIC SCIENCES
PHASE C
20–22 March 2006 (code: C73)
The Royal College of Anaesthetists, London
For further details see page 1714.
Registration fee: £200.

HOW TO TEACH – TEACHING
METHODS WORKSHOP, LONDON
5–6 April 2006 (code: B36)
The Royal College of Anaesthetists, London
An intensive two day workshop for Consultants, SAS Grades and post-fellowship SpR's, about the teaching techniques that are useful for anaesthetists who plan and participate in education programmes for medical students, anaesthetic trainees and consultants. For further details see page 1715. Registration fee: £390

AIRWAY DAY
May 2006 (code: C19)
The Royal College of Anaesthetists, London
The day is designed for trainee, SAS and Consultants in Anaesthesia or critical care with particular emphasis on those engaged in airway management training.
Registration fee: £200

DIPLOMATES’ DAY
3 May 2006
Kensington Town Hall, London
By invitation only.

INTRODUCTION TO TEACHING
23 May 2006 (Code: C18)
Venue in London to be advised
A one day meeting for consultants, SAS grades and SpR's which is designed to introduce doctors to the skills that are required to facilitate effective teaching and training. Registration fee: £190 (£120 for trainees registered with the College)

AIRWAY DAY WORKSHOP –
LONDON
June 2006 (Code: C81)
Venue in London to be advised
With a focus on clinical scenario, group discussion and hands-on skill practice. The Airway workshop will cover a number of topics using experienced small group teachers. Please note that there are limited places for this workshop.
Registration fee: £300.00

CURRENT TOPICS IN
ANAESTHESIA
7–9 June 2006 (code: A32)
Venue in Birmingham to be confirmed
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 (i.e. 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.
Registration fee: £410

DEVELOPING PARAMEDIC
PRACTICE
12 June 2006 (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 pre-hospital 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: £170.

INTENSIVE CARE MEETING
22–23 June 2006 (code: C55)
Institution of Electrical Engineers, London
A joint meeting with the Intensive Care Society. For further details see page 1716.
Registration fee: £360 (£275 for trainees registered with the College).

COLLEGE TUTORS MEETING
6–7 July 2006
Venue in London to be advised
By invitation only.

All meetings have CPD approval on the basis of five points for a full day and three points for half a day.
Members of the Senior Fellows Club are entitled to attend meetings at half price.
Please complete the generic application form or contact the Courses and Meetings/Events Department in the Education Directorate at the College for further information.

Please note that new meetings and updated programmes are available on the College website (www.rcoa.ac.uk)
INTRODUCTION TO TEACHING
9 November 2005 (code: A12)
School of Oriental and African studies (SOAS), London

A one day meeting designed primarily for post-Fellowship SpRs (but open to anyone) who have an interest in teaching and want an introduction to the principles.

09.30 Introduction, including an introduction to teaching adults
   Dr D Greaves
10.15 Discussion
10.30 Coffee
10.45 Teaching for small groups and tutorials
   Dr M Clapham
11.15 Discussion
11.30 Teaching and assessing in theatre, including teaching practical skills
   Dr D Greaves
12.15 Discussion
12.30 Lunch
14.00 Preparing candidates for the exams
   Dr M Clapham
14.30 Discussion
14.45 How to give a lecture
   Dr A Goodwin
15.15 Discussion
15.30 Tea
15.45 Using PowerPoint Effectively
   Dr A Goodwin
16.15 Discussion and Close

Registration fee: £190
(£120 for trainees registered with the College)
Approved for CPD purposes

The Royal College of Anaesthetists
The Association of Anaesthetists of Great Britain and Ireland

SAS JOINT REVIEW DAY
17 November 2005 (code: C12)
The Association of Anaesthetists of Great Britain and Ireland, London

SAS and representation and what the AAGBI can do
Dr R Alladi, Tameside General Hospital, Ashton-under-Lyne

PMETB/GMC: Specialist register and entry of SAS doctors
Mr D Bowman, The Royal College of Anaesthetists

BMA and SAS Doctors
Dr M Khan, BMA chairman of SAS committee

Clinical Directors’ view of SAS Doctors and Glossy
Dr L Gemmell, Wrexham Maelor Hospital, Wales

How to make the best of appraisals
Dr C Cooper, Chesterfield and North Derbyshire Hospital

Discretionary points and optional points – how to get them
Dr J Curran, Nottingham City Hospital

SAS and pensions/financial planning
Dr M Martin, London

Closing remarks
Dr A Lim, Chairman of the SAS committee, RCoA

Registration fee: £200
Approved for CPD purposes
PRIMARY FRCA: BASIC SCIENCE COURSES
The Royal College of Anaesthetists, London

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 (excludes lunch). Each phase will include one evening of tutorials.

Phase A: 9–11 January 2006 (code: B08)
Phase B: 6–8 February 2006 (code B63)
Phase C: 20–22 March 2006 (code C73)

Please do not use the generic registration form. Forms for this course are available from the Courses and Meetings/Events Department at the College.

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 anaesthesia

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

Approved for CPD purposes

CURRENT TOPICS IN ANAESTHESIA
30 January to 1 February 2006 (code: C68)
The Royal College of Anaesthetists, London

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: £410
Approved for CPD purposes

HOW TO TEACH
TEACHING METHODS WORKSHOPS
8–9 February 2006 (code: C84)
5–6 April 2006 (code: B36)
The Royal College of Anaesthetists, London

An intensive two day workshop for Consultants, SAS grades and post-fellowship SpRs, who have some experience in teaching and wish to develop this further. Topics will include:
- In-theatre teaching
- Classroom teaching
- Assessment techniques
- Planning skills for education programmes for medical students, anaesthetic trainees and consultants
- Teaching non-clinical skills
- Small group discussion

Please note that there are limited places for these workshops.

Registration fee: £390
Approved for CPD purposes
ANNIVERSARY MEETING 2006

CLINICAL MONITORING

A joint meeting with the British Journal of Anaesthesia

15–16 March 2006 (code: A03)

The Institution of Electrical Engineers, London

WEDNESDAY, 15 MARCH 2006

Registration and coffee
Welcome and Introduction

Session 1: Man machine interactions in the clinical environment
Getting the best out of alarms
Learning from simulation
Panel discussion
Coffee

Session 2: Perioperative monitoring
Integrating anaesthesia and ICU into the National Care Record
TOE in the OR
Using monitoring to guide pre-optimisation
Panel discussion
Lunch
Joseph Clover Lecture
Annual General Meeting

Session 3: Depth of anaesthesia monitoring (DOA)
Setting the agenda
DOA—technologies in competition
Tea
Evaluating DOA monitoring
State of the art—what’s next and what it might do
Panel discussion
Reception

THURSDAY, 16 MARCH 2006

Session 4: Monitoring the injured brain
ICP—more than a number
Classical bedside measurement of CBF and CBF adequacy—potential and pitfalls
Microdialysis—research technique or clinical tool?
Tissue oximetry and multiparameter probes: a guide to therapy?
Using physiological imaging to validate and refine bedside monitoring
Panel discussion
Coffee

Session 5: Monitoring the critically ill
New technologies for ICU
Messages from the lungs—state of the art ventilators and how they report on lung performance
Does monitoring affect ICU outcome?
Panel discussion
Lunch

Session 6: Using advanced clinical systems to enhance patient safety
Expert systems on the labour ward
Integrating monitoring to protect surgical patients
Panel discussion
Tea

Session 7: Monitoring on the move
Monitoring on the front line—monitors for aeromedical evacuation and military operations
Distant clinics and remote environments
Close and tea

Registration fee: £360 (£275 for trainees registered with the College)

Approved for CPD purposes
**FINAL FRCA COURSE**  
20 February – 3 March 2006 (code: A82)  
*The Royal College of Anaesthetists, 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/Events Department at the College.

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

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**AIRWAY WORKSHOP**  
1 March 2006 (code: C96)  
*Cardiff Marriott Hotel, Mill Lane, Cardiff*

With a focus on clinical scenarios, group discussion and hands-on skills practice. The Airway workshop will cover a number of topics using experienced small group teachers. Please note the places are limited for this Workshop.

10.00 Welcome and aims of the Workshop
10.15 Split into four groups – each group (30 mins, eight delegates) rotates through each station:
   - 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 Four groups – rotating (30 mins) through each small group teaching:
   - 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.

Registration fee: £300  
Approved for CPD purposes

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**INTENSIVE CARE SYMPOLYSM**  
22–23 June 2006 (code: C55)  
*The Institution of Electrical Engineers, London*

Sessions will include:
- Research initiatives in critical care.
- Reviewing the current evidence
- Cardiology update.
- Law and ethics.
- The windows of opportunity? Advances in early resuscitation.

Registration fee: £360 (£275 for trainees registered with the College)  
Approved for CPD purposes
COURSES AND MEETINGS/EVENTS

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/docs/meetings.pdf).

Application forms for the Final FRCA course and Basic Sciences course for the Primary FRCA are available separately from the Courses and Meetings/Events 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. C49 – Anaesthetic Emergencies, Glasgow, 10 March 2006.

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/Events 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 Maestro, or Credit Card (Mastercard/Visa/Delta).

Notice of cancellations must be given in writing to the Courses and Meetings/Events 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 the deduction of an administration fee. Delegates cancelling after this date will NOT be entitled to a refund unless the College 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/Events Department in the Education Directorate at The Royal College of Anaesthetists.
### DELEGATE DETAILS (PLEASE USE BLOCK CAPITALS)

Full name: ____________________________________________________________

College Reference Number (CRN): _______ GMC Number: _______

Full mailing address: ______________________________________________________________________________________

________________________________________________________________________________________

This address is (tick one only): [ ] Temporary [ ] Permanent Date of birth: **DDMMYYYY**

Tel: ________________________________
Fax: ________________________________
Email: ________________________________

Present appointment and hospital: __________________________________________________________

________________________________________________________________________________________

### MEETING/COURSE DETAILS (PLEASE USE BLOCK CAPITALS)

Title: ____________________________________________________________

Date: **DDMMYYYY** Code: _______

Registration fee: £ 0.00

MEMBERS OF THE SENIOR FELLOWS CLUB ARE ENTITLED TO ATTEND COLLEGE MEETINGS AT HALF PRICE.

### 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):

- [ ] Delta
- [ ] MasterCard
- [ ] Visa
- [ ] American Express

Total remittance: £ 0.00

Card number: ________________________________

Expiry date: **MMYYYY** Issue number (Switch Maestro only): [ ] Start date (Switch Maestro only): **MMYYYY**

Cardholder’s name: __________________________________________________________

Signature: ____________________________ Date: **DDMMYYYY**
Why would an anaesthetist take an interest in palliative care? For me it began many years ago. My first Christmas on-call as a consultant was spent in theatre with a patient who was plainly not going to survive however many times the assembled company turned somersaults or danced ‘Swan Lake’ on points. During a break I sought out the poor man’s wife, who was sitting outside ITU on her own waiting for her children to arrive. I sat beside her, held her hand, and explained as gently as I could what was happening and what the outcome was likely to be. It was probably the most useful thing I did all day.

This experience reinforced a growing feeling I had that as doctors we should be looking at the broader picture, acknowledging defeat when appropriate and then using our skills to improve the quality of the patient’s life. It should not be the norm for such patients to die in theatre or in ITU with a tube in every orifice.

Anaesthetists and palliative care

Nowadays we are better at facing these issues, and talking to patients about what they want. And of course palliative care as a specialty has taken off. It seeks to provide the best possible quality of life for patients with incurable or life-limiting disease; multidisciplinary teams address the physical, psychological, social and spiritual problems that can arise in such circumstances. This is just a stuffy way of saying the patient is cared for as a whole person in his own world – for after all that’s what we are and where we live.

Anaesthetists have much in common with palliative care physicians. We palliate (literally ‘cloak’) the symptoms our patients suffer as a result of surgery and anaesthesia; we can’t heal the surgical wound, but we can provide the environment in which healing can take place, and in the meantime ensure the wound isn’t painful. Our contact with the patient may be brief, but we all know the value of good communication skills – just think of the pre-operative visit and those contacts with an anxious family. We also use non-verbal communication, just as they do in palliative care.

On the practical front, too, we have much in common. We are often treating the same symptoms. We use regional blocks. We know how to use analgesic and antiemetic drugs. Sometimes we use the same drugs, but in a different way. Sometimes different drugs are used. Of course the requirements of acute and chronic symptoms may be different, but even so I am led to wonder whether we might not fruitfully compare results across the specialties more often than we do.

There is one fundamental difference, though. Even the most ardent peri-operative physician has to accept that outside of this defined period the patient is cared for by others. We don’t get to know patient and family in the same way; we don’t have the satisfaction of travelling the road to cure or death with them, providing the palliation, support and empathy that is ours to give at the time of surgery.

So it is perhaps not too surprising that some anaesthetists might feel drawn to palliative care. Add to that an interest in the developing world, and the logical outcome for me was to make my way to the Indian state of Kerala, to learn about palliative care at the Institute of Palliative Medicine in Calicut.

The Calicut Palliative Care Project

This is a WHO Demonstration Project in palliative care, where doctors, nurses and community volunteers are trained. One of the modules offered is a six-week Basic Certificate Course in Pain and Palliative Care, aimed at doctors with an interest in, or some experience of, palliative care. But for me the whole experience was so much more than formal education. It was mind-stretching.

The South Indian state of Kerala has long been known for its strikingly good socio-economic indices which are in a different league from those of most other Indian states, and are remarkable even by the standards of the developed world. A few years ago a group of anaesthetists, including Dr Suresh Kumar (the present Director in Calicut) and
some social workers, set up a pain and palliative care service that is now well established. In some towns it runs along Western, hospice-based lines. However, in the area of Calicut, this didn’t work. Volunteers were initially enthusiastic, but lost interest and drifted away, even when the service was de-centralised. So Dr Kumar and his colleagues found the courage to turn the Western model onto its head, and hand over the control and organisation of the service to the volunteers. This has been hugely successful, perhaps because it is now perceived that the service belongs to the people. The volunteers raise all the necessary funds, much of the finance coming from very small, regular donations; they identify people who are in need of the service, so that the scope of palliative care is determined by the community; they provide non-specialist support; and, when the patients need a nurse or a doctor, these are available. Regular medical clinics are held, home visits are made, and when necessary in-patient care is available at the Institute in Calicut. But the volunteers call the shots and the system is truly non-hierarchical.

This policy has resulted in a free, efficient service that is entirely funded by voluntary donations. It works in the context of home-based care. In Kerala there is a strong family tradition. It would be unthinkable for a family not to look after its sick and elderly. The neighbours help too; this is why the palliative care service is called the ‘Neighbourhood Network.’ Everyone in the community knows about it, and they are, rightly, very proud of it.

On my particular course there were seven other doctors, most of them Keralan anaesthetists who had been asked to set up a palliative care service in their hospital. I also met a couple of ENT surgeons, who wanted to be able to include palliative care in their clinical practice because of the high incidence of head and neck cancers in Southern India. In the Calicut Pain and Palliative Care Clinic that we attended every day we saw many people with advanced cancer. They often presented late, some because of fear, some because they could not afford curative treatment, and some because they had relied on traditional healers until it was too late. These patients provided a real challenge, but it is amazing what can be done with a few drugs and the skills demonstrated by Dr Kumar and his colleagues.

Chronic pain comes under the same umbrella, and it is here that regional blocks come into their own. Hypertension and peripheral vascular disease are common in India, and there was a regular flow of young and old needing lumbar sympathetic blockade. We saw young women with chronic backache, brought on by the heavy manual labour that is very often their lot. What kind of lifestyle advice can you give to a 30-year-old who has to do such work in order to feed her children and her husband of 45, who has been rendered hemiplegic by a CVA? Faced with such problems you can’t totally divorce politics from medicine.

Sometimes we saw patients with fascinating diagnostic problems that sent me scurrying for the library or the Internet café. One young man had been referred to us with a diagnosis of cervico-brachial neuralgia, following a fall. However, the numbness in his arms was symmetrical, patchy, and peripheral in its distribution, and the pain was neuropathic in nature, with allodynia being prominent. There were no skin lesions. We prescribed appropriate analgesia, and sent him to the neurologists, who diagnosed mononeuritis multiplex. Although the cause had not been established by the time I left, I could hazard a guess, in the absence of any other obvious explanation like diabetes or alcoholism.

We saw another young man who for some ten years had suffered attacks of severe hemifacial pain accompanied by ptosis, lacrimation and rhinorrhoea. He could no longer work, because no-one would employ a labourer who was sick every other week. He had been passed from pillar to post and had, at last, been sent to the Pain and Palliative Care Clinic. This was beyond my limited sphere of knowledge so I collared one of the consultants, who said he didn’t know either, but he knew a man who did... so as well as getting appropriate analgesia from us, the young man ended up seeing one of the neurologists in that part of India who knew all about hemifacial pain. Again, the story wasn’t over by the time I left, but I reflected that at least the patient had the comfort of knowing that someone cared enough to get the best available advice for him, and to be there in the background as a continuing support if cure wasn’t possible. It is difficult to quantify the therapeutic effect that this knowledge may have for the individual patient.

Though the clinic took up much of our time, we also had daily interactive lectures on the important aspects of palliative care, including communication, and we had a multitude of projects, tasks and presentations to prepare, so that the course was a comprehensive introduction to the subject.
However, for me this was only the start. What was truly inspiring was the way in which the definition of palliative care in Calicut is being gradually broadened by the volunteers themselves. They do not see why a patient should qualify for this kind of management only if he is dying. They identify people who need the sort of help the service can provide. So, for instance, a mother providing sole care for a severely handicapped child will be supported. So too will patients with chronic cardiac, respiratory or renal disease. And now the techniques and skills of palliative care are being embraced by doctors in other specialities, who want to incorporate them into their own clinical practice.

Dr Kumar says that this is only logical. We cannot limit this care of the whole person in his own world to people who are dying, and say we don’t care about the living. After all, many of those living with such conditions would be dead but for medical intervention. So it is perhaps our duty to ensure that their quality of life is as good as it can be.

Bringing it all back home…

Could we achieve something like this here in the UK? We fund our NHS through taxation, but it seems there is never enough money. We no longer have the strong family structure that exists in Kerala, and often paid carers and professionals provide the daily non-specialist support required. We know that this system does not always work well: the chronically sick and their families struggle to get the ‘joined-up’ care they need, despite the dedication of those trying to provide it, and loving kindness is often lost in the struggle to cope with practical problems. On the other hand we have a rich source of people willing to do voluntary work for an hour or two every week, just as they do in Kerala, and among those there will undoubtedly be people with organisational skills. Perhaps we should stop thinking that taxation should cover everything, and start to consider whether we could adopt a ‘Neighbourhood Network’ model adapted to our Western society, something which would belong to the community and of which the community could be proud.

Now perhaps I should just get back in my box, I hear you say. But (in case you hadn’t guessed) I was vastly impressed by the achievements in Kerala. It is good to be made to take a fresh look at what we are trying to achieve here, to consider whether we might have something to learn from our colleagues in India.

Acknowledgement

I am grateful to Dr Suresh Kumar for his factual corrections, and for his helpful advice, also to Jimmy the driver for the photographs.
A survey of UK anaesthetic trainee attitudes towards simulator based training experience

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Professor G B Smith3, Consultant in Critical Care Medicine
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Introduction

The specialty of anaesthesia has been active in developing hi-fidelity, simulator-based learning. Some anaesthetists have already experienced this novel form of training but it is not universally available and there is no consistency in the requirement staff to attend simulation training sessions. This may partly be due to resource shortages, but may also be due to a lack of support from those who direct training programmes in anaesthesia. This survey was undertaken to assess the current availability of simulator-based learning for UK trainees in anaesthesia and to explore their attitudes to it.

Methods

We surveyed delegates attending the Association of Anaesthetists' Group of Anaesthetists in Training (GAT) meeting held in Portsmouth, June 2004. A two-sided questionnaire was distributed at registration with instructions to return it anonymously to collection boxes. Factual information was elicited with simple closed questions and attitudes were surveyed using a five point numerical analogue scale. Basic descriptive statistics were performed using Microsoft Excel software.

Results

Completed forms were received from 106 delegates with representation from all training regions in the United Kingdom. Figure 1 shows the proportion of respondents from each training grade. The six consultants who responded had been recently appointed and were commenting on their experience in training.

In all, 66% of respondents had received previous training in a medical simulator during their anaesthetic training with a median number of one session. Small numbers had experienced it as medical students or in other specialties. In total 60% of trainees were in a region that provided regular sessions and, where this was the case, the mean reported frequency was 1.4 times per year. In total 90% of respondents believed that simulators should form a part of their training (Figure 2).

Figure 3 details those areas for which simulator training was thought to be useful based on median values from trainees’ responses.

Trainees agreed that medical simulation had a role in formative assessment and team training, but were unsure about the other proposed roles, i.e. competency training, summative assessment, and revalidation (Figure 4).
Discussion

This survey canvassed views from a wide variety of training grades and regions, asking specifically about hi-fidelity simulation. Although the majority of trainees had been exposed to this at some point in their training, the experience was rarely repeated and exposure was not uniform across the country. This may reflect variations in simulator availability and differences in support from regional training schools. Motivation to attend is also probably influenced by factors such as funding arrangements and compulsory training requirements. These aspects were not explored in this survey but, despite this, trainee attitudes alone provide good support for the further expansion of simulator-based training opportunities. An overwhelming majority thought that simulators should form a regular part of anaesthetic training and could be useful in a number of roles. Their main reservations were that simulator sessions were not currently available as frequently as they would like and that at present, they were not confident that simulators were appropriate for competency or summative type assessment. Given this response it is interesting to note that simulated scenarios form part of the OSCE stations at The Royal College of Anaesthetists’ Primary Examination (personal communication Mr J McCormick, Examinations Manager).

Our information shows parallels with the early development of simulators in other industries, such as aviation, where it has now become integral to training. The major barriers to its further implementation in medical education probably stem from financial and manpower constraints within the health service. These are unlikely to diminish in the near future, but other forces such as public opinion may make it less acceptable for patients to be used for training purposes, particularly for the novice practitioner. There is also an increasing awareness of safety and the incidence of human error, both of which can be incorporated into the simulated environment.

A number of publications have made progress in demonstrating the reliability of simulator training, but controversy persists regarding its overall validity for assessment. Experience has shown that simple technical procedures are more reliably assessed than the more complex and non-technical aspects of anaesthetic practice. Despite these difficulties most studies have shown that participants thought the sessions valuable and instructive. Our survey echoes this enthusiasm and provides additional support for the wider availability of simulator training. A Royal College of Anaesthetists working party has recently concurred with this view and recommended that simulation should play a greater role in training (personal communication Professor J A W Wildsmith). The challenge will be to ensure that the best use is made of current facilities and that they are available to all anaesthetic trainees, regardless of geography.

Conclusion

This survey shows that:

- simulator-based training is not routinely available to trainee anaesthetists
- simulation training opportunities occur too infrequently
- trainees overwhelmingly support its usefulness as a training tool.

We conclude that current trainee attitudes support the validity and expansion of simulator-based training.

References

The College’s first national audit

Since the publication of the results of our first national audit ‘Supervision and Responsibility’ the reactions of the body of consultant anaesthetists have been largely as one would hope – largely, but not entirely. The implications were spelt out in an editorial published in the same edition of the British Journal of Anaesthesia that contained the audit. Both the audit and the editorial deserve a second (or for some a first) look.

To many it came as a surprise both that there were genuine gaps in the provision of supervision, and that it was not always possible to identify the consultant providing it. If silence can be construed as consent, then we can assume that where there are defects in the induction of and guidelines issued to non-consultants, departments accept that they need to be corrected.

Over two matters Fellows and Members have not been silent and have asked the College to state clearly its position.

The ‘named’ consultant

The first matter is the need to provide a consultant, free by daytime to give supervision and support at short notice, the second is that the concept of the ‘named consultant’ to do so means whoever is named can be held responsible for the actions of an individual trainee or SAS doctor.

We hold firmly to the first, but give reassurance over the second.

It is a collective responsibility of consultant members of an anaesthetic department to arrange assessment of trainees and SAS doctors, leading to allocation of appropriate levels of responsibility. In a good department it is therefore clear when a given non-consultant is able to provide a service to a patient without the need for further discussion. Guidelines should help to make this decision but, because they cannot cover every eventuality, the default position is ‘if in doubt ask’.

It follows that a consultant must be clearly identified and the obvious place to record ‘who’ is in the anaesthetic chart, which the Joint Committee of Good Practice of the College and the AAGBI has been asked to review. Recording ‘who’ also prompts the trainee or SAS to be aware of which consultant is available. The consultant cannot always discharge the responsibility of support without being physically available to assist at short notice, and rostering must take that into account. A consultant may have to be free, or at least accompanied by another anaesthetist who can be left alone if the consultant is needed elsewhere. This is unlikely to be compatible with a consultant running an ICU and cannot be compatible with a consultant anaesthetising ‘solo’.

Our position is that, whatever of the need to maintain elective surgery, there must always be at least one consultant identified as named and available to support trainees and SAS doctors. During daytime, with a more complex chain of command than at night, and with services provided in many theatres this means the consultant must be ‘on site’. Departments providing services at more sites, whether on or off a main campus, may sometimes have to provide more than one consultant, and this must be a decision made at local level.

‘Named’ not ‘blamed’

None of this means unqualified accountability of an individual consultant for the mistakes of another doctor. Failure to provide support, sound advice or any at all might well result in an individual consultant being held accountable. If on the other hand correct advice and support are given with knowledge of what level of responsibility has been allotted to the trainee or SAS doctor, the consultant is discharging the professional obligation on behalf of the anaesthetic department and the hospital, and is entitled to support from them – and from professional colleagues. All of this might provide a good test of the ‘blame free’ culture.

References

4 Joint Committee on Good practice. RCoA and AAGBI 2002.
We thought that it might be of interest to describe the airway training programme that has been developed at the Royal Perth Hospital, where one of the authors (Dr B Patel) has recently worked for six months as an airway fellow. This post formed part of his ‘OOPE’ (Out of Programme Experience year in Australia).

Dedicated airway training sessions

Dedicated airway training sessions are held twice a week, with a maximum of two trainees per session only. One morning is in the ‘dry lab’ area and the other morning in the ‘wet lab’ area (see below). This allows for a more ‘hands-on’ approach in an informal environment without impinging on clinical duties. It is routinely supervised by one of three consultant trainers with specific responsibility in airway skills training, along with the airway fellow. Although difficult airway management is not a modular requirement in the curriculum, it ensures that all trainees attend these sessions during their time at this hospital, as well as allowing consultants (and Professors!) to attend whenever possible.

‘Dry Lab’ airway training area

This is a dedicated room for airway skills teaching located within the theatre complex, making the facility more readily available for anaesthetic personnel. Audio-visual facilities allow video based teaching on airway anatomy, airway blocks, fibreoptic intubation demonstration, etc.

An anaesthetic machine is present, along with a routine intubation trolley and difficult intubation trolley. This allows trainees to be familiar with the equipment present on these trolleys before they are required in an emergency. A manu-jet ventilator is also present as well as a variety of fibrescopes for ‘dry lab’ purposes only.

A selection of ‘bench’ models are present to allow skills training. Simple models allow novice trainees to practice tracheal intubation, e.g. Laerdal™ Airway Management Trainer. A Portex™ model allows cricothyrotomy training. More sophisticated models, e.g. Dexter™ endoscope trainer allow the motor skills and hand eye co-ordination required for fibreoptic intubation to be developed.

There is also a computerised interactive (Sim-Man™) manikin which can be programmed to simulate normal and a variety of difficult airways, e.g. trismus, pharyngeal obstruction, laryngeal oedema, etc. This allows trainees to manage airway emergencies in relation to clinical scenarios with real time oxygen desaturation alarms. Human anatomy is replicated allowing insertion of laryngeal mask airways and fibreoptic intubation if possible.

‘Dry Lab’ session

Airway skills teaching is divided into basic and advanced, depending on the trainee experience. Basic airway management includes teaching on bag and mask ventilation, laryngoscopes, tracheal tubes and laryngeal mask airways. Unanticipated difficult intubation algorithms are also practiced and familiarised. Advanced airway management involves demonstration on equipment including intubating laryngeal masks, double lumen tubes, bronchial blockers, retrograde intubation and airway exchange catheters. This again allows trainees to familiarise themselves with the vast range of airway equipment available before needed in an emergency. Emergency cricothyrotomy and transtracheal ventilation are routinely practiced (see later) by all trainees. Techniques for fibreoptic intubation and difficult awake fibreoptic intubation are also discussed and practiced with dedicated training fibrescopes.
Trainees are encouraged to return and use any of the equipment in the ‘dry lab’ area for further practice.

‘Wet Lab’ session
This session consists of two parts. It begins with trainees being taught cannula and surgical cricothyrotomy techniques using the cricothyrotomy trainers in the ‘dry lab’. Once they are competent with this, they then practice on live sheep – a technique developed at this hospital.

ESAAS – ‘Emergency Surgical Airway Access simulation using Sheep model’
This involves the use of live sheep that have been cannulated, anaesthetised, intubated and ventilated for the purpose of venesection in order to prepare blood agar plate for the microbiology department. These sheep previously would have been sacrificed by lethal injection, but with approval from the Animal Ethics committee we have been given the opportunity to practice the ‘can’t intubate, can’t ventilate’ situation before they are euthanased under supervision from the resident veterinary practitioner.

The ‘wet lab’ resembles an operating theatre. There is a Boyle’s machine, piped gases, suction, audible pulse oximetry with heart rate monitoring and standard difficult intubation trolley equipment. The sheep is then extubated and allowed to desaturate. Anaesthesia is maintained with intravenous barbiturate.

When oxygen saturation levels are below 70%, trainees are then asked to perform cannula cricothyrotomy via the cricothyroid membrane. Once the cannula is inserted and tracheal position confirmed, a ventilation system is attached and return of saturation levels back to normal are used as evidence of successful ventilation. A high-pressure Sanders jet ventilation system with a Luer Lock connection is used, as well as a low-pressure system using a three way tap and oxygen tubing attached to a flowmeter. Trainees use both the Ravussin (VBM™) and 14G cannulae to ensure familiarity.

Participants also get to perform a surgical crico-thyrotomy, as well as using other techniques, e.g. Mini-Trach™.

Advantages and disadvantages of ESASS
One major advantage of using live animal models to replicate the ‘can’t intubate can’t ventilate’ scenario is that desaturation and resaturation occurs in a real time frame. The audible pulse oximeter adds to recreate a more realistic emergency scenario enabling the participants to have a greater responsibility. This is a far more realistic model compared to the plastic and rubber manikins normally used as there is real tissue elasticity, whilst complications using any emergency cricothyroid technique are also realistically encountered, e.g. venous and arterial haemorrhage, paratracheal insertion, aspiration, secretions, failed ventilation and surgical emphysema. It also allows trainees to assess the advantages and pitfalls of cannula and surgical cricothyrotomy techniques and different ventilation sources. Common errors can be experienced before they may be performed in live humans. Trainees and also consultants who have attended have found it a very realistic experience to recreate the potentially fatal ‘can’t intubate can’t ventilate’ scenario. Some trainees have repeated the session to reinforce their learning.

The major disadvantage with this type of teaching is that of ethics. It is not compulsory for trainees to attend, though most have done so. There are also obvious anatomical differences between human and sheep upper airway anatomy, but it is more realistic than that of the manikin. It also poses a burden on resources, cost and time.

Airway teaching lists
A variety of opportunities exist to learn the airway skills mentioned so far on live humans. Fibreoptic skills can be practised easily in the nasoendoscopy ENT clinic, as well as bronchoscopy lists that occur in the theatre suite with anaesthetic supervision. Large numbers of regular maxillofacial, ENT, craniofacial, trauma and spinal cases give ample opportunity to manage difficult airways. We have four Olympus™ video fibrescopes that are readily available for use by consultants and registrars. There are also portable fibrescopes on each of the four difficult intubation trolleys. On average there are ten fibreoptic intubations per week. The airway fellow is also available for difficult airway cases from a learning and teaching perspective.

Airway journal meeting
We have set up a monthly ‘airway’ journal meeting. This focuses on airway related articles in the literature, allowing consultants and trainees to be aware of recent developments.
Fibreoptic intubation course

Awake fibreoptic intubation is also taught with anaesthetic personnel as subjects, without the use of local anaesthetic blocks or sedation. So far, two courses have been run with six volunteers on each course. They experience being endoscoped as well as being the endoscopist. All have found it valuable and have reinforced their prior fibrescope knowledge and skills.

Summary

There are now more airway devices and techniques than ever before. Dedicated airway skills training sessions and dedicated training areas with consultant trainers have been recommended, and these exist at this hospital. They provide an excellent opportunity for existing anaesthetists to keep their airway skills up to date, and, also provide a structured training programme for trainees at the Royal Perth Hospital.

Acknowledgements

Dr Patel wishes to thank the Imperial School of Anaesthesia, London, UK for allowing him the opportunity to work in Australia. He would also like to thank the Department of Anaesthesia at Royal Perth Hospital for their enthusiasm in advancing training in airway management.

Further reading


AS WE WERE ...

Ingenious, but was it ethical?

Gustav S, a paranoid patient who lately became feeble-minded, believes that dirt is added to his food and that he has to inhale dirty material since the surrounding air is contaminated. In order to remove some of the dirt from his body he spits into his food bowl the entire saliva produced throughout the day. The volume of saliva collected in the food bowl over a 4 hour period was measured at a certain time each day for three consecutive days, and found to be fairly consistent at about 10 ccs per hour.

On the fourth day the patient was given 0.5mg hyoscine subcutaneously. After the injection he continued to produce some saliva for approximately 10 min, then lay down and tried hard to spit. He did not succeed in this, got very angry and accused the doctor of having given him so much dirt that everything became bunged up, thus making it impossible for him to get rid of the dirt. Over a period of four hours on a few cubic centimetres of saliva were produced and six hours elapsed before salivary secretion returned to normal.

Hyoscine thus reduces salivary secretion and a paralysis of the secretory nerves is probably responsible for this action.

Reference


David Zuck
History of Anaesthesia Society
Our College voting has always been by postal voting. Earlier this year the local Council elections in Birmingham were brought into disrepute when sackfuls of rigged ballot papers were found. Matt of the Daily Telegraph made fun of this in his general election cartoons: a sticker in the house front window depicted 'I’ve voted by post, apparently'; two policemen discussing their felon 'It’s the worst case of postal vote fraud I’ve seen. He sent in 397 Don’t Knows; and a customer in the Post Office complaining 'Why am I always behind the person who is filling out 3,000 postal votes?' In recent years our College Council elections have been run by the Electoral Reform Society (ERS). There has not been any suggestion of rigging but there is concern within the College about the apparent voter apathy.

There have only been two elections for staff and associate specialists since the inclusion of two Council seats for this category in 2002. Since 2001 there has only been voting required for a trainee vacancy on Council on one occasion, because on two occasions the candidates were elected unopposed. Therefore we concentrate on the voting statistics for consultant vacancies since the year 2000 as shown in Table 1. What conclusions can we draw? There has been a steady increase in the number of anaesthetists eligible to vote, such that this year there were nearly 9,000 ballot papers sent out. We think it is cause for concern that less than 30% exercised their right to vote compared with a 38% return in the year 2000.

Table 1 Consultant vacancies

<table>
<thead>
<tr>
<th>Year</th>
<th>Ballot papers issued (n)</th>
<th>Valid papers returned (n)</th>
<th>% return</th>
<th>Vacancies (n)</th>
<th>Actual votes (n)</th>
<th>Average number of candidates voted for</th>
<th>Average number of candidates voted for</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>7,509</td>
<td>2,854</td>
<td>38.0</td>
<td>2</td>
<td>5,335</td>
<td>1.87</td>
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<td>2001</td>
<td>7,864</td>
<td>2,757</td>
<td>35.1</td>
<td>2</td>
<td>5,176</td>
<td>1.88</td>
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<tr>
<td>2002</td>
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<td>2,832</td>
<td>35.2</td>
<td>4</td>
<td>9,321</td>
<td>3.29</td>
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<tr>
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<td>8,429</td>
<td>2,661</td>
<td>31.6</td>
<td>4</td>
<td>8,749</td>
<td>3.29</td>
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</tr>
<tr>
<td>2004</td>
<td>8,582</td>
<td>2,872</td>
<td>33.5</td>
<td>5</td>
<td>11,231</td>
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<td></td>
</tr>
<tr>
<td>2005</td>
<td>8,896</td>
<td>2,651</td>
<td>29.8</td>
<td>2</td>
<td>4,781</td>
<td>1.8</td>
<td></td>
</tr>
</tbody>
</table>

To canvass opinions about voting for Council elections one of us emailed about 90 anaesthetists whose addresses were available and received replies from most people, if only a short reply. Let us be certain this was not a random selection of anaesthetists, as they have mostly been around a bit (i.e. tend to be older) and are mostly involved in national anaesthetic activities. Not surprisingly virtually all of them indignantly claimed to vote, but recognised that their colleagues may not. Some women mentioned the importance of exercising their right to vote because of the suffragettes gaining us this liberty. Some of the comments were helpful in understanding the issues.

General apathy

There were general and opposing views, some indicating that people do not really care who is on the College Council whilst others implied that the disinterest was due to voter contentment with no burning issues that the College should address. A view was expressed that there is a general disenchantment with anything associated with administration, regulation or the new NHS. Others said that people do realise that the College is not responsible for the state of the NHS, the pensions mess, their declining private practice and the rising cost of school fees.

Knowing the candidate

Overwhelmingly the most influential factor in whether people were motivated to vote was whether they knew the candidate(s). Some people said they would vote for candidates with specialty specific interests, such as pain medicine. Contacts in the North East and Northern Ireland felt they suffered from geographical remoteness and were thus less likely to know the candidates.

What could the College do about making the candidates known to their Fellows? One approach would be to introduce regional seats. This possibility was discussed but rejected during Peter Hutton’s presidency.

Election statements

Election statements are relatively recent. They are short with only up to 100 words being allowed. This has advantages and disadvantages. Many of the responses required from College councillors/officers have to follow a format and the statement could be seen as an ability to
follow instructions, be precise and convey a message. However, it does not allow a candidate to let the electorate know the breadth of what they have already done as well as being explicit about what they would plan to do if elected. It has been suggested that 250 words should be allowed and perhaps this could be available on the website for the discerning voter to glean more information. There are also suggestions that photographs should be included.

Relevance of the College
There is no doubt that the Medical Royal Colleges are perceived as being less powerful than they were formerly; nonetheless, they still seem to be perceived by Tony Blair as having more power or influence than he would like. One suggestion is that there is not enough public evidence of our College being a thorn in the side of Government in speaking for the Fellows.

Perhaps the College is viewed as being stuck in a rut without clear purpose. A suggestion was for the College to present itself in a more exciting manner. It should publish a mission statement, a five-year plan and job descriptions of what successful candidates would be asked to do. Ability to work miracles would be an asset!

Timing of the election
Some years ago the College ballot papers used to come with the Christmas post. Now they arrive well into January with a closing date of early March. This allows sufficient time for overseas voters to use surface mail for their return. Although some commented that the timing was not important, others suggested that the long time delay lessened the urgency of voting and the ballot paper was then forgotten or mislaid. The use of electronic voting with reminders was suggested as an alternative.

These and other issues related to voting will be discussed again in Council. If any of you have useful suggestions please let us know.

Your vote does count
In this year’s election there were only seven votes between one of the successful candidates and the topmost of the unsuccessful candidates. This shows that your vote really does count. Come January, spare the time to decide on your chosen candidate, mark with an x, and – no need to buy a stamp – just put it in the post.

Anaesthesia and renal services
Dr M Heining, Consultant Anaesthetist, Nottingham City Hospital NHS Trust
email: mheining@ncht.trent.nhs.uk

The public demand for renal support services, including renal dialysis and transplantation, continues to rise. In order to rationalise service provision, the Department of Health (DH) published a National Service Framework for Renal Services in 2004. This document included recommendations for the quality and efficiency of elective dialysis access surgery.

Needless to say, one might expect anaesthetists to be involved in planning for the provision of any surgical service. Yet surprisingly, in its discussion of elective surgery in this group of notoriously complex patients, the document contained no reference to anaesthesia.

This was partly rectified when the NHS Modernisation Agency (MA) set up a Modernising Renal Services Working Party, on which I was asked to represent The Royal College of Anaesthetists.

The full report of the MA Working Party is available on the DH website but, for anaesthetists, the main points of relevance are as follows.

1 There should be a significant move towards day case surgery for straightforward arteriovenous fistula surgery.
2 There needs to be a greater use of regional anaesthetic techniques, such as brachial plexus blocks. There is evidence of a shortage of skills in regional techniques (or possibly a lack of application of these skills) in various parts of the country, and this needs to be addressed.
3 The importance of pre-operative assessment, preparation and work-up for all dialysis access surgery is emphasised. There is a strong case for involving a lead clinician from the anaesthetic department in helping to organise the patient pathway and aspects of clinical management.

Clinical directors of anaesthesia, or lead clinicians in day case anaesthesia, may well be asked to apply these recommendations. Interested colleagues are welcome to contact me at the address above.
Chandra Kumar graduated in 1973 from Patna University Medical College, in India. After completing his basic medical training, he worked as a Civil Assistant Surgeon in the Military Police.

He came to England in December 1979, and shortly afterwards started his anaesthetic training in Middlesbrough, the town where he was eventually to settle. Basic and higher specialist training were completed in the Northern Region, and as a consultant anaesthetist, he was to follow clinical interests in ophthalmic and regional anaesthesia. He has been a Fellow of The Royal College of Anaesthetists, London, since 2001.

An intellectual interest in computing applications to medicine led to a Master’s degree with the University of Teesside. However, it is in the inter-related areas of ophthalmic anaesthesia and postgraduate medical education that Chandra has developed an increasing reputation, both in the UK and further afield.

His contributions to ophthalmic anaesthesia are wide. They include the development of a national training workshop on local anaesthesia for ophthalmic surgery. He was the lead organiser of the inaugural meeting of the World Congress of Ophthalmic Anaesthesia which was held in London in April 2004, and has been an invited speaker, chairman and leader of master classes at many international meetings including the World Congress of Anesthesiologists and the American Academy of Ophthalmologists. He has jointly edited a textbook on ophthalmic anaesthesia.

His achievements in postgraduate medical education, his other major area of interest, have progressed steadily from his appointment as College Tutor to the South Cleveland group of hospitals in 1988 to his recent appointment as an Honorary Professor of Anaesthesia within the University of Teesside. An Honorary Clinical Lecturer to the Universities of Newcastle and Durham, he is involved in the delivery of teaching to the new medical school development in Stockton. He plays an active part in the day to day running and administration of an MSc course in Evidence Based Anaesthesia Practice and runs courses on presentation skills at the University of Teesside.

As a member of a Regional Specialist Training Committee in Anaesthesia, he helped to complete the development of a rotational training scheme that was to form the basis of the future Cleveland School of Anaesthesia a few years later. He is also an examiner for the Primary Fellowship Examination of the College of Anaesthetists in Ireland.

His publications are numerous. As well as peer-reviewed papers in anaesthetic and ophthalmic journals, he is a co-author of a number of textbooks, including one on the practical aspects of anaesthetic education. A reviewer for various ophthalmic and anaesthetic peer-reviewed journals, he is on the editorial board of the longstanding anaesthetic continuing medical education journal Current Anaesthesia and Critical Care.

As an effective organiser with seemingly boundless energy, Chandra has been a driving force behind the development of four national specialist societies in anaesthesia, as well as the MSc Evidence Based programme in the University of Teesside. He was Honorary Secretary of the British Ophthalmic Anaesthesia Society and the Society for Education in Anaesthesia, UK, and is an ex-council member of the European Society of Regional Anaesthesia (Great Britain and Ireland). He is an elected council member of the Age Anaesthesia Association, and remains a current council member of the British Ophthalmic Anaesthesia Society. He was recently elected as a council member of the Association of Anaesthetists of Great Britain and Ireland (AAGBI), and is the current President of the Society for Education in Anaesthesia (UK).

Chandra has been involved in the overseas doctors training scheme for more than a decade, and has offered clinical attachments and placed many overseas doctors in training schemes. Locally, he has been an advisor for overseas doctors in anaesthesia for the Northern Region since 1998. So it is, therefore, particularly fitting that he was appointed Bernard Johnson Advisor for Overseas Doctors in August 2005 by The Royal College of Anaesthetists.
I often listen to Sarah Kennedy on the radio in the morning and when someone writes in with an unusual job (usually involving food tasting) she laments: ‘The Convent careers office never told me I could do that’. My experiences with my convent careers officer was that I should either be a maths teacher or an undertaker. I thought strongly of the latter, having a penchant for black, but thought better of it and pursued the former gaining a degree in Mathematics and Economics from the University of London and teaching maths in the evenings and weekends. I was offered a job as a mathematics teacher the day after my results came through, an attractive prospect when you are in debt, but I wanted to do something a bit more exciting so I applied for VSO. Whilst waiting for the decision I spent a month backpacking around Kenya, returning home to an offer of a post in Ghana. Unfortunately, the backpacking had put me off Africa I realised I could not commit to two years without Andrex and Cadbury’s.

So the next thought was finance and banking. I spent a year working ‘in the city’ at an international bank but quickly knew that again this was not for me – I preferred to spend money rather than look after it! I took my civil service exams and chose to work in environment protection. Travel was calling me, however, and I applied for Operation Raleigh (now known as Raleigh International). After a pretty gruelling weekend of tests of stamina and fortitude I was selected as a venturer and was off to Guyana, South America.

A Raleigh expedition lasts around three months and involves service, science and adventure. The ‘service’ bit included selecting patients for cataract operations, working in a leprosy hospital and building a school. The ‘science’ bit was collecting dung beetles and the insects that spread sleeping sickness and the ‘adventure’ bit involved a two-week trek through the jungle, across the savannahs and crossing piranha and cayman populated rivers.

On my return I was employed in the personnel department of the Corporation of London, responsible for amongst other things the cemetery and crematorium (perhaps someone was telling me something). I led the work on grievances and disciplinaries – one unforgettable case was a member of staff disciplined for being drunk in charge of a lawn mower! The unusual nature of the Corporation of London meant that I was also responsible for a number of functions for the Lord Mayor, the most memorable being a celebration of the Far Eastern prisoners of war society. This event was attended by the Queen Mother and Dame Vera Lynn. My most profound memory was of introducing the Queen Mother to a prisoner who had been blinded by torture.

I moved on to the Royal College of Surgeons where I spent 11 years in the intercollegiate training department (Joint Committee on Higher Surgical Training [JCHST]) moving through various roles, with the last seven years as Head of Specialist Training and Regulation. During this time I became a qualified Company Secretary and am now a Fellow of the Institute of Company Secretaries and Administrators. I gained a considerable amount of experience of the training structure and legislation for hospital-based specialties, having joined prior to the introduction of the Specialist Training Authority and the CCST and surviving the first round of assessments for equivalence (for surgery this was over 800 applications).

I was delighted to be asked to join the staff of The Royal College of Anaesthetists in the newly created role of Education Director and Head of Personnel. I was, without doubt, a little daunted at becoming part of a well established and exceptional senior management team however, they have made me feel welcome and encouraged my input and contribution. The President and Council have similarly been welcoming, sharing their knowledge and expertise. I have been impressed by the commitment of all the Council members, with full houses at both my first Education Strategy Committee and my first Courses and Meetings Committee in June. I know that with such commitment and dedication, the Institute of Education will flourish.

My first main task at the College has been to co-ordinate the move to Churchill House. Everyone is excited about the move and looking forward to what the new building has to offer, not least the balcony overlooking Red Lion Square.

In parallel to this is the development of the Institute of Education this is a task that I relish getting my teeth into and I warn you all now that I will be out looking for contributors and participants.

When I am not at work, my husband and I love to travel and when not doing this enjoy planning the next trip. I am a Fellow of the Royal Geographical Society and attend various lectures either to inspire our next trip or to reminisce over places visited. The remainder of my free time is spent as a neighbourhood disputes mediator. So if any of you have a problem with a yapping yorkie or looming leylandii, you know where I am!
Report of a meeting of Council

At a meeting of Council on Wednesday, 20 July 2005, the following was admitted as Regional Adviser:

South West Peninsula
Dr J M Saddler, Royal Devon and Exeter Hospital, Devon

The following names were approved for the Diploma of Fellow of the College (University of primary medical qualification in brackets):

Akrerman, Henry Frank (London)
Aii, Mohiuddin Gymya (Al Fateh)
Ali, Syed Zulfiquar (Kashmir)
Al-Nami, Kamal Taha (Baghdad)
Anderson, Gerry (London)
Annadurai, Saiprasad (Tamil Nadu)
Ans, Jonathan Paul (London)
Appelboam, Rebecca Louise Noel (London)
Baliga, Janardhan (Mysore)
Baruch, Miriam Rosa (Edinburgh)
Baxter, Sally Ann Campbell (Oxford)
Bayshev, Fidel Kazbekovich (Vrach Celjabinsk Medical Institute)
Bearfield, Philip (Leeds)
Beringer, Richard Michael (Nottingham)
Bhatagw, Manasi Mangesh (Bombay)
Bosters, Lucy Hannah (London)
Bowers, Richard Peter (Edinburgh)
Braham, Deborah Laureen (IBM Southampton)
Breerton, Alison (Birmingham)
Buckley, Philip Warren (Birmingham)
Burtenshaw, Andrew John (Birmingham)
Butler, Karen A (Manchester)
Campbell, Georgina Claire (Glasgow)
Carey, Sheila Marie (Sheffield)
Chakravarti-Chattopadhyay, Madhur (Bombay)
Chalmers, Alison Gillian Wemyss (Birmingham)
Chan, Emma Wing-See (London)
Cheung, Jonathan Kwok Ho (Edinburgh)
Chinniah, Sadasivan (Tamil Nadu)
Davies, Simon James (Edinburgh)
Davis, Ross Martin (Bristol)
Dawson, Henrietta E (Newcastle Upon Tyne)
Deepak, Ravindran (Pondicherry)
Desai, Parag Ramesh (Bombay)
Dick, Elaine Sylvia (Glasgow)
Donaldson, Alison J (Newcastle Upon Tyne)
Doraswami, Mano (Tamil Nadu)
Dow, William Allister McGowan (Birmingham)
Duncan, Catriona Marion (Bristol)
Edmands, Deborah Frances (London)
Emmanuel, Johann Naveen (London)
English, William Andrew (Nottingham)
Ferguson, Lee Patrick (Edinburgh)
Fong, Kevin Jeremy (London)
Foster, Susannah Catherine (London)
Foxall, Gillian Louise (Sheffield)
Frels, Carsten (Berlin)
Galvin, Imelda (Dublin)
Gauthama, Priya (Tamil Nadu)
Georgiou, Maria (London)
Girgis, Michael (London)
Girish Sadhu, Narasimha Murthy (Mysore)
Godfrey, Philip David (Newcastle Upon Tyne)
Gomez, Watson (Bangalore)
Gopalakrishnaih, Ullas Kalasapalur (Bangalore)
Gopinath, Niraj (Kerala)
Gosavi, Chandrakant Pandurang (Bombay)
Gowni, Rajashekar Reddy (Andhra Pradesh University of Health Sciences)
Grandhi, Radhika Prasad (Mysore)
Greenwood, Jaime John (London)
Gudipati, Sreedar (Vijayawada)
Gupta, Pawan Kumar (Delhi)
Gupta, Sameer (Delhi)
Halikar, Vikram Govindrao (Marathwada)
Halliwell, Emma Louise (Cambridge)
Hann, Helen Catherine Luis (Leicester)
Haque, Seleena (Southampton)
Harper, Gavin Kenneth (Belfast)
Harrison, Elaine Lesley (London)
Harvey, Laura Jayne (Leeds)
Heam, Christopher Mark (London)
Heredes, Veiko (Vrach University of Tartu)
Hoare, Joan Marion (Ireland)
Holland, Christopher George (Belfast)
Howard, Felicity Emma (Wales)
Hoyle, James Thomas Edward (Sheffield)
Hulme, Jonathan (Birmingham)
Humphreys, Joanne (Manchester)
Ismail, Chowdhury Omar Farouk (London)
Iyer, Gopal Anand (Mysore)
Jackson, Michael Henry Murray (London)
Jackson, Richard Anthony (Birmingham)
Jackson, Timothy John (Leeds)
Jain, Susan Sumita (London)
James, Katherine Margaret Heath (London)
James, Polly Amanda (Manchester)
Janossy, Katherine Monica (Edinburgh)
Jansen, Andrea Helen (Edinburgh)
Jenkins, Ian (London)
Jenkins-Welch, Melvyn Russel James (London)
Jepp, Katharine Elizabeth (Sheffield)
Jones, Tanya (Manchester)
Kadur, Somashekharrappa B (Karnataka)
Kambli, Anil (Bangalore)
Karthik, Sabapathi (Bangalore)
Kaye, Hayley Jillian (Leicester)
Keogh, James William (Manchester)
Khakhri, Mitesh Bhalchandra (London)
Khan, Javid Ahmed (London)
Khan, Kamran Zafar (Punjab)
King, Wendy Diana (London)
Kirk-Bayley, Justin De La Motte (London)
Koertzen, Marta (Charlestown)
Kuchi, Sridivei B (Sri Venkateswara)
Kuduvalli, Preeti Manoj (Nagpur)
Kumar, Manoj (India)
Kumar, Rahul (Gulbarga)
Kupparao, Lakshmi N (Madurai-Kamarajar)
Laws, Philip Gavin (Cambridge)
Lazutin, Juri G (Vrach Tumsk Medical Institute)
Lees, Nicholas James (Leicester)
Lim, Yen Sheng (Cork)
Loew, Christopher Jens (Freiburg)
Longfellow, Ruth Mary (Edinburgh)
Low, Daniel King-Wai (Nottingham)
MacFarlane, Alan James Robert (Glassgow)
Macleannan, Kirsty (Birmingham)
Maddison, Benjamin John (London)
Madon, Keki Shavak (London)
Mahroof, Mohammed Razeen (Southampton)
Makura, Catherine Ndimatse (Zimbabwe)
Mangold, Nikolaus (Cologne)
Mani, Vaithianadan (Pondicherry)
March, Adam Charles (Nottingham)
Marian, Anil Alexander (Kerala)
Marr, Robert James Douglas (London)
Marstin, Sarah Jane (Southampton)
Martin, Alastair James Lindsay (Bristol)
Mathew, Aj Thomas (Mamipala)
McClelland, Stuart Howard (Sheffield)
McConnell, Huw David Smithyman (Dundee)
McCullough, Justine (Leicester)
McGrath, Brendan Anthony (Sheffield)
McManamon, Lucy Jane (Nottingham)
Middle, Justine Victoria (London)
Millar, Linzi Deborah (Glasgow)
Millard, Christopher Leonard (Liverpool)  
Milne, Alistair David (Manchester)  
Mitchell, Edwin Mark (London)  
Mitra, Suman (Calcutta)  
Molyneux, Mathew Keith (London)  
Morgan, Patrick Gower (Leicester)  
Muller, Nadja Sabine (Stellenbosch)  
Myburgh, Adrian Louis (Preatoria)  
Naguib, Maha Ahmed Kamal El Din (Cairo)  
Nariani, Jaya Thakur (University of Mumbai)  
Narre, Srikant (West Indies)  
Nicholson, Christopher James (Otago)  
Noakes, Caroline Margaret (London)  
O’Brien, Benjamin (Berlin)  
Okunuga, Adekunle Moruf Oluwakemi (Ibadan)  
O’Neill, Breda Bernadette (London)  
O’Neill, Sarah Siobhan (Oxford)  
O’Neill, Suzanne Louise (Edinburgh)  
Padoa, Colin Robert James (Cape Town)  
Palihawadana, Rajee Prasanga S (Colombo)  
Parker, Lindsay Clare (Newcastle Upon Tyne)  
Paul, Adam Morton (Edinburgh)  
Pavey, Warren Anthony (Western Australia)  
Pechett, Kenneth James (Manchester)  
Pegg, Rachel Jane (Sheffield)  
Penny, Lisa Antonia (Bristol)  
Perry, Justin MacDonald (Edinburgh)  
Phan, Tuong Dien (Melbourne)  
Philips, Tudor Joseph Colin (Cambridge)  
Phukan, Debaditya Kumar (Dibrugarh)  
Pingle, Anjali Ashok (Amravati University)  
Pollard, Andrew Michael (Leeds)  
Poonawala, Yasmin (Birmingham)  
Pow, Colin Edward Linsay (Aberdeen)  
Prabahar, Thaventhran (Colombo)  
Pryke, Helen Elizabeth (London)  
Pugh, Henry Edward John (Bristol)  
Quasim, Seema (Birmingham)  
Radbourne, Sarah Louise (Leeds)  
Radhakrishnan, Jayachandran (Tamil Nadu)  
Radhakrishnan, Lakshmanan (Tamil Nadu)  
Rafi, Muhammed Amir (Edinburgh)  
Raghavan, Kavitha Chakravarthy (Bangalore)  
Rai, Bharat Shashidhar (Manipal Academy of Higher Education)  
Rajasinghe, Jeewani Shiranthi K (Colombo)  
Ramanan, Ammaippoor (Tamil Nadu)  
Rao, Karthik Narayana (Karnataka)  
Redfern, Daniel (Birmingham)  
Reschreiter, Henrik Peer (Hamboldt)  
Richards, Nicole Anne (Cape Town)  
Rope, Tamsin Caroline (Birmingham)  
Rowlands, Martin (Sheffield)  
Safar, Elham Maria (Newcastle Upon Tyne)  
Sambridge, Neil (Sheffield)  
Scott, Charlotte Helene Rennie (Aberdeen)  
Seal, Philippa Anne (London)  
Sebastian, Roby (Bangalore)  
Seewal, Rahul (Delhi)  
Shahab, Abdul Muthaleeef (Tamil Nadu)  
Shalaby, Ola Ibrahim Abdelaziz (Cairo)  
Sharma, Mukesh Ramprasad (Puna)  
Sharma, Sanjeev (Indira Gandhi Medical College)  
Sharman, Andrew (London)  
Shelton, Jonathan M (Newcastle Upon Tyne)  
Sinclair, Catherine Margaret (Nottingham)  
Singh, Peremendra (Tamil Nadu)  
Skinner, Benjamin Charles (Dundee)  
Snowden, Christopher Robin (Leeds)  
Soinaiya, Meeta (Bombay)  
Southey, Stewart Gunn (Witwatersrand)  
Sri-Chandana, Chunda Hasitha (Zimbabwe)  
Sriharsha, Doddaballapur S (Bangalore)  
Stedman, Alan Jeffrey (Southampton)  
Stevens, Arabella Paula (Manchester)  
Stirling, Sarah Louise (Glasgow)  
Suxena, Ashesh (London)  
Syed, Sanaaia Kalemulla (Bangalore)  
Syed Mohammad, Ausim (Bhopal)  
Tarnal, Vijaykumar (Bangalore)  
Theodosiou, Catherine Anne (Edinburgh)  
Thomas, Huw Brian Watcyn (Edinburgh)  
Thomas, Peter (Mahatma Gandhi)  
Thorp-Jones, Daryl John (London)  
Tilston, Stephanie Jane (Dundee)  
Turner, Matthew Wedgwood (Birmingham)  
Vaghel, Madhvi (London)  
Vamadevan, Shelley (Cape Town)  
Venkatanath, Doraraj (Madras)  
Vermi, Era (Himalchal Pradesh)  
Vizaychipi, Marcia Paola (Argentina)  
Ward, Matthew Marggrave (Bristol)  
Ware, Claire-Louise (Southampton)  
Wares, Gary Mark (Glasgow)  
Welsch, Daniela (Leeds)  
Wenham, Timothy Nigel (Sheffield)  
Whitehead, Ian John (Liverpool)  
Wiles, Matthew Dominic (Nottingham)  
Williams, Susan Louise (Wales)  
Wilson, Emma Georgina (Birmingham)  
Wise, Arlene (Glasgow)  
Woodward, Lynsey Jane (Southampton)  
Wright, Janette Carolyne (Tasmania)  
Yarham, Sarah Isabel (Bristol)  
Yates, David Richard Alexander (Leeds)

**THE ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND**

**11–13 January 2006**
Winter Scientific Meeting, QEII Conference Centre, London

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More detailed information can be obtained from the Association of Anaesthetists of Great Britain and Ireland, 21 Portland Place, London WC1B 1P Y
**telephone** 020 7631 1650, **fax** 020 7631 4352
**email** meetings@aagbi.org  
**website** www.aagbi.org
THE EUROPEAN DIPLOMA IN ANAESTHESIOLOGY AND INTENSIVE CARE
A candidate’s view

Sir, – For most clinicians practising in the UK, the Final FRCA is the last professional examination that they will ever have to encounter. However, there appears to be a distinct possibility for the creation of a European Board of Anaesthesiology to provide an international qualification standard. The requirements for Board Membership would consist of the European Diploma of Anaesthesiology and Intensive care (EDA) as well as specialist registration in an EU country. This seems a sensible idea given the unrestricted movement of workforce throughout a now widened economical area.

Why do it?
Curiosity as well as the awareness that medical knowledge decays in a non-linear fashion in my case (I passed the FRCA in 1994) were deciding factors to sit the EDA. Furthermore, I felt that this activity could be an objective form of continuous professional development. Some of my colleagues thought that the drive for this might have been an element of a midlife crisis or it had something to do with my Germanic upbringing.

The exam
The relevant details are extensively covered on the ESA website. The examination can be taken in a number of languages including English, and examination centres are located all over Europe.

The examination comprises two parts: the first part is aimed at trainees with approximately two to three years’ experience in the specialty, and the second part is an exit exam aimed at anaesthetists with about six years’ professional experience.

Part 1 of the EDA is a multiple choice paper consisting of two papers; the one in the morning has 60 stem questions each with five branches concentrating on basic sciences. There are two hours allowed and the questions are negatively marked. The afternoon paper assesses clinical sciences, lasts two hours and consists of 60 negatively marked questions.

Part 2 is an oral examination consisting of four vivas (two in the morning and two in the afternoon) each of 25 minutes duration with two different examiners equating to a total of eight examiners. The subjects covered are from the following areas.

1 The basic sciences (including physics and measurement).
2 Clinical anaesthesia (including obstetric anaesthesia and analgesia).
3 Resuscitation and emergency medicine.
4 Intensive care.
5 Management of chronic pain.
6 Current literature.

Preparation
This is obviously a matter for each individual to decide how she or he studies and learns most effectively. Therefore the time for preparation will vary significantly. Before the written part, besides reading the standard textbooks, I attended a College refresher course in Birmingham, which proved extremely useful. I read the BJAnum: CPD Reviews and answered the multiple choice questions at the end. The exact breakdown of the written results allows the candidate to identify strengths and weaknesses in knowledge, and gaps can be closed before attending the oral examination. My senior and junior colleagues helped me with viva practice and I attended teaching ward rounds on ICU. Some humiliation before the exam is probably inevitable as part of the learning process.

Further points
The visit to Uppsala for the vivas was most enjoyable and the examiners, as well as the Chairman, Professor Wiklund, were very nice and fair and everything was well organised. The ceremony for the diplomas is integrated with the next ESA meeting in Madrid. A trip to Madrid should be some compensation for all the stress and hardship.

Acknowledgement
I would like to thank my wife, Catherine, for her patience whilst all this was going on.

H Klein, Consultant, Leeds

References
3 ESA website – education (www.euroanesthesia.org/).

Local knowledge
Sir, – Dr D Gray reports an interesting observation regarding the behaviour of SHO anaesthetists attending FRCA Courses (Bulletin 33, September 2005, pg 1684).
One thing leads to another...

Sir, – Unlike Dr P N Young (Bulletin 33, September 2005, pg 1684), as a retired consultant I am grateful that I am still able to prescribe; in particular the antiviral drug oseltamivir for myself and my immediate family – despite its cost.

I am not optimistic that the family would be high on the NHS priority list if and when the flu pandemic strikes.

J Secker-Walker, retired Consultant, Somerset

Sir, – I wonder if a sick Dr P N Young (Bulletin 33, September 2005, pg 1684) would prefer treatment by a retired ‘charlatan’ like myself, to a three-week wait for a doctor’s appointment. Some of my neighbours do!

AS Gardiner, retired Consultant, Kent

Sir, – It may help Dr P N Young to trace the origin of the quotation that he gives (Bulletin 33, September 2005, pg 1684). If he starts by assuming that it is a variation of one of the Aphorisms of Sir William Osler (1849–1919). This is given in ‘The Oxford Dictionary of Medical Quotations’, by Peter McDonald, as ‘A physician who treats himself has a fool for a patient’. A similar entry appears in ‘Familiar Medical Quotations’ edited by Maurice B Strauss.

It may be that Osler was only paraphrasing an early Nineteenth Century Proverb which ran ‘A man who is his own lawyer has a fool fo a client’. (The Oxford Dictionary of Quotations). The wording, and the concept, are much the same.

Whatever the origin of the saying it is, indeed, a very wise one, and I support the opinions of Sir William Osler, and Dr Young, against that of Professor M D Vickers.

JG Fairer, retired Consultant, Somerset

Ed note: This correspondence is now closed!

Overview of training

Sir, – I read with interest Professor J A W Wildsmith’s article ‘Training in Anaesthesia: ensuring academic competency’ (Bulletin 33, September 2005, pg 1657–1658). I feel this raises a number of important issues from a trainee’s perspective.

Firstly, I question the statement that ‘for specialist registrars in years 1 and 2, delivering the necessary specific knowledge would be assured if all trainees at this level attended a one-day course on academic matters.’ A one-day course would surely not be sufficient time to cover, in depth, the topics listed in Table 1. If such courses were to be developed, they should be delivered at either a regional or national level. This would ensure a wider choice of lecturers who could be picked for their expertise and enthusiasm for a given subject.

For specialist registrars in Years 3, 4 and 5, it is stated that ‘all trainees should be required to participate in a research project, a full audit cycle or a published systematic review.’ Although completion of an audit cycle is easily possible within a six- or 12-month placement, participation in a research project is often more difficult. Each placement is generally not sufficient in length to individually plan, seek approval for, and collect data for a research project worthy of publication. Participation in a project already in progress is feasible, but there are generally not sufficient projects for growing numbers of trainees.

It is, however, essential that trainees are taught the intricacies of critically reviewing published evidence, and the processes involved in audit and research projects. A course incorporating these subjects which also has sufficient content to cover some of the common core of non-clinical competencies (Understanding the Responsibilities of Professional Life, Teaching and Medical Education, Healthcare Management, Independent Practice and Medical Ethics and Law) would surely be worthwhile.

It is, at present, proving difficult to complete the common core of non-clinical competencies at a local level. The reasons for this is are multiple, but include a lack of trainers with sufficient time and expertise to dedicate to these subjects, and a perception from trainees that clinical competencies should take priority in the current climate of reduced training hours due to the EWTD.

J Bromilow, SpR, Dorset

Reference

1 The CCST in Anaesthesia IV: Competency Based Specialist Registrars Years 3, 4 and 5 Training and Assessment. A manual for trainees and trainers. Edition 1, April 2003. RCoA London.

Undercover in a French hospital

Sir, – I would like to congratulate Dr G M Cooper on her article drawing on her own experiences of a skiing accident and highlighting the differences in trauma care between the UK and France (Bulletin 33, September 2005, pg 1648–1649). However, I need to comment on her exhortation to all skiers – ‘always check your own bindings’. What should one be looking for and what is one supposed to do about it?

Bindings should be fitted to you
and your boots individually with respect to sole length and forward pressure caused by the position of the heel block, toe height above the anti-friction surface and toe width, as well as individuals’ requirements: weight, height, age, boot sole length and lastly and very importantly skier activity. Boot sole length is the only objective variable that is evident at the time of hire or sale of the ski. Largely, a technician is then dependent on the client’s honesty for the rest! Many technicians will ask about your ‘experience’ as a marker of technical level but this is not strictly relevant. However, individual client activity is and this will depend on speeds, terrain (steepness, bumps, powder, crud etc.) and an appreciation of acceptable risk. An ‘intermediate’ skier who inexplicably ‘pops out’ of bindings on a relatively rare foray into the bumps although there was no ski technique ‘fault’ at the time will understand this. High performance skiers have their bindings set very much tighter, but the greater risks are understood.

Any technician should adjust the bindings with these factors in mind. They have the manufacturer specifications. I would urge the client to make sure that the relevant questions are being asked. If not, then take your custom elsewhere. Do not attempt to alter the ISO settings found fore and aft of the binding. These can be altered quite easily with those screwdrivers that are placed handily at the top of some ski lifts, but that is not the only adjustment that may be necessary.

In summary, do not fiddle with your bindings and use a ski rental shop with a technician who requires the complete dataset and asks the right questions! It’s what instructors (should) do.

IA Jenkins, Alpine Ski Instructor, British Association of Snowsports Instructors Consultant, Children’s Hospital, Bristol

Please take your seats

Sir, – I read with interest the behavioural observations made by Dr Gray in his roles co-ordinating revision courses for surgical and anaesthetic trainees (Bulletin 33, September 2005, page 1684). Having completed basic surgical training and obtained the MRCS (Eng.) in January 2004, and then subsequently seeing the light and resigning my surgical career to become an SHO trainee in anaesthesia, I feel I may be in a position to suggest reasons for the differing seating behaviours exhibited by trainees of the two specialties when attending lectures.

Firstly, if we look at the roles of trainees in their joint working environment, the operating theatre, the nature of the surgical beast is to make a beeline for the operating table. As a petrified inexperienced surgeon, one must quickly learn the rules of survival in theatre. The best method of avoiding the wrath of the scrub nurse or consultant surgeon is not to touch anything but the sterile sanctity of the drapes around the operative field. You soon realise that to receive any training or reference at all, you must be at the cutting edge of the wound, head to head with the senior surgeon, appearing keen and willing to learn. The trainee surgeon develops and perhaps extrapolates this survival tactic when in a lecture theatre, heading straight for the front rows, giving Dr Gray the impression that this SHO species is more eager to learn than their anaesthetic trainee counterparts.

Secondly, the anaesthetic trainee has a completely different role at the head end of the table. Having successfully negotiated induction of anaesthesia, this breed of SHO must then develop the knack of being able to watch everything going on in the theatre environment, lest it should interfere with the smooth functioning of the patient’s physiology and subsequently causing chaos on a neat, tidy anaesthetic chart. The anaesthetic trainee, I quickly learned, has to be able to look above and beyond the sterile field, and the best place for that is just that bit further away from the aforementioned danger zone. The anaesthetic trainee, either by instinct or conditioning, gravitates to positions in any theatre, be it operating or lecture, which offer the best vantage point to observe not only the action on centre stage but all around in the audience. As Dr Gray has encountered at first hand, this means that the wary anaesthetic trainees may need a bit more coaxing to use the front rows of a lecture theatre, as this really is not their natural habitat.

Reflecting upon my own career behaviour, I noticed that throughout medical school lectures, and even in the cinema, I have never liked sitting in the front rows. I always sit in the middle rows of any theatre, even as a surgical trainee on postgraduate courses. I like to ‘people watch’, or if you prefer, be a bit nosey. Had I applied the ‘Gray Principle’ to my own seating behaviour throughout life, perhaps I would never have embarked upon surgical training and saved myself a couple of years of confusion and several hundred pounds on books and courses!

One final point, if I may, is the obvious need for the anaesthetist to employ another act of self-preservation. By sitting further back from the lecture podium or operative field, safely nestled behind a carefully constructed blood brain barrier, the anaesthetic beast protects itself from the inevitable sprays of bodily fluids…

A Darweish, SHO, Exeter

The author advises the College that this letter has also been published in the Bulletin of the Royal College of Surgeons of England.
Sir, – Whilst reading Dr D Gray’s comments on the differing behaviours of anaesthetic and surgical SHOs in filling a lecture theatre (Bulletin 33, September 2005, page 1684), it occurred to me that the candidates may be diffusing in accordance with one of the gas laws that are all too familiar to our anaesthetic colleagues.

Following a quick browse through my A-level Chemistry textbook I happened upon Graham’s law of gaseous diffusion and effusion. It states that all gases spontaneously diffuse at a rate proportional to the square roots of their densities.

My hypothesis obviously falls down on the fact that it implies that surgeons are somewhat denser than anaesthetists – but that’s another debate altogether!

N Hopper, SpR General Surgery, Bangor

Time for a Uni-form?

Sir, – Two letters have appeared recently proclaiming the potential virtue of a nationally agreed and standard anaesthetic chart

Dr S Kannan (Bulletin 32, July 2005 pg 1630-1631).

Dr J Nunez (Bulletin 33, September 2005 pg 1684). As Dr Kannan points out, a lot of time is spent locally trying to devise these documents. However, if this process is removed from the ultimate users, it is even less likely that the optimum result will arise.

It is proposed that the current range of charts can add to clinical risk by mistakes as a consequence of unfamiliarity in layout. I would argue that one of the functions of a chart is as an aide-memoir to anaesthetists. This is reflected in local charts, which may reflect local clinical practice variations. This function would be lost in a unified chart.

Perhaps the main function of the chart is as a monitor through the course of an anaesthetic, I have practised in three continents and the anaesthetic charts have always had a simple grid with numbers at the side to meet this demand. There is no need to be prescriptive about this important function as it is already universally adopted.

I am not sure where the anticipated cost savings come from. Traditionally costs are kept down by competition. Will one national provider give us better value? Any bulk savings would be lost in re-negotiating our current stationary contracts.

And what about the surgeons? If I buy a new car and park it next to my surgical colleagues’ smaller version in the car park, given the surgical mind, he cannot but retaliate by buying an even bigger one. The same will apply to the proposed oversized anaesthetic chart on thick paper advocated by Dr Nunez.

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G Bell, Consultant, Glasgow

ELECTION TO THE SCOTTISH BOARD 2005

Two consultant vacancies on the Scottish Board occur in December 2005. These arise from the retirement of Dr Iain Levack, after completing his full term of service in this capacity, and the resignation of Dr Neil Morton.

At the closing date for applications on Monday, 5 September 2005, two candidates had given notice that they intended to stand for these vacancies. As no other nominations have been received, no ballot is required. The candidates below are therefore elected, effective Monday, 5 December 2005.

Dr David Henry Thomson Scott (Fellow: 1976) (Date of Birth: 19 February 1949) Royal Infirmary of Edinburgh

Dr David Taylor Brown (Fellow: 1977) (Date of Birth: 6 February 1949), Royal Infirmary of Edinburgh.
THE MERSEY WEEKEND SERIES

FINAL FRCA VIVA WEEKEND
2.00 pm Friday, 2 December to 4.00 pm Sunday, 4 December 2005
University Hospital, Aintree, Liverpool

‘Organisation was excellent.’
‘This course has saturated me with more formal vivas than I could ever have arranged myself.’
‘Excellent to go through long cases – very difficult to practice.’
‘I would recommend this course to my peers as I feel it improves one’s probability of passing by double.’
‘Very relevant viva material, good mix of clinical and science vivas.’
‘Will regard as essential practice before the exam.’
‘To be recommended to everyone preparing for the viva!’
‘Tough weekend but worthwhile.’
‘Quite ingeniously organised.’
‘The course format and repetitive practice at speaking is extremely useful.’
‘The course definitely achieved its objective, my presentation skills have improved.’
‘Excellent preparation – scary and intensive!’
‘My heart-rate now doesn’t go beyond 85bpm before and during vivas.’
‘Long and short cases were brilliant.’
‘My sympathetic systems were in less of an overdrive by the end of the course’.
‘This course will benefit future generations of anaesthetic trainees.’
‘I regret that I didn’t do this course last time as I imagine I failed due to my bad viva technique’
‘Very helpful – makes me feel confident of facing the examiner on the big day.’
‘I feel much less panicked by thought of vivas.’
‘Fantastic course. Definitely the best ever intense viva practice that one can have in the limited time!’

PRIMARY FRCA VIVA WEEKEND
2.00 pm Friday, 16 December to 4.00 pm Sunday, 18 December 2005
University Hospital, Aintree, Liverpool

This course is offered in response to the consensual request and advice of a succession of candidates on the Mersey Selective and Primary MCQ Courses over the last few years. To date, the proposal has been resisted as it is never possible to find a window of opportunity in the short period between the results of the MCQ paper being known and the commencement of the Orals. Such time that there is, is committed to the OSCE/Orals (seven day) Course and the OSCE Weekend Course. However, the Director has been assured enough by the lobbying to stage a weekend of Viva Practice irrespective of the MCQ results being available. The opinion among likely candidates is that, Pass or Fail the MCQ paper, the intense Viva Practice and the intelligence gained from it will always be useful, now or later. The format of the course will be identical to that exercised for the Final FRCA Viva Weekend Course (see below) and it is expected that the candidate satisfaction will be of the matching magnitude.

The aim of the both weekends is to suffuse candidates with so much exposure to Viva Practice that, on the day, they will be immune to the Stress & Stupidity that so often spells disaster.

Registration fee: £250 (including breakfast and lunch)

For further details and an application form, please see our website: www.msoa.org.uk
PRIMARY FRCA OSCE WEEKEND

Primary FRCA Examination OSCE Weekend
12 noon Friday, 13 January to 4 pm Sunday, 15 January 2006
University Hospital, Aintree

Important and Relevant Homework*
Master Class in Communication Skills
Master Class in Oral Presentation Skills
Group Practice of OSCE Stations
Group Analysis of OSCE Stations

Quotes from previous feedback:
‘As good a mixture of silent OSCEs as could be expected.’
‘I feel I have gained a lot from this weekend.’
‘We have done a lot in the time available.’
‘Extremely useful.’
‘A shame the course could not be longer.’
‘I think the course is perfectly balanced keeping in mind the limited time.’
‘The only negative part was the time limitation.’
‘Well structured with exposure to many varied topics.’
‘I am glad I came to this course and cancelled my booking for the other course.’

Registration fee: £250 (including breakfast and lunch)
Please see the website for further details and an application form: www.msoa.org.uk

*Homework: Candidates subscribing to the course will be advised as to the homework which requires to be done in preparation for the course.

NB This course is complementary to the Primary Viva Weekend Course in that it is solely concerned with the OSCE. There are no formal Viva Practice sessions as time does not allow.
APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

The College would like to congratulate the following who were admitted in August:

<table>
<thead>
<tr>
<th>Associate Fellows</th>
<th>Members</th>
<th>Associate Member</th>
</tr>
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<tbody>
<tr>
<td>Dr Mark Rowan Nash</td>
<td>Dr Stephen John Adams</td>
<td>Dr Lourdes Erineu Da Cunha</td>
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<tr>
<td>Dr Rajashekar M Reddy</td>
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DEATHS

The College regretfully records the deaths of the following Fellows:

- Dr Derek W Atherley, Leicester
- Dr Alison S Cunningham, Cambridge
- Dr Jesser S Hind, Great Yarmouth, Norfolk
- Professor Eric Nilsson, Sweden
- Dr Ralph C W Thompson, Essex

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

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

- Dr Devaraja Acharya, West Hertfordshire NHS Trust
- Dr Joseph Azzopardi, Guy’s and St Thomas’ Hospital, London
- Dr Ravishankar Rao Baikady, The Royal Marsden Hospital, London
- Dr Margaret N Coakley, University Hospital of Wales, Cardiff
- Dr Douglas Duncan, Western General Hospital, Edinburgh
- Dr Martin James Feast, Sheffield Teaching Hospitals NHS Foundation Trust
- Dr Philip Stuart Jones, St Bartholomew’s Hospital, London
- Dr Roger Piers Lightfoot, Southampton General Hospital
- Dr Jonathan Mole, Queen’s Medical Centre, Nottingham
- Dr Visweswar Nataraj, Royal Surrey County Hospital, Guildford
- Dr Naveen Hosabettu Raj, Royal Liverpool Children’s Hospital
- Dr Justin Roberts, Hope Hospital, Salford
- Dr Shone Smith, Borders General Hospital, Melrose
- Dr Judith Stedeford, Gloucestershire Royal Hospital

The Royal College of Anaesthetists

College Secretary
Mr Kevin Storey

Deputy College Secretary and Training and Examinations Director
Mr David Bowman

Professional Standards Director
Mr Charlie McLaughlan

Director of Education
Mrs Tara Willmott

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Mr Amit Kotecha 020 7908 7339
ansaphone 020 7813 1888
fax 020 7636 8280
email educ@rcoa.ac.uk

Educational approval for Schools of Anaesthesia and hospitals
Ms Marianne Innocenti 020 7908 7339

Examinations Manager
Mr John McCormick 020 7908 7336

Individual Trainees
Mrs Gaynor Wybrow 020 7908 7341

IT Manager
Mr Richard Cooke

Membership Services
Miss Karen Slater 020 7908 7324

Subscriptions
020 7908 7329
Chirocaine Bags and Ampoules (Levobupivacaine Hydrochloride) Prescribing Information. Presentation: Two presentations are available; Chirocaine Solution for Infusion (Bags), and Chirocaine Solution for injection/concentrate for solution for infusion (Ampoules). Chirocaine Solution for Infusion consists of levobupivacaine hydrochloride in sterile water for injection. The ampoules contain levobupivacaine hydrochloride in sterile water for injection. There is no preservative in the solution. The ampoules contain levobupivacaine as levobupivacaine hydrochloride are available in 10ml polypropylene ampoules in packs of 10.

Indications: Adults: Chirocaine bags:
Pain management – Continuous epidural infusion, for the management of post operative pain and labour analgesia.
Surgical anaesthesia – Major, e.g. epidural (including for Caesarean section), intrathecal, peripheral nerve block – Minor, e.g. local infiltration, peribulbar block in ophthalmic surgery.
Pain management – Continuous epidural infusion, single or multiple bolus epidural administration for the management of pain especially post-operative pain in labour analgesia.

Chirocaine ampoules:
Surgical anaesthesia – Bier's block;...events based on experience with bupivacaine. There is no experience of levobupivacaine 7.5mg/ml in obstetric surgery.

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, scrapes, resuscitation equipment and expertise must be ensured. Levobupivacaine should be used with caution for epidural anaesthesia in patients with impaired cardiovascular function e.g. severe cardiac disease or hypovolaemia, patient with known disease with reduced blood flow e.g. shock, diabetes or sepsis, in patients requiring anticoagulant agents with local anaesthetic activity, e.g. minoxidil, in children and patients with impaired renal function, e.g. severe renal failure and patients with liver disease or with reduced liver blood flow e.g. alcoholics or cirrhotics.

Interactions: Chirocaine bags and ampoules: Metabolism 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, bupivacaine or lidocaine. The effects of the local anaesthetics may be potentiated. No clinical studies have been completed to assess levobupivacaine in combination with adrenaline. The effects may be additive. No clinical studies have been completed to assess levobupivacaine in combination with adrenaline. 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 unintentional intravascular injection and may be serious. Adverse local reactions of local anaesthetics can lead to very high spinal anaesthesia with spasm, fever, local anaesthetic toxicity and cardiovascular collapse. The most frequent adverse effects reported with long acting local anaesthetics include hypotension, arrhythmia (tachycardia, arrhythmia), hypotension, increase in heart rate, bradycardia, myocardial ischaemia and severe hypertension that may lead to cardiac arrest. Neurological damage is a rare but well recognised complication of regional and particularly spinal anaesthesia. This may result in localized areas of palsy or anaesthesia, motor weakness, loss of motor control and analgesia. These, if severe, may be permanent.

Use in Pregnancy and Lactation: Chirocaine bags and ampoules: Levobupivacaine should not be used during early pregnancy unless clearly necessary. The risk of foetal harm with levobupivacaine and bupivacaine is not established. Levobupivacaine is excreted in breast milk. In the usual amounts, no adverse effects have been reported in breast fed infants. Levobupivacaine is a beta inhibitor and may cause hypotension. The effects may be additive. No clinical studies have been completed to assess levobupivacaine in combination with adrenaline. Further information is available on request from Abbott Laboratories Ltd., Abbott House, Norden Road, Maidenhead, Berkshire, SL6 4XE PI/93/1-2/001.

Date of Preparation: March 2004.

Why take extra risk? Equal efficacy & lower toxicity than bupivacaine.

Chirocaine® levobupivacaine HCl

Operating with care
ALL AGES  ALL STAGES

Sevoflurane

FROM INDUCTION TO MAINTENANCE